DESOTO MEMORIAL HOSPITAL MEDICAL STAFF BYLAWS

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DEFINITIONS

1. **ALLIED HEALTH PROFESSIONAL ("AHP")** means an Advanced Practice Registered Nurse, certified registered nurse anesthetist, or physician assistant who is authorized by law and by the Hospital to provide patient care services under the supervision of a member of the Medical Staff.

2. **BOARD OF DIRECTORS or BOARD** means the DeSoto Memorial Hospital Sub-Agency Board of Directors that serves as the governing body of DeSoto Memorial Hospital.

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

4 **CHIEF OF STAFF or PRESIDENT** means the practitioner elected by the Medical Staff to serve as its principle elected official, who also serves as the Hospital's Chief Medical Officer.

5. **CLINICAL DEPARTMENT or DEPARTMENT** means an organizational unit of the Medical Staff. When members of a department perform professional review functions, such members of the department shall be acting as a professional review committee.

6. **CLINICAL PRIVILEGING or PRIVILEGING** means the process of determining a health care professional's current skill and competence to perform specific diagnostic or therapeutic procedures that he/she requests, and that the Hospital has the capability and resources to provide, and granting him/her the privilege of performing/conducting those specific procedures.

7. **COMPLETE APPLICATION** means the DeSoto Memorial Hospital Application for Appointment to the Medical Staff approved by the DeSoto County Hospital Board, containing all the information requested, signed and dated by the applicant, along with the completed Delineation of Privileges form and any other attachments, document(s), and information requested, including but not limited to the required number of peer references, and the completed health questionnaire which includes the date of last PPD or other TB screening test, and/or chest x-ray, and date of last flu vaccination.

8. **CREDENTIALING** means the process of reviewing, verifying and evaluating a health care professional's education, clinical training, licensure, board and other certification, clinical experience, letters of reference, other professional background required for membership, affiliation, or a position within the Hospital.

9. **EX OFFICIO** means service as a member of a body by virtue of an office or position held and, unless expressly provided, means without voting rights.

10. **HOSPITAL** means the Hospital operated by the DeSoto County Hospital District doing business as DeSoto Memorial Hospital.

11. **INFORMATION** means record of proceedings, minutes, records, reports, memoranda, statements, recommendations, findings, evaluations, opinions, actions, data, and other disclosures, whether in written or oral form, relating to any of the subject matter.

12. **MEDICAL EXECUTIVE COMMITTEE or MEC** means the Executive Committee of the Medical Staff.

13. **MEDICAL STAFF OR STAFF** means the formal organization of all fully licensed physicians, dentists, oral surgeons, podiatrists, and clinical psychologists who have been appointed and granted clinical privileges by the Board.

14. **MEDICAL STAFF YEAR** means the period from January 1 to December 31.

15. **MEDICO-ADMINISTRATIVE OFFICER** means a practitioner, employed by or otherwise serving the Hospital on a full or part-time basis, whose duties include certain responsibilities, which are both administrative and clinical in nature. Clinical responsibilities are defined as those involving professional capability as a practitioner, such as to require the exercise of clinical judgment with respect to patient care and include the supervision of professional activities of practitioners and Allied Health Professionals under his/her direction.

16. **ORGANIZED HEALTH CARE ARRANGEMENT** means the term used by the HIPAA Privacy Rule to describe a clinically-integrated care setting in which patients typically receive health care from more than one provider (such as a hospital and its medical staff) and which benefits from regulation provisions designed to facilitate compliance with the HIPAA Privacy Rule.

17. **PATIENT CONTACT** means any admission, consultation, procedure, response to emergency call, evaluation, treatment, or service performed in any facility operated by the Hospital. Patient contact does not include request for diagnostic services from pathology, radiology, or other departments of the Hospital.

18. **PREROGATIVE** means a participatory right granted by virtue of Staff category or otherwise, to a Medical Staff member or allied health professional and exercisable subject to the conditions imposed in these Bylaws and in other Hospital and Medical Staff Rules and Regulations, and policies.

19. **PHYSICIAN** means an individual with an M.D. or D.O. degree who is fully licensed to practice medicine in all its phases.

20. **PRACTITIONER** means a licensed physician, dentist, oral surgeon, podiatrist, or clinical psychologist.

21. **PROFESSIONAL PRACTICE EVALUATION** includes, without limitation, the evaluation of patient care; the review and setting of standards of medical care; the evaluation of qualifications of

professional health care providers; the evaluation of complaints filed against members of the Medical Staff and others granted clinical privileges or approved to provide specified services in any clinical department of the Hospital; the receipt, review, analysis, and acting upon variance reports, quality and utilization review functions; and other functions and activities related thereto.

22. **PROFESSIONAL PRACTICE EVALUATION** means any individual or group of individuals appointed and/or authorized by the Medical Staff, the Board of Directors, or the CEO to participate in the professional practice evaluation process, and may include members of the Medical Staff, the Allied Health Professional Staff, or the Board, employees, representatives, agents, attorneys, investigators, experts, assistants, clerks, staff, and any other person or organization who assists in performing professional practice evaluation functions or activities.

23. **REPRESENTATIVE** means the Board and any director or committee thereof; the Chief Executive Officer or his/her designee; the Medical Staff Organization and any member, officer, department, or committee thereof; and any individual authorized by any of the foregoing to perform specific information gathering or disseminating functions.

24. **SPECIAL NOTICE** means written notification sent by certified or registered mail, return receipt requested.

25. **THIRD PARTIES** means both individuals and organizations providing information to any Representative.

PREAMBLE

WHEREAS, the DeSoto County Hospital District, a public body originally created pursuant to Chapter 65-1450, Laws of Florida, as amended, and operated in accordance with Chapter 2008-270, Laws of Florida, operates the not for profit DeSoto Memorial Hospital in Arcadia, Florida (the "Hospital") for the purpose of providing patient care, education and research; and

WHEREAS, there is a single organized Medical Staff that has responsibility for the quality of professional services rendered by persons with clinical privileges, as well as the responsibility for accounting therefore to the Board;

THEREFORE, in order to provide for the organization of the Medical Staff and provide a framework to discharge these duties and responsibilities to the Hospital in an orderly fashion, the physicians, dentists, oral surgeons, podiatrists, clinical psychologist and allied health professionals practicing in DeSoto Memorial Hospital shall function and act in accordance with the following Bylaws and procedures which have been approved by the Medical Staff and the Board. Hospital management shall cooperate and assist Medical Staff members in the accomplishment of their responsibilities to the Hospital.

ARTICLE I. NAME, PURPOSES AND RESPONSIBILITIES

1.1 NAME

There shall be established within DeSoto Memorial Hospital ("Hospital") a Medical Staff, which shall consist of physicians, dentists, podiatrists, and clinical psychologists who have been deemed eligible to apply for Medical Staff membership and/or clinical privileges within the Hospital. No practitioner shall admit or provide medical and health-related services to any patient in the Hospital unless he/she has been granted clinical privileges or temporary privileges. The DeSoto Memorial Hospital Sub-Agency Board of Directors ("Board") shall, in the exercise of its discretion, delegate to the Medical Staff the responsibility for providing appropriate professional care to Hospital patients. The Medical Staff shall conduct a continuing review and appraisal of the quality of professional care rendered in the Hospital and shall report such activities and their results to the Board.

1.2. PURPOSES AND RESPONSIBILITIES

The purposes and responsibilities of the Medical Staff, acting through its duly appointed and functioning clinical departments and committees in accordance with these Bylaws, shall be to:

1.2.1 Provide a formal organizational structure through which the Medical Staff shall carry out its responsibilities and govern the professional activities of its members and other individuals with clinical privileges, and to provide mechanisms for accountability of the Medical Staff to the Board; These Bylaws shall reflect the current organization and functions of the Medical Staff;

1.2.2 Provide patients with the quality of care commensurate with acceptable standards and available community resources;

1.2.3 Collaborate with the Hospital in providing for the uniform performance of patient care processes throughout the Hospital and to serve as a primary means for accountability to the Board concerning professional performance of Practitioners and others with clinical privileges authorized to practice at the Hospital with regard to the quality and appropriateness of health care. This shall be provided through leadership and participation in quality assessment, performance improvement, risk management, corporate compliance, case management, utilization review and resource management, and other Hospital initiatives to measure and improve performance;

1.2.4 Make recommendations to the Board concerning the appointment or reappointment of an applicant to the Medical Staff of the Hospital, to recommend to the Board the Clinical Privileges such applicant shall have in this Hospital and to review and evaluate on a continuing basis such Clinical Privileges as have been granted, and to recommend to the Board any appropriate action that may be necessary in connection with any Medical Staff member;

1.2.5 Establish procedures whereby issues concerning the Medical Staff and the Hospital management or Board may be addressed;

1.2.6 Establish specific rules and regulations to govern actions and professional responsibilities of members of the Medical Staff;

1.2.7 Provide an appropriate educational setting that will maintain scientific standards, lead to continuous advancement in professional knowledge and skill, and encourage and support such clinical and basic research as is authorized from time to time by the Board:

1.2.8 Participate in identifying community health needs and establishing appropriate institutional goals;

1.2.9 Assist the Board by serving as a professional review body in conducting professional review activities, which include, without limitation, focused and/or ongoing professional practice evaluations, quality assessment, performance improvement, and peer review;

1.2.10 Pursue corrective actions with respect to members of the Medical Staff or those individuals granted clinical privileges, when warranted;

1.2.11 Monitor and enforce compliance with these Bylaws, Rules and Regulations, and Hospital policies;

1.2.12 Maintain compliance of the Medical Staff with regard to applicable accreditation requirements and applicable Federal, State, and local laws and regulations; and

1.2.13 Cooperate with universities and other institutions, where appropriate, in undergraduate, graduate and post-graduate education.

ARTICLE II. MEDICAL STAFF MEMBERSHIP

2.1 NATURE OF MEDICAL STAFF MEMBERSHIP

2.1.1 Membership on the Medical Staff is a privilege, which shall be extended only to professionally competent practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws and in the Medical Staff Rules, Regulations and Policies.

2.1.2 No Practitioner shall admit or provide medical or health-related services to patients in the Hospital unless he/she has been appointed to the Medical Staff and has been granted clinical privileges, or temporary privileges pursuant to these Bylaws.

2.1.3 Appointment to and membership on the Staff shall confer on the appointee or member only such clinical privileges and prerogatives as have been granted by the Board in accordance with these Bylaws. A Medical Staff member is not an employee,

independent contractor or agent of DeSoto Memorial Hospital, unless such relationship is separately established by written contract between the Hospital and the Medical Staff member. In the event of a conflict between the language of these Medical Staff Bylaws or the Fair Hearing Procedure and the specific written contract between the Hospital and a Medical Staff member, the language of the contract shall control.

2.2 Organized Health Care Arrangement

The Hospital and all members of the Medical Staff shall be considered members of, and shall participate in, the Hospital's Organized Health Care Arrangement ("OHCA") formed for the purpose of implementing and complying with the Standards for Privacy of Individually Identifiable Health Information ("IIHI") promulgated by the U.S. Department of Health and Human Services pursuant to the Administrative Simplification provisions of the HIPAA. An OHCA is a clinically integrated care setting in which individuals typically receive health care from more than one healthcare provider. The OHCA allows the Hospital to share information with the physicians and the physician's offices for purposes of payment and practice operations. The patient will receive one Notice of Privacy Practices during the Hospital's registration or admissions process, which shall include information about its OHCA with the Medical Staff physicians, allied health professionals with clinical privileges or practice prerogatives, and non-employees who provide patient care under an approved scope of practice. Each Medical Staff member, and each physician with temporary privileges, allied health professional with clinical privileges or practice prerogatives, and non-employee with an approved scope of practice agrees to comply with the Hospital's policies as adopted from time to time regarding the use and disclosure of IIHI and Protected Health Information ("PHI"), as those are defined by the HIPAA or as any similar terms are defined by more stringent state law (collectively, "IIHI/PHI").

2.3 REQUIREMENTS FOR MEDICAL STAFF MEMBERSHIP AND GENERAL QUALIFICATIONS

2.3.1 The Medical Staff includes physicians, dentists, oral surgeons, podiatrists, and clinical psychologists, who are fully licensed by the State of Florida, as permitted by these Bylaws and by the Hospital to provide patient care within the Hospital, and whom the Board appoints. Medical Staff membership is a privilege extended by the Hospital, and not a right of any practitioner or other person. Only those individuals who continuously meet the requirements of these Bylaws shall be extended Medical Staff membership and/or permission to exercise clinical privileges.

2.3.2 Appointment to the Medical Staff or granting of clinical privileges shall confer on the individual only such prerogatives of membership that are granted by the Board or as are afforded to AHPs when clinical privileges are granted to an individual in this category. For purposes of these Bylaws, "membership on" is used synonymously with "appointment to" the Medical Staff. The granting of membership or approval of appointment does not automatically confer clinical privileges. Upon the recommendation of the MEC, the Board has determined the categories of health care professionals eligible for Medical Staff membership and/or clinical privileges, as defined in these Bylaws. All Medical Staff members and individuals with clinical privileges are

subject to these Bylaws and Rules and Regulations. The majority of the Medical Staff must be physicians. Only those individuals meeting all Threshold Eligibility Criteria shall be eligible to apply for appointment to the Medical Staff or clinical privileges, and these professional criteria shall apply uniformly to all applicants.

2.4 THRESHOLD ELIGIBILITY CRITERIA

2.4.1 In order to be eligible for membership on the Medical Staff, or to apply for clinical privileges, an applicant must be a physician, dentist, oral surgeon, podiatrist, or clinical psychologist. Certified registered nurse anesthetists, advanced registered nurse practitioners, physician assistants, licensed social workers, and other health care providers recommended by the Medical Staff and approved by the Board are eligible to apply for membership on the Allied Health Professional Staff and to request clinical privileges consistent with their scope of practice and applicable Florida Statutes. Every applicant must meet the following threshold criteria:

2.4.1.1 Graduation from a school of medicine accredited by the Association of American Medical Colleges or the American Association of Colleges of Osteopathic Medicine, or a school of dentistry accredited by the Commission on Accreditation of the American Dental Association, or a school of clinical psychology accredited by the American Psychological Association or a school of podiatry accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association, or other accredited school appropriate to his/her profession; or

2.4.1.2 If the applicant is a physician who is a foreign medical graduate, he/she must have successfully completed the Education Commission for Foreign Medical Graduates (ECFMG) certification process or participated in an accredited Fifth Pathway Program; a d

2.4.1.3 Completed an accredited postgraduate residency training program;

2.4.1.3.1 for physicians, accredited by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) or an equivalent organization in a country eligible for licensure by endorsement of current license by the licensure board;

2.4.1.3.2 for dentists, accredited by the Commission on Dental Accreditation; or

2.4.1.3.3 for oral and maxillofacial surgeons, accredited by the American Association for Oral and Maxillofacial Surgery (AAOMS); or

2.4.1.3.4 for podiatrists, accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association; and

2.4.1.3.5 for clinical psychologists, accredited by the American Psychological Association; and

2.4.1.4 Have a current, valid, unrestricted license to practice his/her profession in the State of Florida; and

2.4.1.5 Have proof of identity and either U.S. citizenship or evidence of status as a lawful resident of the U.S.; and

2.4.1.6 Where applicable to his/her practice, have a current, unrestricted Federal DEA registration valid for prescribing within the State of Florida and which permits

him/her to prescribe all medications necessary for the treatment of conditions and diagnoses within his/her areas of practice;

2.4.1.7 Document his/her education, experience, background, training, demonstrated clinical competence, good reputation and character, physical health status, mental and emotional health status with sufficient adequacy to demonstrate to the Medical Staff and to the Board that all patients for whom he/she provides care will receive care of the generally recognized professional level of quality and efficiency;

2.4.1.8 Is determined to be qualified to provide a needed service within the Hospital;

2.4.1.9 Is determined, on the basis of documented references, to adhere strictly to generally recognized standards of professional ethics;

2.4.1.10 Is determined to not be sanctioned or deemed an Ineligible Person by the Office of the Inspector General or the General Services Administration; and

2.4.1.11 Has demonstrated through documented professional and other peer references, the capability to work cooperatively with others, and to be willing to participate in the fulfillment of Staff responsibilities.

2.4.1.12 Board Certification

2.4.1.12.1 Has successfully completed and maintained board certification by a board recognized by the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), the American Association of Physician Specialists (AAPS), the American Board of Oral and Maxillofacial Surgery (ABOMS), the American Board of Podiatric Surgery (ABPS), or the American Psychological Association (APA); or

2.4.1.12.2 Is actively in the process of obtaining said board certification, which process must be completed and said board certification be obtained within five (5) years of the granting of privileges, and affirmatively establishes, through the delineation of privileges process, that he/she possesses current clinical competence; or

2.4.1.12.3 Demonstrates to the satisfaction of the MEC, and ultimately to the satisfaction of the Board, competency and training at least equivalent to that required for board certification. Special consideration will be given to applicants who have successfully completed appropriate postgraduate training and a minimum of five (5) years active hospital practice in a facility Accredited by the Joint Commission and/or the American Osteopathic Association;

2.4.1.13 The foregoing requirements related to board certification shall not apply to those individuals who were granted staff appointment and clinical privileges prior to May 30, 1996. Those individuals shall be bound only by any applicable board certification requirements that were in effect at the time of their appointment;

2.4.1.14 Each practitioner granted admitting privileges shall maintain a residence and practice located close enough to the Hospital to fulfill his/her Medical Staff responsibilities and to provide continuous and timely care for his/her patients at the generally recognized professional level of quality and efficiency established by the Hospital, and in his/her absence shall delegate the

responsibility for care of his/her patients only to a practitioner who is a member in good standing of the Medical Staff and who is qualified and approved by the Hospital to undertake this responsibility by the granting of appropriate clinical privileges;

2.4.1.15 Is determined, on the basis of written documentation, to meet the professional liability insurance/financial responsibility coverage requirements of Article 11.3 of these Bylaws.

2.4.1.16 For a physician requesting admitting privileges, has demonstrated, through documented professional peer references, two (2) years of recent experience in caring for patients in an inpatient setting; and

2.4.1.17 Has paid the required processing fee, as recommended by the Medical Staff and approved by the Board.

2.5 EFFECT OF OTHER AFFILIATIONS

No practitioner shall be automatically entitled to membership on the Medical Staff or to the exercise of particular clinical privileges merely because he/she is licensed to practice in Florida or any other state, or because he/she is a member of any professional organization, or because he/she is certified by any clinical board, or because he/she had or presently has staff membership or clinical privileges at this Hospital or at another health facility or in another practice setting.

2.6 NONDISCRIMINATION

No aspect of Medical Staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, handicap, national origin, or sexual orientation, or on the basis any other criterion unrelated to the delivery of quality patient care in the Hospital, to professional qualifications, to the Hospital's purpose, needs and capabilities, or to community need.

2.7 ADMINISTRATIVE AND MEDICO-ADMINISTRATIVE OFFICERS

If the Hospital should enter into any employment or contractual relationship with a practitioner for any Medico-Administrative function (i.e. any job or position which does not involve patient contact), the position description, terms of employment or contractual relationship, and termination of employment or contract will be determined by the contract negotiated between the Hospital and the individual. Termination of a practitioner's medico-administrative position shall not affect his/her Medical Staff membership or clinical privileges unless otherwise provided for in his/her contract with the Hospital. Should the practitioner be involved with patient care, he/she must obtain and retain Medical Staff membership and clinical privileges as provided in these Bylaws.

2.8 BASIC RESPONSIBILITIES OF INDIVIDUAL STAFF MEMBERSHIP

Every member of the Medical Staff or the Allied Health Professional Staff, regardless of staff category, has a continuing obligation to:

2.8.1 Quality Patient Care
Provide patients with that level of care, skill and treatment which is recognized by a reasonably prudent similar health care provider as being acceptable under similar conditions and circumstances;

2.8.2 Abide by Certain Requirements
Abide by the Medical Staff Bylaws, Rules and Regulations, Department Rules and Regulations, and the Medical Staff and Hospital policies and procedures which are not inconsistent with these Bylaws;

2.8.3 Performance of Medical Staff Obligations
Regularly assume and perform such medical staff, committee, or clinical department obligations for which the member is responsible by Medical Staff category assignment, appointment, election, or otherwise;

2.8.4 Complete Medical Records
Prepare and complete in a timely fashion the medical and other required records for all patients that the Staff member admits or in any way provides care to in the Hospital as set forth in the Medical Staff Bylaws, Rules and Regulations, and/or the Medical Staff and Hospital policies and procedures, department rules;

2.8.5 History and Physical Examinations
Perform a history and physical examination on his/her patients in accordance with the provisions set forth in Appendix A of these Bylaws and in the Medical Staff Rules and Regulations;

2.8.6 Continuing Medical Education
2.8.6.1 Satisfy the continuing medical education requirement established by the Florida Department of Business and Professional Regulation or applicable State agency;
2.8.6.2 At least fifty (50) percent of the hours shall be clinical and directly related to the practitioner's clinical privileges and area(s) of specialty; and
2.8.6.3 Other criteria as from time to time may be established by the MEC or the Board.

2.8.7 Ethics
Abide by the generally recognized standards for the profession, and by the Hospital's Code of Conduct and its Ethics and Corporate Compliance policies and procedures;

2.8.8 Patient Care
Provide continuous care and supervision as needed to all Hospital patients for whom he/she is responsible in a manner consistent with ethical and professional guidelines and standards;

2.8.9 Health Status

Possess the ability to safely and competently perform the clinical privileges requested and granted, and report any changes in health status that would affect his/her ability to practice to the Chief of Staff and the CEO within five (5) business days.

2.8.10 Liability Insurance/ Financial Responsibility

Have and continuously maintain professional liability insurance and/or demonstrate compliance with the financial responsibility provisions of Florida Statutes 458.320 and/or as required by the Board, and request and authorize the insurance carrier or financial institution involved to notify the CEO, within five (5) working days, of cancellation, reduction or termination of insurance coverage, escrow account, or irrevocable letter of credit.

2.8.11 Practice Act Compliance

Remain in compliance with Florida Statutes ("FS") 458.320 and the rules promulgated thereunder if a doctor of medicine, or FS 459.0085 if a doctor of osteopathy, or FS 466 if a doctor of dentistry, oral maxillary surgery, podiatry, or FS 490 if a psychologist.

2.8.12 Professional Liability Claims

Report receipt of notification of being named in a professional liability claim, and any final judgments and/or settlements involving professional liability claims to the Hospital CEO within five (5) business days after they are entered or made.

2.8.13 Working Cooperatively

Work cooperatively with Medical Staff members and other members of the patient care team, and avoid behavior that is offensive or disruptive.

2.8.13.1 Offensive behavior shall include:

- 2.8.13.1.1 Use of profanity or obscene gestures in the presence of a patient, visitor, employee or other practitioner or
- 2.8.13.1.2 Loud or boisterous displays of anger, or
- 2.8.13.1.3 Threats of physical harm directed at others; or
- 2.8.13.1.4 Use of racial, ethnic or religious names, terms or labels of a type generally recognized as being offensive; or
- 2.8.13.1.5 Making adverse or critical comments about the professional competency or ability of another patient care professional in the presence of a patient, visitor, employee or other provider; or
- 2.8.13.1.6 Taking or advocating any action or course of action that he/she has been warned not to do by the, Chief of Staff, the Medical Executive Committee, the CEO, or the Board.

2.8.14 Providing Requested Information

Provide timely information requested by the MEC or by the CEO or the Board regarding his/her ability to continuously meet the qualifications, standards, and requirements of these Bylaws;

2.8.15 Disclosing Adverse Action Taken

2.8.15.1 Inform the MEC or the CEO of any action taken by any hospital or health care institution to limit, restrict, deny, revoke, or suspend his/her staff membership or clinical privileges within five (5) business days; or

2.8.15.2 Any limitation, restriction, suspension or revocation of his/her professional or controlled substances licenses immediately;

2.8.16 Patient Referral

Refrain from fee splitting or other inducements relating to patient referral;

2.8.17 Delegating Responsibility

Refrain from delegating responsibility for diagnosis or care of hospitalized patients to a practitioner or an AHP who is not qualified to undertake this responsibility and/or who is not adequately supervised;

2.8.18 Identity of Practitioner Providing Services

Refrain from deceiving patients as to the identity and/or professional credentials of any practitioner(s) or allied health professionals providing treatment or services;

2.8.19 Consultation

Seek consultation whenever necessary and provide consultation as required by the Medical Staff Bylaws, Rules and Regulations, and/or Medical Staff or Hospital policies and procedures.

2.8.20 Disaster Planning

Participate in the Hospital's Disaster Plan and serve on a disaster call roster as determined by the Medical Staff Bylaws, Rules and Regulations of the department in which the practitioner has clinical privileges and Hospital policies and procedures; and

2.8.21 Conflict of Interest

Disclose any conflict of interest or potential conflict of interest in any transaction, occurrence or circumstance which exists or may arise with respect to his/her participation on any committee, hearing panel, appellate review panel or in his/her activities in Medical Staff affairs, including departmental activities and case reviews. Where such conflict of interest exists or may arise, the practitioner shall not participate in the activity or, as appropriate, shall abstain from voting, unless the circumstances clearly warrant otherwise. This provision does not prohibit any person from voting for himself/herself, nor from acting in matters where all others who may be significantly affected by the particular conflict of interest consent to such action. Further, no practitioner shall participate on any committee, hearing panel, appellate review panel, nor shall he/she participate in any other Medical Staff or departmental affairs concerning an affected practitioner when the practitioner is a relative of the affected practitioner, or has a relative who is in a direct professional or business relationship with

the affected practitioner or otherwise has a conflict of interest in the matter which should prohibit him/her from participating.

2.9 DURATION OF APPOINTMENT

2.9.1 Initial Appointment All Initial appointments regardless of the staff category and all initial grants of clinical privileges, whether at the time of appointment, reappointment, or during the term of an appointment, will be provisional and shall be for a period of one (1) year.

2.9.2 Upon recommendation of the Department Chairman and the MEC, a member's provisional status may be extended for a period up to one (1) additional year if the observation requirements of Article 2.10 are not satisfied. In the event the Provisional period is extended, the MEC may recommend to the Board that change(s) be made in staff category, department assignment, or clinical privileges.

2.10 OBSERVATION

2.10.1 Initial (Provisional) Appointment Observation

2.10.1.1 All provisional appointments and initial grants of clinical privileges shall be subject to a period of observation. Each appointee shall be assigned to a clinical department, as defined in Article VI of these Bylaws, where his/her performance will be subject to observation by the chairman of the department(s) in which he/she holds clinical privileges, or by members of the department(s) as designated by the chairman, and/or through the professional practice review process.

2.10.1.2 The initial observation period shall be for a period of twelve (12) months. If it is determined that the provisional appointee does not have sufficient patient contacts to adequately evaluate his/her quality of care and current clinical competence during this twelve (12) months or if there is a question regarding his/her patient care or behavior, upon recommendation of the department chairman and the MEC, and with approval by the Board, his/her provisional status may be extended for a period of no more than twelve (12) additional months. If the provisional appointee does not have sufficient patient contact to adequately evaluate his/her quality of care and current clinical competence within this extended period his/her appointment and clinical privileges will be deemed to have been automatically terminated.

2.10.1.3 Provisional Courtesy and Provisional Consulting members without Admitting Privileges will have the option of assisting the Hospital to obtain primary source verification of activity and quality of care data from the facility where he/she maintains his/her primary practice, sufficient to permit the Medical Staff and Hospital to evaluate his/her quality of care and current clinical competence. If he/she is unable or unwilling to provide this information at least thirty (30) days, prior to the reappointment date his/her appointment and clinical privileges will be deemed to have been automatically terminated.

2.10.2 Term of Observation Period

An observation period for initial appointment or for a modification of membership status or privileges shall extend for no more than twelve (12) months without being subject to review. If deemed necessary by the department chairman and MEC, the appointee shall remain in the provisional status and observation shall be extended for a period of up to twelve (12) additional months.

2.10.3 Right to Due Process

Any provisional appointee or Medical Staff member affected by the provisions of this Article 2.10 shall be given special notice of such termination and shall be entitled to the procedural rights provided in Article XIII of these Bylaws and in the Fair Hearing Plan

2.11 LEAVE OF ABSENCE

2.11.1 Members of the Medical Staff must report to the Chief of Staff and the CEO any time they are away from medical and/or patient care responsibilities for longer than thirty (30) days, and shall provide the reason for such absence.

2.11.2 A practitioner appointed to the Medical Staff may request a leave of absence by submitting a written request to the Chief of Staff and CEO. The request must state the beginning and ending dates of the leave, which shall not exceed one year, and the reason(s) for the leave. For leaves of absence other than leaves for urgent medical reasons, the request for the leave must be accompanied by evidence that the practitioner has completed all medical records.

2.11.3 The Chief of Staff shall consult with the relevant Department Chairman and the CEO, and submit the results of their review of the request to the MEC for action. If the leave is requested because of an urgent medical reason, the Chief of Staff and CEO can grant the leave temporarily and then submit at the next meeting of the MEC for ratification, and then forwarded to the Board for approval.

2.11.4 During the leave of absence, the practitioner shall not exercise any admitting or clinical privileges at the Hospital. In addition, the individual shall relinquish all Medical Staff prerogatives and responsibilities (including without limitation meeting attendance, committee service, voting rights, Emergency Department call obligations) during the period of the leave of absence.

2.11.5 The granting of a leave of absence or reinstatement from a leave of absence may be conditioned upon the practitioner's completion of all medical records.

2.11.6 Practitioners requesting reinstatement shall submit a written summary of their professional activities and other relevant activities during the leave, and any other information that may be requested by the Hospital or the Medical Staff. Requests for reinstatement shall then be reviewed by the chairman of the relevant department(s),

the Chairman of the Credentials Committee, the Chief of Staff and the CEO. If all these individuals make a favorable recommendation on reinstatement, the practitioner may immediately resume clinical practice at the Hospital. This determination shall then be forwarded to the Credentials Committee, then to the MEC, then to the Board for review and approval. If, however, any of the individuals reviewing the request have any questions or concerns, those questions may be noted and the reinstatement request shall be forwarded to the full Credentials Committee and then to the MEC for review and recommendation; and then to the Board for review and approval. However, if a request for reinstatement is not granted for reasons related to clinical competence or professional conduct, the practitioner shall be entitled to request a hearing and appeal under the Fair Hearing Plan.

2.11.7 If the leave of absence was for health reasons, the request for reinstatement must be accompanied by a report from the practitioner's physician(s) indicating that the practitioner is physically and/or mentally capable of resuming his/her hospital practice and safely exercising the clinical privileges requested.

2.11.9 Failure to request reinstatement, without good cause, will be deemed a voluntary resignation from the Staff and will result in automatic termination of Staff membership, clinical privileges, and prerogatives.

2.11.10 A practitioner whose membership is so terminated shall be entitled to the procedural rights provided in Article XIII and the Fair Hearing Plan for the sole purpose of determining the issue of good cause. A request for Staff membership so terminated shall be submitted and processed in the manner specified for applications for initial appointment.

2.11.11 If a practitioner's current reappointment is due to expire during the leave, the reappointment will be placed on hold until sixty (60) days prior to the expiration of the leave, at which time the Medical Staff Office will notify the individual that he/she must apply for reappointment within fifteen (15) days. If he/she fails to apply for reappointment at this time, his/her Medical Staff appointment and clinical privileges shall automatically terminate at the end of the leave of absence period.

2.11.12 Leaves of absence are matters of courtesy, not a right. In the event that it is determined that a practitioner has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination shall be final, with no recourse to a hearing or appeal.

2.11.13 No leave of absence shall be granted to a practitioner who is under investigation by any Medical Staff or Hospital committee unless such leave of absence is approved by the MEC and the Board.

ARTICLE III. CATEGORIES OF THE MEDICAL STAFF

3.1 CATEGORIES

The Medical Staff shall include Active and Provisional Active categories, and there shall also be Courtesy, Provisional Courtesy, Consulting, Provisional Consulting and Honorary categories.

3.2 ACTIVE STAFF

3.2.1 Qualifications: The Active Staff shall consist of practitioners, each of whom:

3.2.1.1 Meets the basic responsibilities and threshold eligibility criteria set forth in Articles 2.3. and 2.4 of these Bylaws;

3.2.1.2 Has thirty (30) or more patient contacts per year or is otherwise regularly involved in the care of patients and/or Medical Staff affairs, but does not hold admitting privileges, as in the case of pathologists, pediatricians, radiologists, anesthesiologists, emergency physicians, and other specialties for which the Hospital enters into an exclusive agreement to provide call coverage and/or care of patients admitted to an inpatient or observation unit of the Hospital; and

3.2.1.3 Has completed one (1) year of satisfactory performance on the Provisional Active (formerly known as Associate) Staff.

3.2.2 Prerogatives: The prerogatives of an Active Staff member shall be to:

3.2.2.1 Admit patients without limitation, except as noted in Article 3.2.1.2 above;

3.2.2.2 Care for patients within the scope of clinical privileges as are granted to him/her pursuant to Article V;

3.2.2.3 Vote on all matters presented at general and special meetings of the Medical Staff and of the clinical department and committees;

3.2.2.4 Hold office in the Medical Staff organization and in the department, and committees of which he/she is a member.

3.2.3 Responsibilities: Each member of the Active Staff shall:

3.2.3.1 Meet the basic responsibilities and the threshold eligibility criteria set forth in Articles 2.3 and 2.4 of these Bylaws.

3.2.3.2 Retain responsibility within his/her area of professional competence for the continuous care and supervision of each patient in the Hospital for whom he/she is providing services, or arrange a suitable alternative for such care and supervision;

3.2.3.3 Actively participate in:

3.2.3.3.1 Patient care, utilization review, other quality evaluation and monitoring activities, and Medical Staff or Hospital committees to which he/she is appointed;

3.2.3.3.2 Supervising provisional appointees as assigned by the Chief of Staff or department chairman;

3.2.3.3.3 With the exception of any specialty or which the Hospital enters into an exclusive agreement with physician practices to provide call coverage and/or care of patients admitted to an inpatient or observation unit of the Hospital, actively participate in Emergency Department call, and

3.2.3.3.4 Fulfilling such other Staff functions as may be required from time to time;

3.2.3.4 Accept consultation assignments when requested; and

3.2.3.5 Satisfy the requirements set forth in Article 9.7 for attendance at meetings of the Medical Staff, clinical department, and committees of which he/she is a member.

3.3 PROVISIONAL ACTIVE STAFF

3.3.1 Qualifications: The Provisional Active Staff shall consist of practitioners, each of whom:

3.3.1.1 Is eligible for advancement to Active Staff membership and will, in the ordinary course of events and unless he/she requests otherwise, be advanced to Active Staff status after serving at least one (1) year on the Provisional Active Staff, or if not so advanced and except for good cause, may be subject to a reduction or to revocation of his/her membership, as set forth in Article 2.10 of these Bylaws.

3.3.1.2 Meets the basic qualifications and threshold eligibility criteria set forth in Articles 2.3 and 2.4 of these Bylaws; and

3.3.1.3 Has thirty (30) or more patient contacts per year at the Hospital or is otherwise regularly involved in the care of patients and/or Medical Staff affairs, but does not hold admitting privileges, as in the case of pathologists, pediatricians, radiologists, anesthesiologists and emergency physicians, and other specialties for which the Hospital enters into an exclusive agreement to provide call coverage and/or care of patients admitted to an inpatient or observation unit of the Hospital; and

3.3.2 Prerogatives: The prerogatives of a Provisional Active Staff member shall be to:

3.3.2.1 Admit patients under the same conditions as specified for Active Staff members;

3.3.2.2 Exercise such clinical privileges as are granted to him/her pursuant to Article V; and

3.3.2.3 Vote on all matters presented at meetings of the department and committees of which he/she is a member, unless otherwise provided by resolution of the Medical Staff, department or committee, and approved by the MEC and the Board.

3.3.3 Provisional Active Staff members shall not be eligible to:

3.3.3.1 Hold an office in the Medical Staff organization

3.3.3.2 Serve on the MEC, or on the Bylaws or Credentials Committees; or

3.3.3.3 Vote on matters at general Staff meetings.

3.3.4 Responsibilities: Each member of the Provisional Active Staff shall be required to fulfill the same responsibilities as those specified in Article 3.2.3 for members of the Active Staff, with the exception of Article 3.2.3.3.2 (supervising provisional appointees). Failure to fulfill those responsibilities shall be grounds for denial of advancement to Active Staff status.

3.4 COURTESY AND PROVISIONAL COURTESY STAFF

3.4.1 Qualifications: The Courtesy and Provisional Courtesy Staff shall consist of practitioners, each of whom:

3.4.1.1 Meets the basic qualifications and threshold eligibility criteria set forth in Articles 2.3 and 2.4 of these Bylaws; and

3.4.1.2 Has fewer than thirty (30) patient contacts at the Hospital; and

3.4.1.3 Is a member of the Staff of another healthcare facility where he/she actively participates in professional practice and patient care monitoring programs and other quality review, evaluation and monitoring activities similar to those required of the Active Staff of this Hospital, or is an active participant in these activities at DeSoto Memorial Hospital.

3.4.2 Prerogatives: The prerogatives of a Courtesy and Provisional Courtesy Staff member shall be to:

3.4.2.1 Admit patients to the Hospital, or otherwise be regularly involved in the care of patients and/or Medical Staff affairs the Hospital without admitting privileges, as in the case of pathologists, pediatricians, radiologists, anesthesiologists and emergency physicians, and under the same conditions as specified in Article 3.2.3.2 of these Bylaws. At times of full Hospital occupancy or of a shortage of hospital beds or other facilities, as determined by the CEO, the elective patient admissions of Courtesy and Provisional Courtesy shall be subordinate to those of Active and Provisional Active members; and

3.4.2.2 Exercise such clinical privileges as are granted to him/her pursuant to Article V of these Bylaws.

3.4.2.3 Courtesy and Provisional Courtesy staff members may be appointed to serve on Medical Staff or Hospital committees;

3.4.2.4 May vote on matters presented at department meetings and committees to which they are appointed; and

3.4.2.5 Must satisfy the attendance requirements set forth in Article 9.7 of these Bylaws.

3.4.3 Courtesy and Provisional Courtesy Staff members shall not be eligible to:

3.4.3.1 Hold Office in this Medical Staff organization;

3.4.3.2 Serve on the Medical Executive Committee, Bylaws or Credentials Committee; or

3.4.3.3 Vote on matters presented at general staff meetings.

3.4.4 Responsibilities: Each member of the Courtesy and Provisional Courtesy Staff shall:

3.4.4.1 Meet the basic responsibilities and the threshold eligibility criteria specific in Articles 2.3 and 2.4 of these Bylaws;

3.4.4.2 Retain responsibility within his/her area of professional competence for the continuous care and supervision of each patient in the Hospital for whom he/she is providing services, or arrange a suitable alternative for such care and supervision; and

3.4.4.3 Courtesy and Provisional Courtesy Staff may be required to participate in the Hospital's Emergency Department call.

3.5 CONSULTING AND PROVISIONAL CONSULTING STAFF:

3.5.1 Qualifications: The Consulting and Provisional Consulting Staff shall consist of practitioners, each of whom:

3.5.1.1 Meets the basic qualification and the threshold eligibility criteria set forth in Sections 2.3 and 2.4. of these Bylaws;

3.5.1.2 Is a recognized specialist in his/her field; and

3.5.1.2 Is a member of the Medical Staff of another healthcare facility where he/she actively participates in a patient care and professional practice monitoring program and other quality review and monitoring activities, or is an active participant in these activities at DeSoto Memorial Hospital.

3.5.2 Prerogatives: The prerogatives of a Consulting and Provisional Consulting Staff member shall be to:

3.5.2.1 Exercise such clinical privileges as are granted to him/her pursuant to Article V of these Bylaws;

3.5.2.2 Attend meetings of the Medical Staff and any Medical Staff or Hospital education programs.

3.5.2.3. Consulting and Provisional Consulting members are not required to serve on Medical Staff or Hospital committees, but with the exception of the MEC and the Credentials, Bylaws and Professional Practice Committees, they may voluntarily do so with the right to vote.

3.5.3 Shall not be eligible to:

3.5.3.1 Admit patients to the Hospital, except for a patient who requires admission for follow-up care related to a procedure that the consulting or provisional consulting practitioner performed at the Hospital, and only if he/she has been specifically granted such admitting privileges;

3.5.3.2 Hold office in the Medical Staff organization; nor

3.5.3.3 Vote on matters presented at meetings of the Staff. .

3.5.4 Responsibilities: Each member of the Consulting and Provisional Courtesy Staff shall:

3.5.4.1 Meet the basic responsibilities and the Threshold eligibility criteria specific in Articles 2.3 and 2.4 of these Bylaws; and

3.5.4. Retain responsibility within his/her area of professional competence for the continuous care and supervision of each patient in the Hospital for whom he/she is providing services, or arrange a suitable alternative for such care and supervision.

3.6 HONORARY STAFF

3.6.1 Qualifications: The Honorary Staff shall consist of practitioners recognized for their outstanding reputations, their noteworthy contributions to the health and medical sciences, or their previous long-standing service to the Hospital.

3.6.2 Prerogatives: Honorary Staff members are not eligible to admit patients or to exercise clinical privileges in the Hospital. They may, however, attend Medical Staff and department meetings and any Staff or Hospital educational meetings. Honorary Staff members shall not be eligible to vote or to hold office in the Medical Staff organization, but may serve on Medical Staff and Hospital committees, except for the Medical Staff Executive Committee, or on the Bylaws or Credentials Committee, and may vote on matters that come before any committee to which he/she is appointed.

3.6.3 Reappointment: Unless specifically requested by the Medical Executive Committee, members of the Honorary Staff shall be exempt from completing applications for reappointment.

3.7 EMERGENCY DEPARTMENT MEDICAL STAFF

3.7.1 Qualifications: The Emergency Department Medical Staff shall consist of physicians who have requested clinical privileges to screen and treat patients in the Emergency Department and to function as hospitalists in accordance with the Medical Staff Policy and Procedure entitled Emergency Department Admissions to the Hospitalist Program. They must meet the same criteria for appointment as all other categories of Medical Staff members.

3.7.2 Prerogatives:

3.7.2.1 Emergency Department physicians shall be granted limited admitting privileges for the purpose of admitting patients being transitioned from the Emergency Department to an Inpatient or Observation Unit and to function as hospitalists in accordance with the Medical Staff Policy and Procedure entitled Emergency Department Admissions to the Hospitalist Program.

3.7.2.2 The Medical Director of the Emergency Department and one (1) additional Emergency Department physician, as designated by the Medical Director shall be eligible for appointment to the Active Medical Staff after completing one (1) year as a Provisional Active member.

3.8 LIMITATION OF PREROGATIVES

The prerogatives set forth under each Staff category are general in nature and may be subject to limitation by special conditions attached to a practitioner's Staff membership, by other

Sections of these Bylaws, the Medical Staff Rules and Regulations, and by policies of the Medical Staff or Hospital.

3.9 WAIVER OF QUALIFICATIONS

Any qualifications not mandated by federal or state laws and regulations and/or Standards of the Joint Commission, may be waived by the Board upon the recommendation of the MEC, and upon determination that such waiver will serve the best interests of patient care in the Hospital. Any such waiver shall be reviewed at the time of reappointment of the practitioner.

ARTICLE IV. GENERAL PROCEDURES FOR INITIAL APPOINTMENT & REAPPOINTMENT

4.1 GENERAL PROCEDURES FOR INITIAL APPOINTMENT

4.1.1 The Medical Staff, through its designated clinical departments, committees and officers, shall investigate and consider each application for appointment or reappointment to the Staff and for each request for modification of Staff membership status, and for clinical and/or admitting privileges and shall adopt and transmit recommendations thereon to the Board. The Medical Staff shall perform the same investigation, evaluation and recommendation functions in connection with any Allied Health Professional or other individual who seeks to exercise clinical privileges or provide specified services in any clinical department of the Hospital, whether or not such individual is eligible for Staff membership.

4.1.2 No individual shall be denied appointment or clinical and/or admitting privileges on the basis of gender, race, creed, national origin, or sexual orientation.

4.2 APPLICATION CONTENT

The application form shall include:

4.2.1 **Acknowledgment and Agreement:** A statement that the applicant has been given access to, and has had the opportunity to review, these Medical Staff Bylaws and Rules and Regulations, and applicable policies of the Hospital, Medical Staff, Clinical Department and Section, and that he/she agrees to be bound by the terms thereof without regard to whether or not he/she is granted membership and/or clinical privileges, and that the applicant agrees to abide by such Bylaws, Rules and Regulations, and applicable policies as may be from time to time enacted;

4.2.2 **Qualifications:** Detailed information concerning the applicant's qualifications, including information in satisfaction of the TEC specified in Article 2.4 and of any additional qualifications specified in the Bylaws for the particular staff category to which the applicant requests appointment;

4.2.3 **Requests for Staff Category and Clinical Privileges Requests:** stating the Staff category, department and clinical privileges for which the applicant wishes to be considered;

4.2.4 Peer References: The names and contact information of at least three (3) professional peers who have recently worked with the applicant, have directly observed his/her professional performance over a reasonable period of time, and who will provide reliable information regarding the applicant's current clinical competence and ability, ethical character, and ability to work harmoniously with others;

4.2.4.1 One of the peer references shall be from:

4.2.4.1.1 The department chairman or chief of staff at a hospital or healthcare facility where the applicant currently holds appointment to the Active or Provisional Active Staff holds clinical privileges and, actively participates in a patient care monitoring program and other quality review and monitoring activities; or

4.2.4.1.2 The residency director if the applicant has been in practice for less than two (2) years.

4.2.5 Professional Sanctions: Information as to whether any of the following have ever been revoked, suspended, reduced, not renewed, or voluntarily or involuntarily relinquished, and whether action is now pending, and the particulars of any such actions;

4.2.6 Staff membership status and clinical privileges at any other hospitals or healthcare institutions and a copy of his/her case logs for the past two (2) years;

4.2.7 Membership/fellowship in local, state or national professional organizations;

4.2.8 Specialty Board Certification or Eligibility;

4.2.9 License to practice any profession in any jurisdiction;

4.2.10 Participation in any federal or state health insurance program (e.g. Medicare, Medicaid, CHAMPUS);

4.2.11 Drug Enforcement Agency or other controlled substance license number;

4.2.12 Financial Responsibility: A statement, and supporting documentation, indicating that the applicant has met the Financial Responsibility provision of Florida Statutes as outlined in Article 11.3 of these Bylaws; and information on his/her professional liability claims history and experience including, at a minimum, any final judgments or settlements during the past ten (10) years; and a consent to release of information by present and past professional liability insurance carriers and/or financial institutions involved in escrow accounts, irrevocable letters of credit, or other documents used to meet these financial responsibility provisions;

4.2.13 Notification of Release and Immunity Provisions: Statements notifying the applicant of the scope and extent of the authorization, Article 4.3 and Article X of these Bylaws;

4.2.14 Administrative Remedies: A statement whereby the practitioner agrees that when an adverse ruling is made with respect to his/her Staff membership, Staff status and/or clinical privileges, he/she will exhaust the administrative remedies afforded by these Bylaws before resorting to formal legal action;

4.2.15 Location of Practice and Residence: The exact geographic location of the applicant's practice and residence;

4.2.16 Criminal Charges: Information as to whether he/she has ever been named as a defendant and/or convicted in a criminal action and details regarding any such instances;

4.2.17 Citizenship: Information on the citizenship and visa status of the applicant; and

4.2.18 Other Information: Such other information as the Medical Staff and/or Board may require.

4.3 EFFECT OF APPLICATION

Every application for Staff appointment shall be signed by the applicant and in doing so the applicant:

4.3.1 Signifies his/her willingness to appear for interviews in regard to his/her application;

4.3.2 Authorized Hospital representatives to consult with others who have been associated with him/her and/or who may have information bearing on his/her competence and qualifications;

4.3.3 Consents to Hospital representatives inspecting all records and documents that may be material to an evaluation of his/her professional qualifications and competence to carry out the clinical privileges he/she requests, and of his/her ethical qualifications;

4.3.4 Releases all Hospital representatives from any and all liability for their acts performed in good faith and without intentional fraud in connection with evaluating the applicant and his/her credentials;

4.3.5 Releases from any and all liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to Hospital representatives in good faith and without intentional fraud concerning the applicant's competence, professional ethics, character, physical and mental health, emotional stability, and other qualification for Staff appointment and clinical privileges.

4.3.6 Authorizes and consents to Hospital representatives providing other hospitals, medical associations, licensing boards and other organizations concerned with provider performance and the quality and efficiency of patient care with any information

relevant to such matters that the Hospital may have concerning him/her, and releases Hospital representatives from liability for so doing, provided that such furnishing of information is done in good faith and without intentional fraud;

4.3.7 States that he/she has received and read a copy of such Bylaws, Rules and Regulations of the Medical Staff and of the department in which he/she seeks privileges, as are in force at the time of his/her application; and agrees to abide by them without regard to whether or not he/she is granted appointment to the Medical Staff or clinical privileges;

4.3.8 Attests to the accuracy, correctness and completeness of all information furnished or provides an explanation as to those sections of the application which are incomplete;

4.3.9 Agrees to report immediately to the Chief of Staff and the CEO, or his/her designee, any changes in the information provided in his/her application that occurs between the time the application was completed and submitted to the Hospital and the final action on the application by the Board;

4.3.10 Authorizes any of the applicant's insurance carriers and/or financial institutions involved in fulfilling his/her financial responsibility mandated by Florida Statutes as outlined in Article XI Article 11.3 of these Bylaws to furnish the Hospital information when requested by the Hospital.

4.3.11 Agrees to provide patients with that level of care, skill and treatment which is recognized by reasonably prudent similar health care providers as being acceptable under similar conditions and circumstances;

4.3.12 Agrees to participate in emergency call obligations and the care of unassigned patients, and to accept referrals from the Emergency Department for follow-up care of patients treated in the Emergency Department consistent with the practitioner's staff category;

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

4.3.14 Agrees to refrain from delegating responsibility for hospitalized patients to any individual who is not qualified or adequately supervised;

4.3.15 Agrees to refrain from deceiving patients as to the identity of any individual providing treatment or services;

4.3.16 Agrees to participate in an Organized Health Care Arrangement with the Hospital and to abide by the Hospital's Notice of Privacy Practices with respect to health care delivered in the Hospital;

4.3.17 Agrees to notify the Chief of Staff and the CEO or their designees immediately of receipt of any:

4.3.17.1 Notice of the revocation, suspension, restriction, imposition of probation, or the voluntary or involuntary relinquishment of the practitioner's professional license to practice his/her profession or of his/her DEA license in the State of Florida;

4.3.17.2 Notice of being excluded from participation in any federal or state health insurance program including, but not limited to Medicare or Medicaid;

4.3.18 Agrees to notify the Chief of Staff and the CEO or his/her designee, within five (5) calendar days of receiving notice of:

4.3.18.1 A notice of intent to sanction from any peer review or professional review organization; or

4.3.18.2 The revocation, suspension, probation, restriction of Medical Staff membership or clinical privileges at any hospital, or other healthcare organization or institution, or the voluntary or involuntary relinquishment thereof;

4.3.18.3 A notice of intent to sanction from any peer review or professional review organization; or

4.3.18.4 Any notice of the commencement of a formal investigation or the filing of charges by the department of Health and Human services, or any law enforcement agency, health regulatory agency, or professional licensing agency of the United States, the State of Florida or any other state or territory; and

4.3.19 Understands that any misstatement in, or omission from, the application, is grounds for the Hospital to stop processing the application. If appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished. In either situation, there shall be no entitlement to a hearing or appeal in accordance with Article XIII and/or the Fair Hearing Plan;

4.3.20 Agrees that the Hospital has a right to request the results of a current criminal background check and

4.3.21 Supports and participates in the training and education programs of the Hospital.

4.4 PROCESSING THE APPLICATION:

4.4.1 Applicant's Burden:

4.4.1.1 The applicant shall have the burden of producing adequate information for a proper and complete evaluation of his/her background, education, training, experience, current clinical competence and skills, demonstrated ability, ethics, and physical and mental health status, and of resolving any doubts about these or any of the other threshold eligibility criteria ("TEC") specified in Article 2.4 of these Bylaws, and any additional qualifications required for the Staff category to which he/she requests appointment, and of satisfying any reasonable requests for information or clarification (including physical or mental health examinations) made of him/her by representatives of the Medical Staff or the Board.

4.4.1.2 The completed application shall be returned to the CEO or his/her designee within sixty (60) days of the applicant's receipt of said application. In the event the application is not completed and returned in a timely manner, the file will be closed. In that event, should the applicant wish to apply for appointment and/or clinical privileges at any future time, the entire application process will be followed, including the payment of the required application fee.
4.4.1.3 For the purposes of this Article of the Bylaws, the term "completed application" shall be defined as an application that includes all information, documentation and attachments requested.
4.4.1.4 The applicant shall have the burden of providing evidence that the statements made and the information given about the application are factual, true and complete.

4.4.2 Verification of Information: The applicant shall deliver a completed application to the CEO or his/her designee, who shall, in a timely fashion, seek to collect or verify through primary sources (including, but not limited to, the AMA, AOA, and National Practitioner Data Base) licensure, education, specific training, experience and current board certification. The CEO or designee shall promptly notify the applicant of any problem in obtaining the information required, and it shall then be the applicant's obligation to assist the Hospital to obtain the required information. When collection and verification are accomplished, the CEO shall transmit the application and all supporting materials to the Department Chairman and the Medical Staff Credentials Committee.

4.4.3 Department Action: Upon receipt of the completed application and all supporting documentation, the department chairman shall:
4.4.3.1 Review the application and supporting documentation; and
4.4.3.2 Make recommendations to the Credentials Committee as to Staff appointment and, if appointment is recommended, as to Staff category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment and/or clinical privileges.
4.4.3.3 A department chairman may also recommend that the Credentials Committee defer action on the application.
4.4.3.4 The reason for each recommendation shall be stated and supported by reference to the completed application and all other documentation considered by the chairman.

4.4.4 Credentials Committee Action: Upon receipt of the completed application and all supporting documents, the application will be presented at the next regularly scheduled Credentials Committee Meeting. The Credentials Committee shall:
4.4.4.1 Review the application and supporting documentation;
4.4.4.2 Recommend to the Medical Executive Committee as to Staff appointment and, if appointment is recommended, as to Staff category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment; and

4.4.4.3 The Committee may also recommend that the Medical Executive Committee defer action on the application.
4.4.4.4 The reason for each recommendation shall be stated and supported by reference to the completed application and all other documentation considered by the Committee. Any minority views shall be reduced to writing, supported by reasons and references and transmitted to the Medical Executive Committee.

4.4.5 Medical Executive Committee Action: At its next regular meeting after the receipt of the Credentials Committee's report and recommendations, the MEC shall consider information in the application and documents that support the application, the Credentials Committee's recommendation, the recommendation of the department chairman, and other relevant information available to it. The Chairman of the MEC or his/her designee will report the MEC's recommendations as to Staff appointment and, if appointment is recommended, Staff category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment to the Board at the Board's next meeting. The MEC may also defer action on the application.
4.4.5.1 The reasons for each recommendation shall be stated and supported by reference to the completed application and all other documentation considered by the MEC, all of which shall be transmitted with the report. Any minority view shall also be reduced to writing, supported by reasons and references, and transmitted with the majority report.

4.4.6 Effect of MEC Action:
4.4.6.1 Deferral: Action by the MEC to defer the application for further consideration must be followed up within thirty (30) days, with a subsequent recommendation for appointment with specified clinical privileges or for denial of membership.
4.4.6.2 Favorable Recommendation: When the recommendation of the MEC is favorable to the applicant, the Chairman of the MEC or his/her designee shall promptly forward it, together with all supporting documentation, to the Board.
4.4.6.3 For the purposes of this Article 4.4, "all supporting documentation" includes the application form and its accompanying information and the reports and recommendations of the department chairman and of the Credentials Committee and minority views. All recommendations to appoint shall also specifically recommend the clinical privileges to be granted, which may be qualified by any probationary conditions relating to such clinical privileges.
4.4.6.4 Adverse Recommendation: When the recommendation of the MEC is adverse to the applicant, the CEO shall immediately inform the applicant by special notice, and he/she shall be entitled to the procedural rights as provided in Article XIII and in the Fair Hearing Plan. For the purposes of this Article 4.4.6.4, an "adverse recommendation" by the MEC is as defined in Article 13.2.3 of these Bylaws.

4.4.7 Board Action: The Board shall consider all recommendations and supporting documents forwarded to it by the MEC and:

4.4.7.1 On Favorable MEC Recommendation, the Board shall, in whole or in part, adopt or reject a favorable recommendation of the MEC, or refer the recommendation back to the MEC for further consideration, stating the reasons for such referral back and setting a time limit within which a subsequent recommendation shall be made by the MEC.

4.4.7.1.1 If the Board's action is adverse to the applicant, as defined in Article 13.2.3 of these Bylaws, the CEO shall promptly so inform the applicant by special notice, and he/she shall be entitled to the procedural rights as provided in Article XIII and in the Fair Hearing Plan.

4.4.7.2 Without Benefit of MEC Recommendation: If the Board does not receive an MEC recommendation within the time period specified in Article 4.4.12 of these Bylaws, it may, after notifying the MEC, take action on its own initiative in the manner set forth in the Hospital Corporate Bylaws. If such action is favorable to the applicant, it shall become effective as the final decision of the Board. If such action is adverse, as defined in Article 13.2.3 the CEO shall promptly so inform the applicant by special notice, and he/she shall be entitled to the procedural rights as provided by Article XIII and in the Fair Hearing Plan.

4.4.7.3 After Procedural Rights: In the case of an adverse MEC recommendation pursuant to Article 4.4.6, or an adverse Board decision pursuant to Article 4.4.7 the Board shall take final action in the matter only after the applicant has exhausted or has waived his/her procedural rights as provided in Article XIII and in the Fair Hearing Plan. Action thus taken shall be the conclusive decision of the Board.

4.4.7.3.1 The Board may defer final determination by referring the matter back to the MEC for further reconsideration. Any such referral shall state the reason(s) therefor, shall set a time limit within which a subsequent recommendation to the Board shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt;

4.4.7.3.2 After receipt of such subsequent recommendation and of new evidence in the matter, if any, the Board shall make a final determination.

4.4.8 Denial for Hospital's Inability to Accommodate:

4.4.8.1 A recommendation by the MEC or a decision by the Board to deny Staff membership, a clinical department affiliation, a Staff category assignment, or particular clinical privileges, shall not be considered adverse in nature and shall not entitle the applicant to the procedural rights as provided in Article XIII and in the Fair Hearing Plan when such recommendation or decision is made:

4.4.8.1.1 On the basis of the Hospital's present inability, as supported by documented evidence, to provide adequate facilities or support services for the applicant and his/her patients;

4.4.8.1.2 On the basis of an insufficient current or expected patient load to support an additional staff member with the skills and training of the applicant; or

4.4.8.1.3 On the basis of inconsistency with the Hospital's written plan of development, including the mix of patient care services to be provided, as currently being implemented.

4.4.8.2 Upon written request by the applicant to the CEO, the application shall be kept In a pending status for the next succeeding two (2) years. If, during this period, the Hospital finds it possible to accept Staff applications for which the applicant is eligible, and there is no obligation to applicants with prior pending status the CEO shall promptly so notify him/her by special notice. Within thirty (30) days of receipt of such notice the applicant shall provide, in writing on the prescribed form, such supplemental information as is required to update all elements of his/her original application. Thereafter, the procedure for initial appointments provided in Article 4.4 of these Bylaws shall apply.

4.4.9 Conflict Resolution:

4.4.9.1 Whenever the Board's proposed decision will be contrary to the MEC's recommendation, the matter shall be submitted to the Joint Conference Committee for reviewand recommendation before making its final decision (See Article 8.8 of these Bylaws).

4.4.10 Notice of Final Decision:

4.4.10.1 Written notice of the Board's final decision shall be given, through the CEO to the Chairman of the MEC, to the chairman of each clinical department concerned, and to the applicant.

4.4.10.2 A decision and notice to appoint shall include:

4.4.10.2.1 The Staff category to which the applicant is assigned;

4.4.10.2.2 The clinical department to which the applicant is appointed;

4.4.10.2.3 The clinical privileges the applicant may exercise; and

4.4.10.2.4 Any special conditions attached to the appointment.

4.4.11 Reapplication after Adverse Appointment Decision:

An applicant who has received a final adverse decision regarding appointment shall not be eligible to reapply to the Medical Staff for a period of two (2) years. Any such reapplication shall be processed as an initial application and the applicant shall submit such additional information as the Credentials Committee, Medical Executive Committee or the Board may require in demonstration that the basis for the earlier adverse action no longer exists.

4.4.12 Time Periods for Processing:

Applications for Staff appointments shall be considered in a timely and good faith manner by all individuals and groups required by these Bylaws to act thereon and, except for good cause, shall be processed within the time periods as follows:

4.4.12.1 The CEO shall transmit the application and supporting documents, including the recommendation of the department chairman if he/she is not a member of the Credentials Committee, to the Credentials Committee upon completing the required information collection and verification tasks, but in any event within forty-five (45) days after receiving the completed application.
4.4.12.2 The Credentials Committee shall complete its review of the application and supporting documents, and make its recommendation to the MEC within thirty (30) days after receiving it from the CEO.
4.4.12.3 The MEC shall complete its review of the application and supporting documents, and make its recommendation to the Board within fifteen (15) days after receiving the Credentials Committee's report and recommendation.
4.4.12.4 The Board, or the appropriate committee thereof, shall then take final action on the application at its next regular meeting.
4.4.12.5 The time periods specified herein are guidelines to assist those named in accomplishing their tasks, and shall not be deemed to create any right for the applicant to have his/her application processed within those time periods.

4.5. Expedited Initial Appointment Process:

4.5.1 Upon request from the applicant for initial appointment, the expedited credentialing process outlined in the Medical Staff Expedited Credentialing Policy and Procedure may be followed provided:
4.5.1.1 The completed application has been received;
4.5.1.2 All primary source verifications, peer references, affiliation verifications, the National Practitioner Data Bank Report, the criminal background check, and the OIG/GSA sanctions verification are obtained; and
4.5.1.3 There is no current challenge or previously successful challenge to license to practice, or DEA licensure;
4.5.1.4 The applicant has not received an involuntary termination of medical staff or AHP staff membership at another health care organization;
4.5.1.5 The applicant has not received any involuntary limitation, reduction, denial, or loss of clinical privileges at another health care organization;
4.5.1.6 The applicant has not voluntarily resigned his/her medical staff appointment or accepted a limitation, denial or loss of clinical privileges to avoid an adverse action at any other healthcare organization;
4.5.1.7 The applicant has been determined to not be sanctioned or deemed an Ineligible Person by the Office of the Inspector General or the General Services Administration; and
4.5.1.8 The Hospital determines that there has not been either an unusual pattern or excessive number of professional liability actions resulting in final judgment or payment, or pending against the applicant.

4.5.2 Department Chairman Action:

When the applicant for initial appointment requests expedited processing of his/her application, the Department Chairman shall make a recommendation to the Chairman

of the Credentials Committee when all of the requirements set forth in this Article 4.5 and the Medical Staff Expedited Credentialing Policy and Procedure have been met.

4.5.3 Credentials Committee Action:
When the applicant for initial appointment requests expedited processing of his/her application, the Chairman of the Credentials Committee may make a recommendation to the Medical Executive Committee on behalf of the Credentials Committee when all of the requirements set forth in this Article 4.5 and the provisions of the Medical Staff Expedited Credentialing Policy and Procedure have been met.

4.5.4 Medical Executive Committee Action:
When the applicant for initial appointment requests expedited processing of his/her application, the Chairman of the Medical Executive Committee and one other Committee member, who may be the Department Chairman, may make a recommendation to the Board on behalf of the MEC when all of the requirements set forth in this Article 4.5 and the provisions of the Medical Staff Expedited Credentialing Policy and Procedure have been met.

4.5.5 Board Action:
When the applicant for initial appointment requests expedited processing of his/her application, two Board members, designated by the Board, may make a decision on behalf of the Board when all of the requirements set forth in this Article 4.5 and the provisions of the Medical Staff Expedited Credentialing Policy and Procedures have been met.

4.5.6 Appointments and privileges granted under this Expedited Credentialing process shall be reviewed and affirmed at the next regular meetings of the Credentials and Medical Executive Committees and the Board.

4.6 General Procedure for Reappointment:

4.6.1 Reappointments to any category of the Medical Staff shall be for a period not to exceed twenty-four (24) months and insofar as feasible, will coincide with the anniversary date.

4.6.2 If a physician has not utilized the Hospital's facilities and/or services during the previous twelve (12) months, he/she shall be notified, by the CEO, that failure to show good cause for the non-utilization of the Hospital will be deemed a voluntary relinquishment of his/her Staff appointment and clinical privileges, and no reappointment application will be sent to the practitioner, and said practitioner will automatically be removed from the Medical Staff of the Hospital when the current appointment period expires.
4.6.2.1 A Staff member so notified may request that a reappointment application be sent to him/her. The Hospital may, at its sole discretion, approve the request, and if it does so the Staff member will be required to provide a written plan outlining how he/she will use the patient care services of the Hospital if he/she is reappointed.

4.6.2.2 If the Hospital declines the request for a reappointment, such action shall not be considered adverse and shall not entitle the Staff member the right to due process as outlined in Articles XII and XIII of these Bylaws.

4.6.3 Application for Reappointment:

4.6.3.1 At least ninety (90) days prior to the expiration date of the current Staff appointment of each Medical Staff member the CEO or his/her designee shall provide the member with an application for reappointment.

4.6.3.2 Each Staff member who desires reappointment shall send his/her completed reappointment application to the CEO at least forty-five (45) days prior to the expiration date of his/her current appointment. Failure, without good cause, to so return the completed application shall be deemed a voluntary resignation from the Staff and shall result in automatic termination of Staff appointment and clinical privileges at the expiration of the Staff member's current appointment. A practitioner whose Staff membership is so terminated shall be entitled to the procedural rights provided in Article XII and the Fair Hearing Plan for the sole issue of determining the issue of good cause.

4.6.4 Content of the Reappointment Application:

4.6.4.1 The Reappointment Application shall request data necessary to update Medical Staff file on the Staff member's healthcare-related activities and his/her current clinical competence. This form shall include, but not be limited to information about the following:

4.6.4.1.1 Continuing education, training and experience that qualify the Staff member for the privileges sought on reappointment;

4.6.4.1.2 Current physical and mental health status, including TB screening and flu vaccination status;

4.6.4.1.3 The name and address of any organization or any other healthcare organization or practice setting where he/she provided clinical services during the preceding period;

4.6.4.1.4 Memberships, awards, or other recognition conferred or granted by any professional healthcare societies, institutions or organizations;

4.6.4.1.5 Revocation, revision, reduction, limitations, voluntary or involuntary relinquishment of privileges imposed or pending by any other healthcare institution, professional healthcare organization, regulatory agency , or licensing authority;

4.6.4.1.6 Proof of compliance with the Financial Responsibility provisions of applicable Florida Statutes as outlined in Article 11.3 of these Bylaws, including cancellations, non-renewals, and limits;

4.6.4.1.7 Information on claims, law suits, judgments and/or settlements;

4.6.4.1.8 Ability to work collaboratively and respectfully with other members of the healthcare team;

4.6.4.1.9 The names and contact information of peer references according to Staff status of the applicant. Applicants for reappointment to the:

4.6.4.1.9.1 Active status are required to have at least one (1) peer reference provided they have sufficient quality and professional practice data on file at the Hospital. If sufficient data is not available at the Hospital, they will be required to provide two (2) additional peer references

4.6.4.1.9.2 Courtesy or Consulting Staff who have sufficient quality and professional practice data on file are required to provide at least two (2) peer references. If sufficient data is not available at the Hospital, they will be required one (1) additional peer reference.

4.6.4.1.10 Such other specifics about the Staff member's professional ethics, current clinical competence, judgment, clinical skills, qualifications and ability that may bear on his/her ability to provide quality patient care in the Hospital.

4.6.5 Verification of Information:

4.6.5.1 The CEO or his/her designee shall, in timely fashion, seek to collect and verify the information provided on each reappointment application and to collect materials or information deemed pertinent regarding the Staff member's:

4.6.5.1.1 Professional activities, performance and conduct in this Hospital and/or in any other healthcare organization;

4.6.5.1.2 His/her fulfillment of Staff membership obligations; and

4.6.5.1.3 Any physical or mental health issues which may adversely affect his/her ability to provide quality medical care.

4.6.5.1.4 The CEO or his/her designee shall promptly notify the Staff member of any problems or delays in obtaining the required information. The Staff member shall then have the same burden of producing adequate information and resolving any doubts or issues. When collection and verification are accomplished, the CEO shall transmit the information and supporting materials to the chairman of each department in which the Staff member requests privileges.

4.6.6 Department Action:

In the event the chairman of the department(s) in which the applicant seeks clinical privileges is unable to attend the Credentials Committee meeting, he/she shall review the application and all supporting documents, and shall make a written recommendation to the Credentials Committee and the Medical Executive Committee.

4.6.7 Credentials Committee Action:

Upon receipt of the completed application and all supporting documents, the application will be presented at the next regularly scheduled Credentials Committee Meeting. The Credentials Committee shall:

4.6.7.1 Review the application and supporting documentation;

4.6.7.2 Recommend to the Medical Executive Committee as to Staff reappointment and, if reappointment is recommended, as to Staff category, department

affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment; and

4.6.7.3 The Committee may also recommend that the Medical Executive Committee defer action on the application.

4.6.7.4 The reason for each recommendation shall be stated and supported by reference to the completed application and all other documentation considered by the Committee. Any minority views shall be reduced to writing, supported by reasons and references and transmitted to the Medical Executive Committee.

4.6.8 Medical Executive Committee Action:

At its next regular meeting after the receipt of the Credentials Committee's report and recommendations, the MEC shall consider information in the application and documents that support the application, the Credentials Committee's recommendation, and other relevant information available to it. The Chairman of the MEC or his/her designee will report the MEC's recommendations as to Staff reappointment and, if reappointment is recommended, Staff category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment to the Board at the Board's next meeting.

4.6.9 Final Processing and Board Action:

Thereafter, the procedure provided in Articles 4.4.6 through 4.4.10 shall be followed. For purposes of reappointment, the terms "applicant" and "appointment" as used in those Sections shall be read respectively, as "Staff member" and "reappointment."

4.6.10 Basis for Recommendation:

Each recommendation concerning the reappointment of a Staff member and the clinical privileges to be granted upon reappointment shall be based on such member's professional ability and clinical judgment in the treatment of patients, his/her professional ethics, discharge of Staff obligations, compliance with the Medical Staff Bylaws, Rules and Regulations and policies and with Hospital policies, continued good physical and mental health, ability to work collaboratively with other members of the healthcare team and with patients, and other matters bearing on his/her ability and willingness to contribute to quality patient care in the Hospital. The Staff member has the right to submit a peer recommendation of his/her choice to attest to the fact that he/she has satisfactorily demonstrated his/her ability to exercise the clinical privileges to be granted to him/her. The Medical Staff and/or CEO has a right to request such peer recommendations as they deem appropriate.

4.6.11 Time Periods for Processing:

Transmittal of the reappointment application to a Staff member and his/her return of it shall be carried out in accordance with Articles 4.6.3.1 and 4.6.3.2 of these Bylaws. Thereafter, and except for good cause, each person, department and committee required by these Bylaws to act thereon shall complete such action in timely fashion such that all reports and recommendations concerning the reappointment of a Staff

member shall have been transmitted to the MEC for its consideration and action and then to the Board for its action all prior to the expiration date of the Staff appointment of the member being considered for reappointment.

4.7 REQUESTS FOR MODIFICATIONS OF MEMBERSHIP STATUS OR CLINICAL PRIVILEGES:

A Staff member may, either in connection with reappointment or at any other time, request modification of his/her Staff category, department assignment, or clinical privileges by submitting a written application to the CEO. This request must be supported by documentation of additional training and/or experience, and may include a recommendation from his/her peers if the Staff member so desires or if the Medical Staff or CEO requests it. Such application shall be processed in substantially the same manner as provided in Article 4.5 for reappointment.

ARTICLE V. DETERMINIATION OF CLINICAL PRIVILEGES

5.1 EXERCISE OF PRIVILEGES:

A practitioner or AHP providing direct clinical services at the Hospital by virtue of Medical Staff membership or otherwise shall, in connection with such practice and except as otherwise provided in Articles 5.5 and 5.6, be entitled to exercise only those clinical privileges or specified services specifically granted to him/her by the Board. Said privileges and services must be within the scope of his/her license, certificate or legal credential authorizing him/her to practice in the State of Florida and consistent with any restrictions thereon. No Staff member shall admit or provide services to patients in the Hospital unless he/she is a member of the Staff or has been granted temporary privileges in accordance with the procedures set forth in Article 5.5. of these Bylaws, or is providing services to a patient under the conditions provided in Article 5.6.

5.2 DELINEATION OF PRIVILEGES:

5.2.1 Requests:

Each application for appointment and reappointment to the Medical Staff must include a request for the specific clinical privileges desired by the applicant, made by completing the Delineation of Privileges form recommended by the MEC and approved by the Board.

5.2.2 Basis for Privileges Determination:

Requests for clinical privileges shall be evaluated on the basis of the practitioner's current licensure, education, training, experience and demonstrated ability, health status and judgment. The basis for privilege determinations to be made in connection with appointment, reappointment, revocation, or revision, shall include quality of care, observed clinical performance and the documented results of the patient care monitor and other quality review and evaluation activities required by these Bylaws, the Hospital Corporate Bylaws, and by Medical Staff and/or Hospital policies. Privilege determinations shall also be based on pertinent information concerning clinical performance and quality of patient care information obtained from other sources,

especially other institutions and health care setting where a practitioner exercises, or has exercised clinical privileges. This information shall be maintained in the Medical Staff credentials file and/or the practitioner's quality file established for the Staff member.

5.2.3 Procedure:

All requests for clinical privileges shall be processed as outlined in Article IV of these Bylaws.

5.3 SPECIAL CONDITIONS FOR CONSULTING, DENTAL AND PODIATRIC PRIVILEGES:

Requests for clinical privileges from Consulting Staff members, dentists and podiatrists shall be processed in the manner specified in Article 5.2. Surgical procedures performed by consulting physicians, dentists, and podiatrists shall be under the overall supervision of the Chairman of the Department of Surgery or his/her designee. At the discretion of the operating surgeon and/or anesthesia provider, patients of Consulting Staff members, dentists, and podiatrists shall receive the same basic medical appraisal as patients admitted to other surgical services, by a physician member of the Active Medical Staff, who shall also be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization and shall determine the risk and effect of the proposed surgical procedure on the total health status of the patient.

5.4 SPECIAL CONDITIONS FOR ALLIED HEALTH PROFESSIONALS:

Requests to perform specified patient care services from AHP's shall be processed in the manner specified in the Allied Health Professional Bylaws of the Hospital. An AHP may, subject to and licensure requirements or other legal limitations, exercise independent judgment within the areas of his/her professional competence, and may participate directly in the medical management of patients under the supervision of a physician who has been accorded privileges to provide such care and who has ultimate responsibility for the patient's care.

5.5 TEMPORARY PRIVILEGES:

5.5.1 Circumstances:

Upon the concurrence of the Chairman of each Department(s) where privileges will be exercised, and the Chairman of the Credential Committee, and upon the applicant having met all the conditions as set forth in Article 5.2.2, the Chief of Staff and the CEO may grant temporary privileges in the following circumstances:

5.5.1.1 **Pendency of Application:**

Temporary privileges may be granted for a maximum period of ninety (90) consecutive days, with or without special requirements of supervision and reporting when:

5.5.1.1.1 An applicant for initial appointment has submitted a completed application and the application is pending review by the Medical Executive Committee and/or the Board;

5.5.1.1.2 The verification process has been completed, including verification of current licensure, relevant training and experience, board certification,

ability and current clinical competence to exercise the privileges requested and current financial responsibility documentation in accordance with the provisions of the applicable Florida Statutes, claims history, assessment of physical and mental health, compliance with privileges criteria, consideration of information from the National Practitioner Data Bank and the OIG/GSA query; and

5.5.1.1.3 The applicant has demonstrated that there are no current or previously successful challenges to his/her licensure or registration, and he/she has not been subject to involuntary termination of Medical Staff membership, or involuntary limitation, reduction, denial, or loss of clinical privileges at another health care facility;

5.5.2 Care of Specific Patients:

Upon receipt of a request for specific temporary privileges to provide care for a specific patient, an appropriately licensed practitioner of documented competence, who is not an applicant for appointment to the Medical Staff may be granted temporary privileges for the care of one or more specific patients. Such privileges shall be exercised with the conditions specified in Article 5.5.6 and shall be restricted to the treatment on a case by case basis by any practitioner, after which such practitioner shall be required to apply for appointment to the Medical Staff before being permitted to attend additional patients.

5.5.3 Locum Tenens:

Upon receipt of a request for specific temporary privileges, an appropriately license practitioner of documented competence who is serving locum tenens for a member of the Medical Staff without applying for appointment to the Medical Staff may be granted temporary privileges for an initial period of thirty (30) days. Such privileges may be renewed for two (2) successive periods of thirty (30) days each, but not to exceed his/her service as locum tenens, shall be limited to treatment of the patients of the practitioner for whom he/she is serving as locum tenens, and shall be exercised in accordance with the conditions specified in Article 5.5.4. He/she shall not be entitled to admit his/her own patients to the Hospital.

5.5.4 Conditions:

5.5.4.1 Temporary privileges shall be granted only when the information available reasonably supports a favorable determination regarding the requesting practitioner's qualifications, ability and judgment to exercise the privileges requested, and only after the practitioner has satisfied the requirements regarding the financial responsibility provisions of applicable Florida Statutes as outlined in Article XI of these Bylaws.

5.5.4.2 Special requirements of consultation and reporting may be imposed by the Department Chairman/Chairmen responsible for supervision of a practitioner granted temporary privileges.

5.5.4.3 Before temporary privileges are granted, the practitioner must acknowledge in writing that he/she has received or been given access to, and has read the Medical Staff Bylaws and Rules and Regulations, and applicable Medical Staff, Hospital, and Departmental policies and procedures, and that he/she agrees to be bound by the terms thereof in all matters relating to his/her exercise of the temporary privileges extended to him/her.

5.5.5 Revocation/Termination of Temporary Privileges:

5.5.5.1 The CEO or the Chief of Staff shall, upon discovery of any information or the occurrence of any event that raises questions about the practitioner's professional qualifications, conduct, or ability to exercise any or all of the temporary privileges granted, and may at any other time after consultation with the Department Chairman responsible for supervision of the practitioner, terminate any or all of said practitioner's temporary privileges.

5.5.5.2 If a situation arises where the life or well-being of a patient is determined to be endangered by continued treatment by the practitioner, the termination may be affected by any person entitled to impose a precautionary suspension under Article XII of these Bylaws.

5.5.5.3 Temporary privileges will be immediately revoked by the Chief of Staff and/or the CEO upon notice of any failure by the practitioner to comply with any special requirements of supervision and reporting conditions.

5.5.5.4 In the event of any such termination, the practitioner's patients then in the Hospital shall be assigned to another practitioner by the Department Chairman responsible for supervision. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner.

5.5.6 No Procedural Rights:

5.5.6.1 The granting of temporary admitting privileges and /or clinical privileges is a courtesy on the part of the Medical Staff and Hospital. Neither the granting, denial, modification, restriction, nor termination of temporary privileges shall entitle the individual concerned to any of the procedural rights provided by these Bylaws, without limitation, with respect to hearings and appeals as set forth in Articles XII and XIII of these Bylaws.

5.5.6.2 Nothing herein shall be construed as entitling the practitioner:

5.5.6.2.1 with emergency privileges to compensation from the Hospital;

5.5.6.2.2 to bill patients or other third parties for services; or

5.5.5.2.3 to Medical Staff appointment or privileges other than as described herein.

ARTICLE VI. CLINICAL DEPARTMENTS

6.1 ORGANIZATION OF CLINICAL DEPARTMENTS:

Each clinical department shall be organized as a separate part of the Medical Staff and shall have a chairman who is elected by the Medical Staff and has the authority, duties and responsibilities as specified in Article VII.

6.2 DESIGNATION:

6.2.1 Current Clinical Departments are:

6.2.1.1 **Medicine**--includes the following specialty areas:

6.2.1.1.1 Cardiology;
6.2.1.1.2 Emergency Medicine;
6.2.1.1.3 Family Medicine/General Practice;
6.2.1.1.4 Gastroenterology;
6.2.1.1.5 Internal Medicine;
6.1.1.1.6 Nephrology ;
6.2.1.1.7 Neurology Telemedicine;
6.2.1.1.8 Oncology;
6.2.1.1.9 Outpatient Hyperbaric Medicine/Wound Care;
6.1.1.1.10 Pediatrics;
6.1.1.1.11 Psychiatry;
6.2.1.1.12 Radiology.

6.2.1.2 **Surgery**--includes the following specialty areas:

6.2.1.2.1 Anesthesiology;
6.2.1.2.2 General Surgery
6.2.1.2.3 Gynecology;
6.2.1.2.4 Neurosurgery
6.2.1.2.5 Ophthalmology;
6.2.1.2.6 Orthopedics Surgery
6.2.1.2.7 Otorhinolaryngology;
6.2.1.2.8 Pain Management
6.2.1.2.9 Pathology;
6.2.1.2.10 Plastic Surgery
6.2.1.2.11 Podiatry;
6.2.1.2.12 Urology; and
6.2.1.2.13 Vascular Surgery

6.2.2 Future Clinical Departments or Sections:

Subject to the approval of the Board, the Medical Executive Committee may create new departments, eliminate departments, create sections within departments, or otherwise reorganize the department structure.

6.3 ASSIGNMENT TO CLINICAL DEPARTMENTS:

6.3.1 Upon initial appointment to the Medical Staff, each member shall be assigned to a clinical department. Assignment to a particular department does not preclude an individual from seeking and being granted clinical privileges typically associated with a specialty in another department.

6.3.2 An individual may request a change in department assignment to reflect a change in the his/her clinical practice.

6.4 FUNCTIONS OF THE CLINICAL DEPARTMENTS:

The departments shall be organized for the purpose of implementing processes to:

6.4.1 Monitor and evaluate the quality and appropriateness of the care of patients served by the department;

6.4.2 Monitor the practice and current clinical competence of all those with clinical privileges in a specialty within the department;

6.4.3 Provide appropriate specialty coverage in the Emergency Department, consistent with the provisions of these Bylaws and related documents;

6.4.4 Work collaboratively with the Credentials Committee and the MEC to establish and monitor adherence to guidelines for granting of clinical privileges;

6.4.5 Conduct, participate in, and make recommendations regarding the need for continuing educational programs pertinent to changes in professional practice and to findings of review, evaluation and monitoring activities conducted by the department and/or Medical Staff or Hospital committees;

6.4.6 Participate in monitoring adherence to the Medical Staff Bylaws, Rules and Regulations, and Medical Staff and Hospital policies and procedures, especially as related to sound principles of clinical practice, emergency preparedness, fire and other regulations designed to promote patient safety;

6.4.7 Coordinate the patient care provided by department members with other members of the healthcare team;

6.4.8 Report to the Medical Staff concerning findings and results of the department's review, evaluation and monitoring activities, recommendations for improving the quality of care provided in the department and Hospital, and such other matters as may be requested from time to time by the MEC, the Medical Staff, or the Board;

6.4.9 Make recommendations to the MEC and Hospital Administration regarding equipment needs;

6.4.10 Meet as necessary to carry out the assigned functions; and

6.4.11 Establish such committees as necessary and desirable to perform the assigned functions.

6.5 QUALIFICATIONS OF DEPARTMENT CHAIRMEN:

Each department chairman shall:

6.5.1 Be an Active Staff member of the Medical Staff;

6.5.2 Be certified by an appropriate specialty board or possess comparable competence, as determined through the credentialing and privileging process; and

6.5.3 Satisfy the eligibility criteria in Article 7.1.2.

6.6. APPOINTMENT AND REMOVAL OF DEPARTMENT CHAIRMEN:

6.6.1 Department chairmen shall be selected by the Medical Staff Nominating Committee, subject to confirmation by the Active members of the Department and the Board.

6.6.2 A Department Chairman shall serve a term of two-years or until a successor is elected.

6.6.3 There shall be no limitation on the number of terms department chairmen may serve.

6.6.4 A Department Chairman may be removed by a two-thirds majority vote of the Department, of the Medical Executive Committee, or of the Board.

6.6.5 Grounds for removal shall be:

6.6.5.1 Failure to comply with applicable policies and procedures, Bylaws, or Rules and Regulations;

6.6.5.2 Failure to remain in good standing on the Medical Staff, including being the subject of an adverse recommendation and/or having automatically relinquished privileges pursuant to Article XII of these Bylaws;

6.6.5.3 Failure to perform the duties of the position;

6.6.5.4 Conduct detrimental to the interests of the Hospital and/or its Medical Staff; or

6.6.5.5 An infirmity that renders the individual incapable of fulfilling the duties of the office.

6.6.6 At least ten (10) calendar days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which such action shall be considered. The individual shall be afforded an opportunity to speak to the Department or the MEC, or the Board, as applicable, prior to a vote on such removal.

6.6.7 A successor shall be appointed to fill the remainder of the term of a chairman removed from office, using the process outlined in Article 7.8.3.

6.7 Duties of Department Chairmen:

Each Department Chairman is accountable for the following:

6.7.1 All clinically related activities of the Department;

6.7.2 All administratively related activities of the Department, unless otherwise provided for by the Hospital;

6.7.3 Recommending criteria for clinical privileges that are relevant to the care provided in the Department;

6.7.4 Evaluating requests for clinical privileges for each member of the Department;

6.7.5 Evaluation of all provisional appointees and reporting thereon to the Credentials Committee;

6.7.6 Enforcement of the Medical Staff Bylaws, all applicable policies and procedures, and applicable Rules and Regulations;

6.7.7 Integration of the Department into the primary functions of the Hospital;

6.7.8 Coordination and integration of interdepartmental and intradepartmental services;

6.7.9 Development and implementation of policies and procedures that guide and support the provision of services;

6.7.10 Continuous assessment and improvement of the quality of care and services provided;

6.7.11 Maintenance of quality monitoring, patient safety, and professional practice evaluation programs, as appropriate;

6.7.12 Implementation within the Department of actions taken by the Medical Executive Committee;

6.7.13 Recommendations for space and other resources needed by the Department; and

6.7.14 Performance of all functions authorized in the credentialing provisions of these Bylaws, including collegial intervention in accordance with the Hospital's Chain of Command Policy and Procedures.

ARTICLE VII. OFFICERS

7.1 OFFICERS OF THE MEDICAL STAFF

7.1.1 The officers of the Medical Staff shall be the President, President-elect, Immediate Past President, and Secretary-Treasurer.

7.1.2 Eligibility Criteria: Only those practitioners who are members of the Medical Staff and who satisfy the following criteria, initially and continuously, shall be eligible to serve as an officer of the Medical Staff. They must:

7.1.2.1 Be appointed in good standing to the Active Staff;

7.1.2.2 Have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges;

7.1.2.3 Not presently be serving as a medical staff or corporate officer, board member, or department chairman at any other hospital and shall not so serve during their term of office;

7.1.2.4 Be willing to faithfully discharge the duties and responsibilities of the office;

7.1.2.5 Attend continuing education related to Medical Staff leadership and/or credentialing functions, as appropriate, prior to or during the term of office; and

7.1.2.6 Have demonstrated an ability to work well with others.

7.1.3 The President-Elect shall not be eligible again for election to that post until he/she has ceased to hold the office of President/Chief of Staff for a period of one (1) term.

7.2 Other Officials of the Medical Staff:

Other officials of the Staff include Department Chairmen and such other officials as may be selected to perform or manage functions required by these Bylaws. To the extent that any such official performs clinical functions, he/she must become and remain a member of the Medical Staff. In all events, he/she is subject to these Bylaws, the Medical Staff Rules and Regulations, and all other applicable policies and procedures of the Medical Staff and the Hospital.

7.3 Nominations:

7.3.1 The Nominating Committee:

7.3.1.1 Appointment: The President, with the approval of the Medical Executive Committee shall appoint a Nominating Committee at least forty (40) days prior to the Annual Meeting of the Medical Staff in even-numbered years.

7.3.1.1 Composition: The Nominating Committee shall consist of the Medical Staff President, who shall serve as the Chairman, and two (2) Active members of the Medical Staff

7.3.1.2 Duties: The Nominating Committee shall convene a meeting at least forty (40) calendar days prior to the Annual Meeting of the Medical Staff (see Article 9.1.1.) and shall nominate one (1) or more qualified nominees for the offices of President-elect, Secretary-Treasurer, Chairman of the Department of Medicine, and Chairman of the Department of Surgery.

7.3.1.3 Meetings and Reports: The Committee shall meet as necessary, but at least as required in Article 7.3.1.2, and shall maintain a permanent record of its proceedings, and report its recommendations to the MEC and the CEO.

7.3.2 Notice of the slate of nominees shall be provided to the Active members of the Medical Staff within five (5~~)~~ working calendar days.

7.3.3 Nominations may then be made in writing by petition signed by two (2) Active Staff members. Such nominations must be provided to the Medical Staff Office at least twenty-one (21) calendar days prior to the Annual Meeting of the Medical Staff. In order for a nominee to be placed on the ballot, the candidate must meet the qualifications in Article 7.1.2, and must be willing to serve.

7.4 Election:

7.4.1 The election shall be by written ballot, which will be mailed to each Medical Staff member eligible to vote not less than fifteen (15) calendar days before the Annual meeting. Ballots may be returned in person, by mail, by facsimile, or by E-mail. All ballots must be received by the Medical Staff Services Office by noon on the day before the Annual Meeting of the Medical Staff.

7.4.2 Candidates who receive a majority of the votes cast shall be elected, subject to approval of the Board. If no candidate receives a simple majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes.

7.5 Exceptions:

Sections 7.3 and 7.4 above shall not apply to the offices of President and Immediate Past President.

7.5.1 The President-elect, upon the completion of his/her term of office in that position, shall succeed to the Office of President on the first day of the new Medical Staff year.

7.5.2 The President, upon completion of his/her term of office in that position, shall succeed to the Office of Immediate Past President on the first day of the new Medical Staff year.

7.6 Term of Office:

Officers shall serve for a term of two (2) years or until a successor is elected. The officers shall assume office on the first day of the Medical Staff year following election, except that an officer elected or appointed to fill a vacancy assumes office immediately. Each officer serves until the end of his/her term and until a successor is elected, unless he/she resigns or is removed from office.

7.7 Removal of Officers:

7.7.1 Except as otherwise provided, an elected officer may be removed by the Board acting upon its own recommendations, or by a majority vote of the members of the Active Medical Staff, or by a majority vote of the MEC.

7.7.2 Grounds for removal shall be:

7.7.2.1 Failure to comply with applicable policies and procedures, Bylaws, or Rules and Regulations;

7.7.2.2 Failure to remain in good standing on the Medical Staff, including being the subject of an adverse recommendation pursuant to these Bylaws, or having

automatically relinquished privileges pursuant to the applicable provisions of these Bylaws;
7.7.2.3 Failure to perform the duties of the position held;
7.7.2.4 Conduct detrimental to the interests of the Hospital and/or the Medical Staff; or
7.7.2.5 An infirmity that renders him/her incapable of fulfilling the duties of the office.

7.7.3 At least ten (10) calendar days prior to initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the Board, the Active Staff, or the MEC prior to a vote on removal.

7.8 Vacancies:

7.8.1 A vacancy in the office of President shall be filled by the President-elect, who shall serve until the end of the President's unexpired term, and shall then continue on to serve his/her full term.

7.8.2 A vacancy in the office of President-elect shall be filled by the Secretary-Treasurer.

7.8.3 In the event there is a vacancy in another office, the MEC shall appoint an individual to fill the office. The acting officer serves pending the outcome of a special election to be conducted as expeditiously as possible, provided that the MEC may decide not to call a special election if the regular election for the office is to be held within one hundred eighty (180) days. In this later instance, the acting officer serves only until succeeded by a newly elected officer.

7.8.4 Actions by the MEC to remove an officer and/or appoint a successor to fill a vacancy as defined in this Article 7, shall be subject to the approval of the Board.

7.9 Duties of the Officers:

7.9.1 **President**: The President shall serve as the Chief Medical Officer of the Hospital and as the principal elected official of the Medical Staff. As such he/she shall:
7.9.1.1 Act in coordination and cooperation with Hospital leadership in matters of mutual concern involving the care of patients in the Hospital;
7.9.1.2 Receive and interpret the policies of the Hospital and the Board to the Medical Staff and serve as the Medical Staff's representative for clinical performance and maintenance of quality with respect to the delegated responsibility to provide medical care to the patients of the Hospital;
7.9.1.3 Communicate and report on the activities of the Medical Staff to the EO and to the Board;
7.9.1.4 Serve as chairman and call, preside at, and be responsible for the agenda of all meetings of the Medical Staff and the MEC;
7.9.1.5 Unless otherwise expressly provided, appoint all committee chairmen and committee members, in consultation with the MEC;

7.9.1.6 Be an ex officio member of all other Medical Staff standing committees with the right to vote.
7.9.1.7 Promote adherence to the Medical Staff Bylaws, Rules and Regulations of the Medical Staff and to the Policies and Procedures of Medical Staff and the Hospital;
7.9.1.8 Appoint Medical Staff representatives to Hospital interdisciplinary committees; and
7.9.1.9 Perform all functions authorized in all applicable policies, including collegial intervention in accordance with the Hospital's Chain of Command Policy and Procedures.

7.9.2 The President-Elect shall:
7.9.2.1 Serve as Chairman of the Bylaws Committee;
7.9.2.2 Serve as Chairman of the Credentials Committee;
7.9.2.3 Assume all the duties and have the authority of the President in his/her absence, temporary or permanent; and
7.9.2.4 Perform such additional duties as may be assigned to him/her by the President, the MEC, or the Board.

7.9.3 The Immediate Past President shall:
7.9.3.1 Be a member of the MEC and perform such other advisory duties as are assigned to him/her by the President, the MEC, or the Board;
7.9.3.2 Be an ex officio member of the Board, with the right to vote, serving as the representative of the Medical Staff to the Board, who is selected by the Medical Staff in accordance with the provisions of the Board Bylaws and in compliance Joint Commission standard LD.01.03.01(9); and
7.9.3.3 Attend the regular and special meetings of the Board to represent the Medical Staff.
7.9.3.4 In the event the Immediate Past President is unable or unwilling to serve on the Board, the MEC will appoint a member of the Active Medical Staff to fill the position of Representative of the Medical Staff to the Board. The individual appointed to this position shall meet all of the same qualifications and requirements as other Medical Staff Officers, and shall be an ex officio member of the MEC with the right to vote.

7.9.4 The Secretary/Treasurer shall:
7.9.4.1 Be a member of the MEC;
7.9.4.2 Be responsible for providing all notices as specified in these Bylaws;
7.9.4.3 Ensure that accurate and complete minutes are maintained for all meetings of the MEC and Medical Staff;
7.9.4.3 Be responsible for the collection of, accounting for, and disbursement of any funds collected, donated, or otherwise assessed and present in the Medical Staff Library Fund, and report to the MEC thereon; and
7.9.4.4 Perform additional duties as ordinarily pertain to the office or as assigned by the President of the Medical Staff or the MEC.

ARTICLE VIII. COMMITTEES AND FUNCTIONS

8.1 MEDICAL STAFF COMMITTEES AND FUNCTIONS:

There shall be a Medical Executive Committee ("MEC") and such other standing and special committees of the Medical Staff as may, from time to time be necessary and desirable to conduct the business of the Medical Staff and to carry out peer review and other performance improvement functions that are delegated to the Medical Staff by the Board.

8.1.1 **T**he MEC may, by resolution and upon approval of the Board, establish additional Staff committees to perform one or more of these staff functions. In the same manner, the MEC may dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions.

8.1.2 Those functions requiring participation of, rather than direct oversight by, the Medical Staff may be discharged by Medical Staff representation on such Hospital interdisciplinary committees as are established to perform such functions.

8.1.3 Any function required to be performed by these Bylaws which is not assigned to an individual, a standing committee or a special task force shall be performed by the MEC or the Staff as a whole.

8.1.4 Each Medical Staff standing and special committee shall report to the MEC, and shall only act in accordance with the authority delegated to it by the MEC.

8.2 PERFORMANCE IMPROVEMENT FUNCTIONS:

8.2.1 The Medical Staff is actively involved in performance improvement review functions, including reviewing data, and recommending and implementing processes to address:

8.2.1.1 Patient safety, including processes to respond to patient safety alerts, meet the National Patient Safety Goals, and reduce patient safety risks;

8.2.1.2 The Hospital's and individual practitioner's performance on the Joint Commission Standards and CMS core measures;

8.2.1.3 Medication usage, including review of significant adverse drug reactions, medication errors, and the use of experimental drugs and procedures;

8.2.1.4 The utilization of blood and blood components, including review of significant transfusion reactions;

8.2.1.5 Operative and other procedures, including tissue review and review of discrepancies between pre-operative and post-operative diagnoses;

8.2.1.6 Education of patients and family members;

8.2.1.7 Coordination of care, treatment and services with other practitioners and Hospital personnel;

8.2.1.8 Accurate, timely and legible completion of medical records;

8.2.1.9 The quality of histories and physical examinations;

8.2.1.10 The use of developed criteria for autopsies;

8.2.1.11 Sentinel events, including root cause analyses and responses to unanticipated adverse events;

8.2.1.12 Nosocomial infections and the potential for infections;
8.2.1.13 Unnecessary procedures or treatments;
8.2.1.14 Appropriate resource utilization;
8.2.1.15 Plans for response to fire and other disasters; and
8.2.1.16 Any other matters as may be required to assess and maintain quality patient care.

8.3 FOCUSED /ONGOING PROFESSIONAL PRACTICE EVALUATION

8.3.1 Department Chairman's Duties and Functions:

8.3.1.1 Evaluate the professional performance of individual practitioners and AHPs, Identifying opportunities to improve patient care based on recognized professional standards;

8.3.1.2 Use multiple sources of information including, but not limited to, review of individual cases, aggregate data, compliance with Medical Staff Bylaws, Rules and Regulations, and Medical Staff and Hospital policies, recognized standards and use of rates compared with established benchmarks and norms;

8.3.1.3 Review clinical standards, including medication usage, blood and blood component usage, discrepancies between pre-operative and post-operative diagnoses, nosocomial infections, and mortality;

8.3.1.4 Provide practitioners and AHPs with feedback for personal improvement, confirmation of personal achievements related to effectiveness of their professional, technical, and interpersonal skills in providing patient care;

8.3.1.5 Conduct additional evaluations based on an unusual, adverse care or clinical patterns of care as defined by the Department Chairman, Chief of Staff, MEC, CEO, or Risk Manager, and

8.3.1.6 Provide quality data and evaluations of individual practitioners and AHPs tothe Credentials Committee for the purpose of evaluating current clinical competence at the time reappointment to the Medical Staff or AHP Staff.

8.4 APPOINTMENT OF MEDICAL STAFF STANDING COMMITTEE CHAIRMEN AND MEMBERS:

8.4.1 All committee chairmen and members of Medical Staff standing committees shall be appointed by the Chief of Staff, in consultation with the MEC.

8.4.2 Committee chairmen and members shall be appointed for a term of one (1) year, beginning on the first day of the Medical Staff year, but may be reappointed for additional terms. All appointed chairs and members may be removed and vacancies filled by the Chief of Staff at his/her discretion in consultation with the MEC.

8.4.3 When necessary to accomplish a function or task assigned to a committee, the committee chairman may call on outside consultants, special advisors from clinical specialties and/or administrative or patient care sources with expertise in the subject matter involved, after consultation with the Chief of Staff and the CEO.

8.4.4 Unless otherwise provided, all Hospital and administrative representatives on Medical Staff standing committees shall be appointed by the CEO in consultation with the Chief of Staff. All such representatives shall serve on the committee without vote unless otherwise expressly indicated.

8.4.5 The Chief of Staff and the CEO, or their respective designees, shall be members on all standing committees, ex officio, without vote unless otherwise expressly indicated.

8.4.6 The Chief of Staff, in collaboration with the MEC, shall appoint the practitioner members, who shall have the right to vote, to those interdisciplinary Hospital committees requiring representation and participation by the Medical Staff.

8.4.7 Unless otherwise indicated, each committee described in these Bylaws shall meet as necessary to accomplish its function and shall maintain a permanent record of its findings, proceedings, and actions. Each committee shall make a timely written report to the MEC after each meeting and to other committees and individuals as may be indicated.

8.5 MEDICAL EXECUTIVE COMMITTEE:

8.5.1 Composition:

The MEC shall include the officers of the Medical Staff, the chairman of each clinical department, and other members of the Active Medical Staff as, from time to time, may be deemed appropriate by the Chief of Staff and the CEO, and approved by Board. The CEO shall be an ex officio member of the MEC without vote.

8.5.2 Duties and Functions:

The MEC is delegated the primary authority over activities related to the functions of the Medical Staff and the AHP Staff, and for performance review, assessment and improvement of the professional services provided by individuals with clinical privileges.

8.5.2.1 The MEC is responsible for;

8.5.2.1.1. Acting on behalf of the Medical Staff in the intervals between Medical Staff meetings. The officers are empowered to act in urgent situations between MEC meetings.

8.5.2.1.2 Making recommendations directly to the Board on at least the following:

8.5.2.1.2.1 The Medical Staff structure;

8.5.2.1.2.2 The mechanism used to review credentials and to delineate individual clinical privileges;

8.5.2.1.2.3 Applicants for Medical Staff and AHP Staff appointment;

8.5.2.1.2.4 Delineation of clinical privileges for each eligible applicant;

8.5.2.1.2.5 Participation of the Medical Staff in Hospital performance improvement activities and quality of professional services being provided by members of the Medical Staff;

8.5.2.1.2.6 The mechanism by which Medical Staff appointment may be terminated; and

8.5.2.1.2.7 Fair Hearing procedures.

8.5.2.1.3 The MEC shall also:

8.5.2.1.3.1 Provide reports and recommendations from Medical Staff committees, departments, and other groups to the Board as appropriate;

8.5.2.1.3.2 Consult with the CEO on quality-related aspects of contracts for patient care services;

8.5.2.1.3.3 Receive and act on reports and recommendations from Medical Staff committees, departments, and other groups as appropriate;

8.5.2.1.3.4 Review or delegate review of quality indicators to ensure uniformity regarding patient care services;

8.5.2.1.3.5 Provide leadership in activities related to patient safety;

8.5.2.1.3.6 Provide oversight in the process of analyzing and improving patient satisfaction;

8.5.2.1.3.7 Prioritize continuing medical education activities;

8.5.2.1.3.8 Review or delegate to the Bylaws Committee the responsibility to review the Bylaws, Policies, Rules and Regulations, and associated documents of the Medical Staff and recommend such changes as may be necessary or desirable at least Annually.

8.5.2.1.3.9 Provide and promote effective liaison among the Medical Staff, Administration, and the Board; and

8.5.2.1.3.10 Perform such other functions as are assigned by these Bylaws and associated documents, the Board, or applicable policies.

8.5.3 Quorum:

The presence of fifty (50) percent of the voting members of the MEC shall constitute a quorum.

8.5.4 Meetings and Reporting:

The MEC shall meet monthly, at least ten (10) times per year; shall maintain a permanent record of its proceedings and actions; and shall report thereon to the Board.

8.6 CREDENTIALS COMMITTEE:

8.6.1 Composition:

The Credentials Committee shall consist of the President-Elect who shall act as Chairman, at least three (3) members of the Active Medical Staff, and the CEO without vote. The three members of the Active Medical Staff shall include at least one representative from the Department of Medicine and from the Department of Surgery.

8.6.2 Duties and Function:

8.6.2.1 The Credential Committee shall:

8.6.2.1.1 Review the credentials of all applicants for Medical Staff appointment, reappointment, and clinical privileges, conduct a thorough review of the applications, and interview such applicants as may be desirable or necessary;

8.6.2.1.2 Review the credentials of all applicants for Allied Health Professional Staff appointment, reappointment, and scope of service, conduct a thorough review of the applications, and interview such applicants as may be desirable or necessary;

8.6.2.1.3 As may be requested by the MEC, review all information available regarding the current clinical competence and behavior of individuals currently appointed to the Medical Staff or Allied Health Professional Staff and, as a result of such review, make a written report of findings and recommendations to the MEC and to the CEO; and

8.6.2.1.4 When deemed appropriate, conduct interviews in person or by phone, with;

8.6.2.1.4.1 The applicant;

8.6.2.1.4.2 The applicant's professional /peer references; and/or

8.6.2.1.4.3 Any other individuals as deemed appropriate by the Committee.

8.6.2.1.5 Review the recommendation(s) of the department chairman of each clinical department in which clinical privileges are requested; and

8.6.2.1.6 Review and make recommendations regarding appropriate threshold eligibility criteria for clinical privileges within the Hospital, including clinical privileges for new procedures and clinical privileges that cross specialty lines.

8.6.3 Meetings and Reporting:

The Credentials Committee will meet monthly at least ten (10) times a year, shall maintain a permanent record of its activities, and shall report its recommendations to the MEC and to the CEO.

8.7 BYLAWS COMMITTEE:

8.7.1 Composition:

The Bylaws Committee consists of at least four (4) members of the Active Medical Staff. The CEO shall be an ex officio member of the Committee, without voting rights. The President-Elect shall serve as the Chairman of the Committee.

8.7.2 Duties and Functions:

The Bylaws Committee shall:

8.7.2.1 Conduct an annual review of the Medical Staff Bylaws and the Bylaws-related documents, including without limitation, the Medical Staff and AHP Rules and Regulations, and the Fair Hearing Plan, to assure their compliance with current guidelines and standards promulgated by the CMS and Joint Commission, the Bylaws of the Board, and applicable federal and state legislation; and

8.7.2.2 Draft amendments to the Medical Staff Bylaws and the Bylaws-related documents, present amendments to the MEC for discussion and action. In performing this function, the Committee may interact with Hospital legal counsel.

8.7.3 Meetings and Reporting:

The Bylaws Committee shall meet as often as necessary, but at least annually, to fulfill its duties and functions, shall maintain a permanent record of its activities, and shall report its recommendation to the MEC and to the CEO.

8.8 JOINT CONFERENCE COMMITTEE:

8.8.1 Composition:

The Joint Conference Committee shall consist of the Chairman, Vice-Chairman and Secretary-Treasurer of the Board, and the President, President-Elect, and Secretary-Treasurer of the Medical Staff. The CEO shall be an ex officio member without voting rights. The President of the Medical Staff will serve as Chairman.

8.8.2 Duties:

The Committee's primary function is to serve as a forum for discussion of matters pertaining to patient care. The Committee shall:

8.8.2.1 Provide for medical administrative liaison among the Board, the Medical Staff, and Hospital Administration relative to matters of Medical Staff and Hospital policy and practice; and

8.8.2.2 Review and make recommendations with respect to corrective or disciplinary action, where the proposed final action of the Board is contrary to the recommendations of the MEC.

8.8.3 Meetings and Reporting:

The Committee shall meet as needed and shall transmit a written report of its activities to the Board, the MEC, and the CEO.

8.9 CONTINUING MEDICAL EDUCATION/LIBRARY COMMITTEE:

8.9.1 Composition:

The Continuing Medical Education/Library Committee shall consist of representatives from the Medical and Surgical Departments of the Medical Staff, a representative from the AHP Staff, and a representative from Hospital Administration.

8.9.2 Duties:

The Continuing Medical Education/Library Committee shall:

8.9.2.1 Develop, plan and implement a continuing medical education programs for the benefit of the Medical Staff, the AHP Staff, Hospital patient care personnel, and the medical community at large;

8.9.2.2 Interface with Medical Staff and/or Hospital committees and functions to provide medical education programs tailored to the interests and needs of the Medical Staff, the AHP Staff, and other patient care Hospital personnel;
8.9.2.3 Make recommendation to the MEC and/or Hospital Administration with regard to the expenditure of funds for continuing medical education and scholarships;
8.9.2.4 Advise regarding the purchase of library materials;
8.9.2.5 Supervise the collection of funds for the Medical Staff Library Fund and review expenditures of such funds; and
8.9.2.6 Make recommendations to improve the operation of the Hospital Library.

8.9.3 Meetings and Reporting:
The Committee shall meet at least annually, shall maintain a permanent record of its findings, proceedings and actions, and shall make a report thereof to the MEC and the CEO.

8.10. NOMINATING COMMITTEE:

8.10.1 The composition, duties, and the meeting and reporting requirements of the Nominating Committee are as defined in Article 7.3 of these Bylaws

8.11 PARTICIPATION IN INTERDISCIPLINARY COMMITTEES AND FUNCTIONS:

8.11.1 Staff functions are responsibilities related to liaison with the Board and Hospital Administration. These include, but are not limited to, Hospital accreditation, disaster preparedness, patient safety, facility and services planning, financial management, quality and risk management, ethics, and corporate compliance. Such functions shall be addressed in part by various officers and organizational components of the Medical Staff as described in these Bylaws, and in part by appointment of Medical Staff members to Hospital committees. Such committee appointments shall be made by the President of the Medical Staff, and such committees shall operate in accordance with the Hospital Corporate Bylaws and the written policies and procedures of the Hospital and the Medical Staff.

8.11.2 Terms: Unless otherwise specifically provided, the Medical Staff Committee members shall serve a one (1) year term commencing on the first day of the Medical Staff year, and shall continue until a successor is appointed or elected, unless she/she shall sooner resign or be removed from the committee.

8.11.3 Vacancies: Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which the original appointment to such committee was made.

8.12 INFECTION PREVENTION COMMITTEE:

The Infection Prevention Committee shall be an interdisciplinary Hospital Committee. The Committee Chairman, or his/her designee, shall have the authority to initiate any

surveillance, prevention, or control measures necessary when there is reason to believe that the health of patients or personnel may in jeopardy from nosocomial infection.

8.12.1 Composition:

The Infection Prevention Committee shall consist of at least three (3) representatives of the Medical Staff, the Infection Prevention Coordinator, the Director of Quality and Infection Prevention, at least one representative from Hospital Administration, Nursing Services, Respiratory Therapy, Employee Health, and other Hospital representatives deemed appropriate by the CEO.

8.12.2 Duties:

The duties of the Committee shall be as outlined in the Hospital's Infection Prevention Plan.

8.12.3 Meetings and Reporting:

The Committee shall meet at least quarterly, shall maintain a permanent record of its findings, proceedings, and actions, and shall make a report thereon to the MEC and the CEO.

8.13 PHARMACY, THERAPEUTICS AND NUTRITION COMMITTEE:

The Pharmacy, Therapeutics and Nutrition ("P,T & N") Committee shall be an interdisciplinary Hospital committee.

8.13.1 Composition:

The Committee shall consist of at least three (3) physicians who are members of the Medical Staff, one of whom will be the Medical Director of the Emergency Department or his/her designee, and representatives from Nursing Services, Hospital Administration, Nutritional Services, Pharmacy and other as deemed appropriate by the CEO. A representative from the Pharmacy shall serve as secretary of the Committee.

8.13.2 Duties:

The P,T & N Committee's duties shall be as outlined in the Hospital's Pharmacy and Therapeutics Plan and Nutritional Services Plan, and shall include review and/or approval of:

8.13.2.1 The Hospital Pharmacy Formulary;
8.13.2.2 Adverse Drug Reactions;
8.13.2.3 Clinical Services provided by the Pharmacists;
8.13.2.4 The Hospital Diet Manual;
8.13.2.5 The Enteral Nutrition Formulary; and
8.13.2.6 The Food, Drug & Herbal Supplements Interactions Guide

8.13.3 Meetings and Reporting:

The P,T & N Committee shall meet at least quarterly, shall maintain a permanent record of its findings, proceedings, and actions, and shall report thereon to the MEC and the CEO.

8.13.4 MEDICATION MANAGEMENT COMMITTEE:

The Medication Management Committee shall be a sub-committee of the P,T&N Committee.

8.13.4.1 Composition:

The Medication Management Committee shall consist of one (1) or more physician members of the Medical Staff who is a member of the P.T&N Committee and who shall serve the Chairman of the Committee, the CNO or Director of Nursing, the Director of Pharmacy, and the Director of Risk Management.

8.13.4.2. Duties:

The Medication Management Committee shall:

8.13.4.2.1 Review reports from the clinical medical errors team and analyze cases, some of which may relate to Medical Staff members;

8.13.4.2.2 Provide follow up with letters and educational information to practitioners and AHPs when indicated;

8.13.4.2.3 Monitor reports for trends and patterns, report thereon to the MEC; and follow up as requested by the MEC.

8.13.4.3 Meetings and Reporting:

The Medication Management Committee shall meet at least quarterly, shall maintain a permanent record of its findings, proceedings and actions, and shall report thereon to the MEC.

8.14 UTILIZATION MANAGEMENT COMMITTEE:

The Utilization Management Committee shall be an interdisciplinary Hospital committee.

8.14.1 Composition:

The Committee shall consist of one (1) or more physician members of the Medical Staff, and representatives from Nursing Services, Hospital Administration, Case Management, and others as deemed appropriate by the CEO.

8.14.2 Duties:

The duties of the Utilization Management Committee shall be as outlined in the Hospital's Utilization Management Plan.

8.14.3 MEETINGS AND REPORTING:

The Utilization Management Committee shall meet at least quarterly, maintain a permanent record of its findings, proceedings and actions, and report thereon to the MEC and the CEO.

8.14.3.1. The Committee shall report any situation, within its jurisdiction, involving questions of clinical competence, patient care and treatment, or case management (with or without recommendations) related to a member of the Medical Staff or the AHP Staff to the MEC and/or the appropriate Medical Staff Department Chairman, with or without recommendations, for consideration and appropriate action.

ARTICLE IX. MEDICAL STAFF MEETINGS

9.1 GENERAL STAFF MEETINGS:

9.1.1 Regular Meetings:

The Medical Staff shall meet at least one (1) time a year. This meeting shall be held in November of each year and shall be designated as the Annual Medical Staff meeting.

9.1.2 Order of Business and Agenda:

The order of business at the general staff meeting shall be determined by the Chief of Staff in consultation with the MEC and the CEO. The agenda shall include at least:

9.1.2.1 Reading and acceptance of the minutes of the last regular meeting and of any special meetings held since the last regular meeting;

9.1.2.2 Reports from the Chief of Staff, the CEO, the Clinical Department Chairmen, and from Committees as appropriate and requested;

9.1.2.3 Election of officers;

9.1.2.4 Consideration/approval of changes in the Bylaws and Rules and Regulations of the Medical Staff and AHP Staff as necessary;

9.1.2.5 Reports and discussion of the overall results of patient care monitors and other quality review, evaluation and monitoring activities of the Staff and on the fulfillment of other required Staff functions;

9.1.2.6 Recommendations for improving patient care within the Hospital; and

9.1.2.7 New business.

9.1.3 SPECIAL MEETINGS OF THE MEDICAL STAFF:

Special meetings of the Medical Staff may be called at any time by the Chief of Staff, the MEC, the Board, or by petition signed by not less than one-third (1/3) of the members of the Active Staff. No business shall be transacted at any special meeting except that stated in the meeting notice.

9.2 COMMITTEE AND CLINICAL DEPARTMENT MEETINGS:

9.2.1 Regular Meetings:

Committees may, by resolution, provide the time for holding regular meetings and no notice other than such resolution shall be required. The Departments of Medicine and Surgery will meet at least annually either immediately before or after the Medical Staff Annual Meeting.

9.2.2 SPECIAL MEETINGS OF A COMMITTEE OR MEDICAL STAFF DEPARTMENT:

A special meeting of any committee or department may be called at any time by, or at the request of, the Chairman thereof, the Chief of Staff, the MEC, the Board, or by petition signed by not less than one-third (1/3) of the Active members of a department, or the current members of a committee.

9.3 NOTICE OF MEETINGS:

9.3.1 Written or printed notice stating the place, date and time of any general staff meeting, or of any regular committee or department meeting not held pursuant to resolution, or of any special committee or department meeting shall be delivered either personally, or by mail, E-mail, or FAX to each person entitled to be present thereat not less than four (4) business days, nor more than ten (10) business days, before the date of such meeting. Notice of committee or department meetings held pursuant to resolution may be given orally or by E-mail or FAX. If mailed, the notice of the meeting shall be deemed delivered seventy-two (72) hours after deposited, postage prepaid, in the United States Mail, addressed to each person entitled to such notice at his/her address as it appears on the records of the Hospital. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

9.4 Quorum:

9.4.1 General Staff Meetings:

9.4.1.1 The presence of thirty percent (30%) of the voting members of the Active Medical Staff at any regular or special meeting shall constitute a quorum.

9.4.2 Clinical Department and Committee Meetings:

9.4.2.1 Unless otherwise expressly provided, the presence of thirty percent (30%) of the voting members of the Active and Provisional Active Medical Staff at any Department meeting shall constitute a quorum.

9.4.2.2 Unless otherwise expressly provided, the presence of thirty percent (30%) of the voting members of a committee, but not less than two (2) members, shall constitute a quorum.

9.5 MANNER OF ACTION: Except as otherwise specified in these Bylaws, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. Action may be taken without a meeting by a department or committee by a writing setting forth the action so taken, signed by each member entitled to vote thereat.

9.6 MINUTES: Minutes of all meetings shall be prepared and shall include a record of attendance and the vote taken on each matter. Copies of such minutes will be signed by the presiding officer, approved by the attendees, and made available to the members. A permanent file of minutes of each meeting shall be maintained in the Medical Staff Office, or in the Office of the CEO, Quality Director, Risk Manager, or Corporate Compliance Officer for a period of three (3) years and then may be stored off-site until such time as they may be destroyed in accordance with federal and state legal requirements and the applicable Hospital policies.

9.7 ATTENDANCE REQUIREMENTS:

9.7.1 Each member of a Staff category required to attend under Article III of these Bylaws shall be required to attend:

9.7.1.1. At least fifty percent (50%) of all Medical Staff meetings duly convened pursuant to these Bylaws; and

9.7.1.2 At least fifty percent (50%) of all meetings of each department and/or committee of which he/she is a member.

9.7.2 Absence from Meetings:

Any member who is compelled to be absent from any Medical Staff, Department, or committee meeting shall promptly provide to the regular presiding officer, or his/her designee, thereof the reason for such absence. Unless excused for good cause, failure to meet these attendance requirements may be grounds for any of the corrective actions specified in Article 12.3.7, and including, in addition, removal from such department or committee. Reinstatement of a Staff member whose membership has been revoked because of absence from meetings shall be made only on application, and any such application shall be processed in the same manner as an application for initial appointment.

9.7.3 Special Appearance:

A practitioner whose patient's clinical course of treatment is scheduled for discussion at a regular Department, committee or Medical Staff meeting may be so notified. Whenever apparent or suspected deviation from standard clinical practice is involved, special notice shall be given at least four (4) days prior to the meeting and shall include the date, time and place of the meeting, a statement of the issue involved and that the practitioner's appearance is mandatory. Failure of a practitioner to appear at any meeting with respect to which he/she was given such special notice shall, unless excused by the MEC upon a showing of good cause, result in an automatic suspension of all or such portion of the practitioner's clinical privileges as the MEC may direct. Such suspension shall remain in effect until the matter is resolved by subsequent action of the MEC or of the Board, or through corrective action, if necessary.

9.8 PROXY:

There shall be no voting by proxy by any member of the Medical Staff at any meeting.

9.9 RULES OF CONDUCT: Unless otherwise specified, all Medical Staff meetings and meetings of Medical Staff committees shall be conducted in accordance with Robert's Rules of Order.

ARTICLE X. CONFIDENTIALITY, IMMUNITY AND RELEASES

10.1 AUTHORIZATIONS AND CONDITIONS:

By applying for, or exercising clinical privileges or providing specified patient care services within this Hospital, a practitioner or AHP:

10.1.1 Authorizes representatives of the Hospital and the Medical Staff to solicit, provide and act upon information bearing on his/her professional ability and qualifications;
10.1.2 Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative who acts in accordance with the provisions of this Article; and
10.1.3. Acknowledges that the provisions of this Article are express conditions to his/her application for, or acceptance of, Staff membership and the continuation of such membership or to his/her exercise of clinical privileges or provision of specified patient services at this Hospital.

10.2 CONFIDENTIALITY OF INFORMATION:

Information with respect to any practitioner submitted, collected or prepared by any representative of this Hospital or any other health care facility, organization, or Medical Staff for the purpose of evaluating and improving the quality and efficiency of patient care rendered, reducing morbidity and mortality, contributing to clinical research, or establishing and enforcing guidelines to keep health care costs within reasonable bounds shall, to the fullest extent permitted by law, be confidential and shall not be disseminated to anyone other than a representative of the Hospital or Medical Staff, nor be used in any way except as provided herein or except as otherwise required by law. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall not become part of any particular patient's file or of the Hospital's general records.

10.3 IMMUNITY FROM LIABILITY:

The Board, any committees of the Medical Staff and/or of the Board who conduct professional practice review activities, and any individuals within the Hospital authorized to conduct professional practice review activities, hereby constitute themselves as professional review bodies as defined in the Health Care Quality Improvement Act of 1986 and in the Florida Peer Review Act. Each professional review body hereby claims all privileges and immunities afforded to it by said federal and state statutes. Any action taken by a professional review body pursuant to these Medical Staff Bylaws shall be in the reasonable belief that it is in furtherance of quality healthcare (including the provision of care in a manner that is not disruptive to the delivery of quality medical care at the Hospital) only after a reasonable effort has been made to obtain the true facts of the matter, after adequate notice and hearing procedures are afforded to any applicant or Medical Staff member, and only in the reasonable belief that the action is warranted by the facts known after a reasonable effort has been made to obtain the facts.

10.3.1 For Action Taken:

No representative of the Hospital or Medical Staff shall be liable to a practitioner for damages or other relief for any action taken or statement or recommendation made within the scope of his/her duties as a representative, if such representative acts in good faith and without intentional fraud after a reasonable effort under the circumstances to ascertain the truthfulness of the facts and in the reasonable belief that the action, statement, or recommendation is warranted by such fact. Truth shall be an absolute defense in all circumstances.

10.3.2 For Providing Information:

No representative of the Hospital or Medical Staff and no third party shall be liable to a practitioner for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative of this Hospital or Medical Staff or to any other health care facility or organization of health professionals concerning a practitioner or AHP who is or has been an applicant to or member of the Staff or who did or does exercise clinical privileges or provide specified services at this Hospital, provided that such representative or third party acts in good faith and without intentional fraud and provided further that such information is related to the performance of the duties and functions of the recipient and is reported in a factual manner.

10.4 ACTIVITIES AND INFORMATION COVERED:

10.4.1 Activities:

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

10.4.1.1 Applications for appointment, clinical privileges or specified services;
10.4.1.2 Periodic reappraisals for reappointment, clinical privileges or specified services;
10.4.1.3 Corrective action;
10.4.1.4 Hearings and appellate reviews;
10.4.1.5 Patient care monitoring activities;
10.4.1.6 Ongoing or focused professional practice evaluation activities
10.4.1.7 Utilization reviews;
10.4.1.8 Claims reviews;
10.4.1.9 Profiles and profile analyses; and/or
10.4.1.10 Other Hospital, department, committee or Medical Staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

10.4.2 Information:

The acts, communications, reports, records, minutes, recommendations, findings, evaluations, opinions, disclosures and other information referred to in this Article may relate to a practitioner's professional qualifications, clinical ability, judgment, character, physical and mental health, emotional stability, and/or professional conduct.

10.5 RELEASES:

Each practitioner shall, upon request of the Hospital, execute general and specific releases in accordance with the tenor and import of this Article, subject to such requirements, including those of good faith, absence of intentional fraud, and the exercise of a reasonable effort to

ascertain truthfulness, as may be applicable to the laws of the State of Florida. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

10.6 CUMULATIVE EFFECT:

Provisions of these Bylaws and in7 application forms relating to authorizations, confidentiality of information and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof, and in the event of conflict, the applicable law shall be controlling.

10.7 DISCIPLINARY ACTION REPORTING:

DeSoto Memorial Hospital will comply fully with Article 458.337, Florida Statutes, pertaining to the reporting to the Florida Department of Health of any disciplinary action taken against any physician. The Hospital or its authorized representative shall also report all adverse actions, as defined in the Health Care Quality Improvement Act of 1986, to the National Practitioner Data Bank only upon the adoption by the Board of such action as being a final action of the Board, or as otherwise required by law.

ARTICLE XI. GENERAL PROVISIONS

11.1 MEDICAL STAFF RULES AND REGULATIONS:

Subject to approval by the Board, the Medical Staff shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found in these Bylaws. These shall relate to the proper conduct of Medical Staff organizational activities, as well as embody the level of practice that is to be required of each practitioner or AHP in the Hospital. Such Rules and Regulations shall be part of these Bylaws, except that they may be amended or repealed by a majority of those present and eligible to vote:

11.1.1 At any regular meeting at which a quorum is present and without previous notice, or

11.1.2 At any special meeting on thirty (30) days' notice.

11.1.3 By written ballot, provided at least thirty (30) days written notice of the intention to Take such action has been given, accompanied by the proposed Rules and Regulations changes.

11.1.4 Such changes shall become effective when approved by the Board.

11.2 CLINICAL DEPARTMENT RULES AND REGULATIONS:

Subject to approval of the Medical Executive Committee, each clinical department may formulate its own Rules and Regulations for the conduct of its affairs and the discharge of its responsibilities. Such Rules and Regulations shall not be inconsistent with these Bylaws, the general Rules and Regulations of the Medical Staff, or other policies of the Hospital and Medical Staff.

11.3 PROFESSIONAL LIABILITY INSURANCE/FINANCIAL RESPONSIBILITY:

Each practitioner granted clinical privileges in the Hospital shall provide proof of compliance with the financial responsibility provisions of Florida Statute 458.320 through one of the following methods:

11.3.1 FS 458.320 (2) (a) Establishing and maintaining an escrow account;

11.3.2 FS 458.320 (2) (b) Obtaining and maintaining professional liability coverage from an authorized insurer, as defined under FS chapter 624.09;

11.3.3 FS 458.320 (2) (c) Obtaining and maintaining an unexpired irrevocable letter of credit, established pursuant to FS chapter 675;

11.3.4 FS 458.320.5 (g) 1 A practitioner holding an active license under this chapter who agrees to meet all of the criteria of sub-section 1., 2., 3., 4., and 5;

11.3.5 FS 458.320 (5)(a) A practitioner who practices medicine exclusively as an officer, employee, or agent of the Federal Government or of the state or its agencies or its subdivisions, and who is eligible for coverage under any self-insurance or insurance program authorized by the provisions of FS 768.28(16).

NOTE: Florida Statute 458.320, Financial Responsibility, may be found at:
www.flsenate.gov/Laws/Statutes/458.320

11.4 APPOINTMENT AND REAPPOINTMENT FEES:

Subject to the approval of the Board, the MEC shall have the power to set the amount of the appointment and reappointment fees for each category of Medical and/or Allied Health Professional Staff membership, and to determine the manner of expenditure of funds received.

11.5 FORMS:

Application forms and any other prescribed forms required by these Bylaws for use in connection with staff appointments, reappointments, delineation of clinical privileges, corrective action, notices, recommendations, reports, and other matters shall be subject to adoption by the Board after considering the advice of the MEC.

11.6 CONSTRUCTION OF TERMS AND HEADINGS:

Words used in these Bylaws shall be read as the masculine or feminine gender and as the singular or plural, as the context requires. The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws.

11.7 TRANSMITTAL OF REPORTS:

Reports and other information which these Bylaws require the Medical Staff to transmit to the Board shall be deemed to be transmitted when delivered, unless otherwise specified, to the CEO.

11.8 BOARD ACTION:

Whenever these Bylaws require or authorize action by the Board, such action may be taken by a committee of the Board to which the Board has delegated the responsibility and authority to act for it on the particular subject matter, activity or function involved.

11.9 EFFECTIVE COMMUNICATION:

The President of the Medical Staff may attend all regular meetings of the Board of Directors, without the right to vote, for the purpose of assuring that there is an open avenue for effective communication between the Medical Staff, the Board of Directors, and Administration.

11.10 GOVERNING LAW:

These Medical Staff Bylaws shall be governed by, and construed in accordance with, the Health Care Quality Improvement Act of 1986 and, to extent not inconsistent therewith, Florida law.

11.11 REMOVAL FROM OFFICE OF MEDICO-ADMINISTRATIVE OFFICER:

11.11.1 Unless otherwise provided in a medico-administrative officer's employment agreement or other arrangement, removal from a medico-administrative office shall have no effect on the Staff membership status or clinical privileges of the removed officer.

11.11.2 A removed officer who believes that removal has subjected him/her to any one of the adverse effects specified in items 1 through 14 of Article 13.2.3) shall be entitled to the following procedural rights:

11.11.2.1 The procedural rights provided by his/her employment agreement or other arrangement; or

11.11.2.2 If there is no employment agreement or other arrangement, or if the same is silent on the issue of procedural rights, to the procedural rights provided in Sections 13.1 and 13.2 and in the Fair Hearing Plan.

11.12 CHANGE IN MEMBERSHIP STATUS OR CLINICAL PRIVILEGES OF A MEDICO-ADMINISTRATIVE OFFICER:

Unless a medico-administrative officer's employment agreement or other arrangement specifies otherwise, alteration in the officer's Staff membership status and/or clinical privileges in any of the respects listed in items 1 through 14 of Article 13.2.3 must be initiated and processed in accordance with Article XII.

ARTICLE XII. CORRECTIVE ACTION

12.1 ONGOING AND FOCUSED PROFESSIONAL PRACTICE EVALUATION FILE:

A professional practice evaluation file on each Medical Staff member and each individual exercising clinical privileges in the Hospital will be maintained in the Medical Staff Office and/or the office of the Quality Director, and as otherwise delineated in these Bylaws, under the jurisdiction of the Chief of Staff and the CEO of the Hospital. The Medical Staff will be responsible for developing a policy for access to records and confidentiality. The credentials and peer review files will contain:

12.1.1 All materials regarding the evaluation of credentials;
12.1.2 All current monitoring reports; and
12.1.3 Any request for corrective action, which has been forwarded to the Chief of Staff.
12.1.2 Files containing quality, professional practice evaluation, Or complaint information concerning a Medical Staff member shall not be in any area of the Hospital, including the department to which the individual is assigned, other than the Medical Staff office and/or in the offices of the Risk Manager, the Quality Improvement Director, and/or the Corporate Compliance Officer. An individual has the right to review his/her professional review file and/or credentials file maintained in the above referenced locations at any reasonable time during ordinary working hours. The individual may respond in writing to anything in the file and have the response included in the applicable file.

12.2 DISCRETIONARY INTERVIEW:

Medical Staff officers, department chairmen, or the CEO of the Hospital may informally assess possible grounds for corrective action, interview the involved practitioner(s), and attempt to resolve all such matters without resort to formal corrective action. Informal counseling is expected and encouraged, but not required. It is hoped that requests for corrective action will not ordinarily be used until and unless informal methods have failed. This interview process shall not constitute an investigation but rather an informal assessment of possible grounds for an investigation. Refer to the Medical Staff Policy and Procedure entitled Physician/AHP Wellness and Impairment.

12.3 ROUTINE CORRECTIVE ACTION:

12.3.1 Criteria for Initiation:

Whenever a practitioner with clinical privileges shall engage in, make, or exhibit acts, statements, demeanor or professional conduct, whether within or outside of the Hospital, and the same is, or is reasonably likely to be:

12.3.1.1 Detrimental to patient safety or to the delivery of quality patient care; or
12.3.1.2 Disruptive to Hospital operation; or
12.3.1.3 Demeaning to the Medical Staff organization or the medical profession; or
12.3.1.4 An impairment to the community's confidence in the Hospital, corrective action against such practitioner may be initiated by any Officer of the Medical Staff, or by the Chairman of any Clinical Department in which he/she holds appointment and/or clinical privileges.

12.3.2 Grounds for Discipline:

The Medical Staff shall suspend, deny, revoke, or curtail staff privileges, or reprimand, counsel or require education of any Staff Member after a final determination has been made that one or more of the following grounds exist:

12.3.2.1 Being unable to practice medicine with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition and/or failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances;

12.3.2.2 Being found liable for medical negligence or malpractice involving negligent conduct by a court of competent jurisdiction;
12.3.2.3 One or more settlements exceeding Fifty Thousand Dollars ($50,000.00) for medical negligence or malpractice involving negligent conduct by the Staff member (grounds for disciplinary action include "repeated malpractice"; action must be, and will be, taken if three or more such incidents occur in a five-year period);
12.3.2.4 Medical negligence other than as specified in paragraphs 12.3.2.1 through 12.3.2.3 above;
12.3.2.5 Failure to comply with the policies, procedures, or directives of the Risk Management, Quality Management, Patient Safety or Corporate Compliance Programs;
12.3.2.6 Incompetence;
12.3.2.7 Being found to be a habitual user of intoxicants or drugs to the extent that he/she is deemed dangerous to himself/herself, or others; and/or
12.3.2.8 Mental or physical impairment which may adversely affect patient care.

12.3.3 Requests and Notices:

All requests for corrective action shall be in writing, submitted to the MEC, and supported by reference to the specific activities or conduct which constitute the grounds for the request, and shall identify any witnesses, medical records, or other documentation known by the person or the committee requesting the action. The Chairman of the MEC shall promptly notify the CEO in writing of all requests for corrective action received by the MEC and shall continue to keep him/her fully informed of all action taken in conjunction therewith.

12.3.4 Investigation:

After deliberation, the MEC may either act on the request for corrective action or direct that an investigation concerning the grounds for the corrective action request be undertaken. The MEC may conduct such investigation itself, or it may assign this task to an Ad Hoc Investigation Committee. This investigative process shall not be deemed a "hearing" as that term is used in Article XIII and in the Fair Hearing Plan, and none of the procedural rules provided with respect to hearings shall apply. Part of such investigation shall include an opportunity for the affected Medical Staff member to interview with the MEC or its designee. Such an investigating committee shall be considered a professional review committee under these Bylaws.
If the investigation is accomplished by a group or individual other than the MEC, such group or individual shall forward a written report of the investigation to the MEC as soon as is practicable after the assignment to investigate has been made. The MEC may at any time, within its discretion, and shall at the request of the Board (or appropriate committee thereof), terminate the investigative process and proceed with action as provided in Article 12.3.7 below.

12.3.5 Appointment of Ad Hoc Investigation Committee:

It is the explicit intention of the Medical Staff that the Ad Hoc Investigation Committee shall consist of the Chief of Staff (or his/her designee), two (2) Medical Staff members appointed by the CEO and two (2) Medical Staff members appointed by the Chief of Staff. The Chief of Staff (or his/her designee) shall serve as Chairman of the Ad Hoc Investigation Committee. A

designee of the Chairman of the department to which the affected Medical Staff member is assigned shall serve as a consultant to the Ad Hoc Investigation Committee. The Ad Hoc Investigation Committee shall have no voting members who are in direct economic competition with the Medical Staff member who is the subject of the investigation. In the event there are not a sufficient number of Medical Staff members who meet such criteria, the CEO in collaboration with the Chief of Staff, may appoint physicians who are not affiliated with the Hospital who meet such criteria. The affected Medical Staff member shall be advised of the names of the Ad Hoc Investigation Committee members within ten (10) days of the appointment of such Ad Hoc Investigation Committee. If the Medical Staff member who is the subject of the investigation advises the Chief of Staff that he/she believes a member of the Ad Hoc Investigation Committee does not meet this criterion, the Chief of Staff shall determine the merit of such contention and, if the contention is found to be correct, shall appoint a substitute to serve on the Ad Hoc Investigation Committee. An investigation by an Ad Hoc Investigation Committee shall be considered an administrative matter and not an adversarial proceeding. A Medical Staff member who is the subject of an investigation shall not be entitled to have legal counsel present during any meetings or discussions between such Medical Staff member and members of an Ad Hoc Investigation Committee. Testimony and documentary evidence taken informally at the ad hoc investigation stage must be verified under oath if considered at any later hearing.

12.3.6 Preliminary Report of Ad Hoc Investigation Committee:

Upon conclusion of its investigation, the Ad Hoc Investigation Committee, if one is assigned by the MEC, shall submit a preliminary report to the CEO, to the MEC, and to the affected Medical Staff member. Such report shall contain a statement detailing the preliminary findings, conclusions and recommendations of the Ad Hoc Investigation Committee. The CEO, the MEC, and the affected Medical Staff member shall each be given the opportunity to submit comments on the preliminary report of the Ad Hoc Investigation Committee within fifteen (15) days following receipt of the preliminary report.

12.3.7 MEC Action:

As soon as is practicable after the conclusion of the investigative process, if any, but in any event within ten (10) days after receipt of the Ad Hoc Investigative Committee report, unless deferred pursuant to Article 12.3.8, the MEC shall take action upon such request for corrective action. Such action may include, without limitation, recommending:

12.3.7.1 Rejection of the request for corrective action;

12.3.7.2 A warning, a letter of admonition, or a letter of reprimand;

12.3.7.3 Terms of probation or individual requirements of consultation;

12.3.7.4 Reduction, suspension or revocation of clinical privileges;

12.3.7.5 Reduction of staff category or limitation of any staff prerogatives directly related to the Practitioner's delivery of patient care; and/or

12.3.7.6 Suspension or revocation of Staff Membership.

2.3.8 Deferral:

If additional time is needed to complete the investigative process, the MEC may defer action on the request, but only upon the written consent of the affected practitioner. A subsequent recommendation for any one or more of the actions provided in Article 12.3.7.1 through 12.3.7.6 above must be made within the time specified in such written consent, and if no such time is specified, then within thirty (30) days of the deferral.

12.3.9 Procedural Rights:

Any recommendations by the MEC pursuant to Article 12.3.7.3 through 12.3.7.6, or any combination of such actions, shall entitle the practitioner to the procedural rights as provided in Article XIII and in the Fair Hearing Plan.

12.3.10 Other Action:

12.3.10.1 If the MEC's recommended action is to reject the request for corrective action, such recommendation, together with all supporting documentation, shall be transmitted to the Board. Thereafter, the procedure to be followed shall be as provided in Sections 4.4.7, 4.4.9 and 4.4.10.1, as applicable.

12.3.10.2 If the MEC's recommended action is a warning, admonition or reprimand, such recommendation, together with all supporting documentation, shall be transmitted to the Board. Board action to adopt such MEC recommendation without substantive modification shall conclude the matter and notice of final decision shall be given as provided in Article 4.4.10.1. If the Board's proposed action modifies substantively the MEC's recommendation, the provisions of Article 4.4.9 shall be followed. If the Board's action is adverse to the applicant as defined in Article 13.2.3, the CEO shall promptly so inform the practitioner by special notice, and he/she shall be entitled to the procedural rights as provided in Article XIII and in the Fair Hearing Plan.

12.3.10.3 If, in the Board's determination, the MEC fails to act in timely fashion in processing and recommending action on the request for corrective action, the Board (or an appropriate committee thereof) may, after notifying the MEC, take action on its own initiative. If such action is favorable, it shall become effective as the final decision of the Board. If such action is adverse as defined in Article13.2.3, the CEO shall promptly so inform the practitioner by special notice, and he/she shall be entitled to the procedural rights as provided in Article XIII and in the Fair Hearing Plan.

12.4 PRECAUTIONARY SUSPENSION:

12.4.1 Criteria for Initiation:

Whenever a practitioner's conduct requires that immediate action be taken to protect the life of any patient(s) or to reduce the substantial likelihood of immediate injury or damage to the health or safety of any patient, employee or other persons present in the Hospital, either the Chief of Staff, the Chairman of the Department, the CEO, the Executive Committee of either the Medical Staff or the Board, or the Board shall have the authority to enact a precautionary suspension of the Medical Staff membership status or all or any portion of the clinical privileges of such practitioner. Such precautionary suspension shall become effective immediately upon imposition, and the

CEO shall promptly give special notice of the suspension to the practitioner. In the event of any such suspension, the practitioner's patients then in the Hospital whose treatment by such practitioner is terminated by the precautionary suspension shall be assigned to another practitioner by the department chairman. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner.

12.4.2 MEC Action:

As soon as possible after such precautionary suspension, a meeting of the MEC shall be convened to review and consider the action taken. The MEC may modify, continue or terminate the terms of the precautionary suspension.

12.4.3 Procedural Rights:

Unless the MEC immediately terminates the suspension and ceases all further corrective action, the practitioner shall be entitled to the procedural rights as provided in Article XIII and in the Fair Hearing Plan.

12.4.4 Other Action:

If the MEC's action pursuant to Article 12.4.2 is to terminate the suspension and to cease all further corrective action, such action shall be transmitted immediately, together with all supporting documentation, to the Board. Thereafter, the procedure to be followed shall be as provided in Article 4.4.7, 4.4.8, and 4.4.10.1, as applicable. The terms of the precautionary suspension as originally imposed shall remain in effect pending a final decision by the Board.

12.5 AUTOMATIC SUSPENSION:

Situations that shall result in Automatic Suspension:

12.5.1 License

12.5.1.1 Revocation: Whenever a practitioner's or AHP's license, certificate or other legal credential authorizing him/her to practice in the State of Florida is revoked, his/her Staff membership and clinical privileges or specified services shall be immediately and automatically revoked.

12.5.1.2 Restriction: Whenever a practitioner's or AHP's license, certificate or other legal credential authorizing him/her to practice in the State of Florida is limited or restricted by the applicable licensing or certifying authority, those clinical privileges or specified services which he/she has been granted that are within the scope of said limitation or restriction shall be immediately and automatically suspended.

12.5.1.3 Suspension: Whenever a practitioner's or AHP's license, certificate or other legal credential authorizing him/her to practice in the State of Florida is suspended, his/her Staff membership and clinical privileges or specified services shall be automatically suspended, effective upon and for at least the term of the suspension. Further action on the matter shall proceed pursuant to the provisions of Article 12.5.3.

12.5.1.4 Probation: Whenever a Staff member or AHP is placed on probation by the applicable licensing or certifying authority, his/her voting and office-holding

prerogatives shall be automatically suspended, effective upon and for at least the term of the probation. Further action on the matter shall proceed pursuant to Article 12.5.3.

12.5.2 Controlled Substance Number:

12.5.2.1 Revocation: Whenever a practitioner's Drug Enforcement Agency (DEA) or other controlled substances number is revoked, he/she shall immediately and automatically be divested at least of his/her right to prescribe medications covered by the number. Further action on the matter shall proceed pursuant to Article 12.5.3.

12.5.2.2 Suspension: Whenever a practitioner's DEA or other controlled substances number is suspended, he/she shall be divested at least of his/her right to prescribe medications covered by the number, effective upon and for at least the term of the suspension. Further action on the matter shall proceed pursuant to Article 12.5.3.

12.5.2.3 Probation: Whenever a practitioner is placed on probation insofar as the use of his/her DEA or other controlled substances number is concerned, action on the matter shall proceed pursuant to Article 12.5.3.

12.5.3 MEC Deliberation:

As soon as practicable after action is taken as described in Articles 12.5.1 or in Article 12.5.2, the MEC shall convene to review and consider the facts under which such action was taken. The MEC may then recommend such further corrective action as is appropriate to the facts disclosed in its investigation, including limitation of prerogatives. Thereafter, when the matter involves a practitioner, the procedure to be followed shall be as provided in Sections 12.3-9 and 12.3-10., as applicable. When the matter involves an AHP, Hospital policies and procedures shall determine the manner of final processing.

12.5.4 Failure to Satisfy Special Appearance Requirement:

A practitioner who fails to satisfy the requirements of Article 9.7.3 shall automatically be suspended from exercising all or such portion of his clinical privileges in accordance with the provision of said Article 9.7.3.

12.5.5 Medical Records Completion:

For failure to complete medical records in a timely fashion, a practitioner's clinical privileges (except with respect to his/her patients already in the Hospital, and any unassigned patients who present to the emergency room without a private physician), his/her rights to admit patients and to consult with respect to patients, and his/her voting and office-holding prerogatives shall, with written warning of delinquency, be automatically suspended and shall remain suspended until those medical records are completed. Should any practitioner have privileges suspended for more than thirty (30) consecutive days because of failure to complete medical records, he/she may then be dismissed from Medical Staff membership. Medical Staff membership and clinical privileges may be reinstated only by application for appointment, as a new applicant in

accordance with the procedures for appointments set forth in Article IV of these Bylaws. A Medical Staff member whose clinical privileges or membership has been automatically suspended pursuant to this Article 12.5.5 shall not be entitled to the procedural rights provided in Article XIII and the Fair Hearing Plan. In the case of those patients already in the Hospital and/or those unassigned emergency room patients without a private physician, when a suspended physician is on call, this physician must follow these patients during their entire course of treatment in the Hospital.

12.5.6 Malpractice Insurance/Financial Responsibility:
For failure to continuously comply with the financial responsibility requirements of Florida Statutes as required under Article 11.3, a practitioner's Medical Staff membership and clinical privileges shall immediately be suspended. A practitioner under automatic suspension by operation of this Article 12.5,6 shall not be entitled to the procedural rights provided in Article XIII and in the Fair Hearing Plan.

12.5.7 Failure to Report Licensure Restriction: A Medical Staff member who fails to report to the Hospital any imposed restriction, condition, or probation with respect to his/her license by the Florida Board of Health within thirty (30) days of the imposition of such restriction, condition, or probation.

12.5.8 Federal or State Healthcare Program Participation:
A Medical Staff member has his/her right to bill Medicare, Medicaid, or any other federal or state healthcare program revoked or suspended in any manner.

12.5.9 Federal or State Healthcare Program Exclusion:
A Medical Staff member has his/her name placed on any list of providers excluded from billing Medicare, Medicaid, or any other federal or state healthcare program.

12.5.10 Geographic Proximity:
A Medical Staff member subject to the geographic proximity requirement set forth in Article 2.4.1.14 of these Bylaws who no longer meets such requirement.

12.5.11 Contract Termination:
A Medical Staff member whose contractual arrangement with the Hospital is terminated pursuant to the terms of such contract.

12.5.12 Minimum Admissions/Procedures:
Medical Staff member is subject to the minimum admissions/procedures requirement in Article 4.6.2 of these Bylaws and fails to meet such requirement.

ARTICLE XIII. HEARINGS AND APPELLATE REVIEW

13.1 PREAMBLE:

The Board of Directors, in conjunction with the Medical Staff and any committees, panels, and departments thereof, in order to conduct professional peer review activity, hereby constitute themselves as Peer Review and Professional Review Committees as defined by the Florida hospital licensing statute and peer review statutes, and the Health Care Quality Improvement Act of 1986. Such committees hereby claim all privileges and immunities afforded to them by said federal and state statutes. The purpose of these Hearing and Appellate Review Procedures is to provide a fair mechanism through which a fair hearing and appeal might be provided to all practitioners as defined in these Bylaws. This Article is intended to comply with the Health Care Quality Improvement Act of 1986, and Florida Statutes Annotated Sections 395.0191, 395.0193, 455.225. As such, any action taken pursuant to this Article shall be in the reasonable belief that such was in the furtherance of quality health care only after a reasonable effort has been made to obtain the facts of the matter, after adequate notice and hearing procedures are afforded to any professional health care provider involved and only in the reasonable belief that the action was warranted by the facts known after a reasonable effort has been made to obtain the facts.

13.2 HEARINGS AND APPELLATE REVIEW:

13.2.1 Adverse MEC Recommendation:

When any practitioner receives a special notice of an adverse recommendation of the MEC, as defined in Article 13.2.3, he/she shall be entitled, upon written request, to a hearing before an ad hoc hearing committee of the Medical Staff. If the recommendation of the MEC following such hearing is still adverse to the practitioner, he/she shall then be entitled, upon written request, to an appellate review by the Board before a final decision is rendered.

13.2.2 Adverse Board Decision

When any practitioner receives a special notice of an adverse decision by the Board, as defined in Article 13.2.3, he/she shall be entitled, upon written request, to a hearing by an ad hoc hearing committee appointed by the Board. If such hearing does not result in a favorable recommendation, he/she shall then be entitled, upon written request, to an appellate review by the Board before a final decision is rendered.

13.2.3 Adverse Recommendations or Actions Defined:

13.2.3.1 The following recommendations or actions shall, if deemed adverse pursuant to the provisions of these Bylaws, entitle the practitioner affected thereby to a hearing, upon his/her timely written request for same:

13.2.3.1.1 Denial of a completed application for initial staff appointment, unless such denial was based on the Hospital's inability to accommodate the practitioner under Article 4.4.8;

13.2.3.1.2 Denial of reappointment;

13.2.3.1.3 Suspension of Staff membership, unless such suspension was an automatic suspension based on the practitioner's failure to comply with Article 12.5;

13.2.3.1.4 Revocation of Staff membership unless such revocation was automatic based on practitioner's failure to comply with Article 12.5;

13.2.3.1.5 Denial of requested advancement in Staff Category;

13.2.3.1.6 Reduction in Staff Category;

13.2.3.1.7 Limitation of the right to admit patients, except related to temporary privileges or to automatic suspension under Article 12.5;

13.2.3.1.8 Denial of requested department, department and service affiliations;

13.2.3.1.9 Denial of requested clinical privileges;

13.2.3.1.10 Reduction in clinical privileges, except for the reduction of temporary privileges;

13.2.3.1.11 Suspension of clinical privileges, except for the suspension of temporary privileges or automatic suspension under Article 12.3;

13.2.3.1.12 Revocation of clinical privileges, except for the revocation of temporary privileges or automatic suspension under Article 12.3;

13.2.3.1.13 Terms of probation; and/or

13.2.3.1.14 Individual imposition or application of mandatory consultation requirement.

13.2.3.2 A recommendation or action listed in Article 13.2.3.1 above shall be deemed adverse only when it has been:

13.2.3.2.1 Recommended by the MEC;

13.2.3.2.2 Taken by the Board contrary to a favorable recommendation by the MEC under circumstances where no prior right to request a hearing existed; or

13.2.3.2.3 Taken by the Board on its own initiative without benefit of a prior recommendation by the MEC.

13.2.3.3 When Deemed Non-Adverse: The following recommendations or actions are not adverse and shall not give rise to a right to a hearing:

13.2.3.3.1 Suspension, revocation, or termination of temporary or emergency privileges;

13.2.3.3.2 Reprimand or warning (oral or written);

13.2.3.3.3 Voluntary resignation of membership or voluntary reduction of clinical privileges;

13.2.3.3.4 Automatic suspension or termination of membership or clinical privileges under Article 12.5;

13.2.3.3.4 Requirement of obtaining a mental and/or physical examination;

13.2.3.3.5 Retrospective or concurrent monitoring of health care provided, any general consultative requirement, the imposition of a requirement for retraining, additional training or continued education;

13.2.3.3.6 Precautionary suspension under Article 12.4.1; and

13.2.3.3.7 Denial of an initial application for Medical Staff appointment when such denial was based on the inability of Hospital to accommodate practitioner under Article 4.4.8.

13.2.3.4 Procedure and Process:
All hearings and appellate reviews shall be in accordance with the procedure and safeguards set forth in the Fair Hearing Plan.

13.2.3.5 Exceptions:
Neither the issuance of a warning, a letter of admonition, a letter of reprimand, nor the denial, termination or reduction of temporary privileges, nor any other actions except those specified in Article 13.2.3.2 shall give rise to any right to a hearing or appellate review.

ARTICLE XIV. ADOPTION AND AMENDMENTS OF BYLAWS

14.1 MEDICAL STAFF RESPONSIBILITY:

The Medical Staff shall have the initial responsibility to formulate, adopt and recommend to the Board Medical Staff Bylaws and amendments thereto which shall be effective when approved by the Board. Such responsibility shall be exercised in good faith and in a reasonable, timely and responsible manner, reflecting the interests of providing patient care of the generally recognized professional level of quality and efficiency and of maintaining a harmony of purpose and effort with the Board and with the community.

14.2 METHODOLOGY:

Medical Staff Bylaws may be adopted, amended, or repealed by the following combined action:

14.2.1 Medical Staff:
The affirmative vote of a majority of the Staff Members eligible to vote on this matter, either by written ballot or by action at a meeting at which a quorum is present, provided at least thirty (30) days' written notice, accompanied by the proposed Bylaws and/or alterations, have been given of the intention to take such action; and

14.2.2 Board:
The affirmative vote of a majority of the Board, provided, however, that in the event the Medical Staff shall fail to exercise its responsibility and authority as required by Article 14.1, and after notice from the Board to such effect including a reasonable period of time for response, the Board may resort to its own initiative in formulating or amending Medical Staff Bylaws. In such event, Medical Staff recommendations and views shall be taken into account by the Board during its deliberations and in its actions pursuant to this Article 14.2.2.

14.2.3 Amendments:
Amendments may also be proposed directly to the Board by a petition signed by at least fifty (50) percent of the voting members of the Medical Staff.

14.2.4 Urgent Need to Amend Bylaws:

In the event of a documented need for an urgent amendment of the Medical Staff Bylaws to comply with laws, regulations or accreditation standards, the Medical Executive Committee may provisionally adopt, and the Board may provisionally approve the urgent amendment without prior notification of the voting members of the Medical Staff. In such cases, the voting members of the Medical Staff shall be notified by the Medical Executive Committee of the urgent amendment within ten (10) days after the Board has approved the amendment. The voting members of the Medical Staff shall have an additional twenty (20) days within which to retrospectively review the amendment and provide written comment to the Medical Executive. If there are not comments opposing the provisional amendment, then the provisional amendment shall become final. If there are comments opposing the provisional amendment, then the Medical Staff process for conflict management shall be implemented, and a revised amendment shall be submitted to the Board if necessary.

14.3 NOTIFICATION TO STAFF OF REVISIONS:

When significant changes are made in the Bylaws, Rules & Regulations or policies of the Medical Staff or Hospital, all members of the Medical Staff and other individuals who have delineated clinical privileges or scopes of practice will be provided with a written or electronic copy of the revised texts.

The foregoing Medical Staff Bylaws, as Amended, were ADOPTED by the Medical Staff of DeSoto Memorial Hospital, on the 16th day of April, 2019

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Gregory Arov, D.O., President, Medical Staff

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Ana Hernandez, M.D., Secretary-Treasurer, Medical Staff

The foregoing Medical Staff Bylaws, as Amended and Adopted by the Medical Staff were APPROVED by the Board of Directors of DeSoto Memorial Hospital on this 18th day of April, 2019

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Robert Heine, Jr., Chairman, District Board of Director

APPENDIX A
RULES GOVERNING HISTORIES AND PHYSICAL EXAMINATIONS

(1) A complete history and physical examination shall be performed by a practitioner or allied health professional appointed to the Medical Staff, and a report dictated, entered into the patient's electronic medical record, or completed using preprinted forms approved by the Medical Executive Committee within twenty-four (24) hours of admission. If provided by an Allied Health Professional (AHP), it must be approved, dated, timed and signed by the supervising practitioner within twenty-four hours.

(2) The medical record shall document a current, thorough history and physical examination prior to the performance of any inpatient or outpatient surgery or other invasive procedure requiring moderate or deep sedation. This report will be dated, timed, and dictated, entered into the patient's electronic medical a record, or completed using preprinted forms approved by the Medical Executive Committee. However, in an emergency, when there is not time to record the complete History and Physical Examination, a dated, timed and signed progress or admission note, describing a brief history and appropriate physical findings and the preoperative diagnosis shall be recorded in the medical record prior to the surgery or procedure. Unless the attending practitioner determines and documents that an emergency situation exists, the procedure will be canceled or postponed.

(3) When the history and physical examination is performed by an AHP, the findings, conclusions and risk assessments must be confirmed and approved (signed, dated and timed) by the supervising practitioner prior to surgery or other invasive diagnostic or therapeutic intervention.

(4) The medical history shall include:
a. The chief complaint;
b. History of present illness;
c. Allergies and medications;
d. Past medical, social and family histories;
e. Physical examination;
f. Review of systems;
g. Impression(s);
h. Plan for care; and
i. Informed consent, including risks, benefits, and alternatives to treatment, when applicable.

(5) If a complete history and physical examination has been performed within thirty (30) days prior to admission, a dated, timed, durable, legible copy of this report may be used in the patient's Hospital medical record, provided these reports are recorded by a practitioner or AHP appointed to the Medical Staff and there has been no change subsequent to the original examination or the changes have been recorded at the time of admission.

(6) History and physical examination are valid for thirty (30) days after which the practitioner must prepare a new and complete history and physical examination.