MEDICAL STAFF BYLAWS

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PREAMBLE

Whereas, Banner Churchill Community Hospital is owned and operated by Banner Health, a nonprofit corporation organized under the laws of the State of Arizona;

Whereas, its purpose is to serve as a general acute care hospital providing quality health care to the patients, and the surrounding rural communities;

Whereas, it is recognized that the Medical Staff has the initial responsibility for the quality of medical care in the Hospital and must accept and discharge this responsibility, subject to the ultimate authority of the Governing Board, and that the cooperative efforts of the Medical Staff, the Administrator and the Governing Board are necessary to fulfill the Hospital’s obligation to provide quality, consumer sensitive health care to its patients;

Therefore, the physicians, dentists and podiatrists practicing in the Hospital are hereby organized into the Medical Staff in conformity with these Bylaws.

NAME

The name of this organization shall be the Medical Staff of Banner Churchill Community Hospital.
ARTICLE I: PURPOSES

The Medical Staff shall continually seek to provide quality patient care for all patients admitted to, or treated in, any of the facilities, departments or services of the Hospital.

The Medical Staff shall organize into committees in order to review the professional practices of Members and others granted privileges within the Hospital for the purpose of reducing morbidity and mortality. Such review shall include assessment of, and formulation of recommendations concerning the nature, quality and necessity of the care provided. These Bylaws have been developed and adopted by the Medical Staff and approved by the Governing Board, in order to provide a mechanism for such review, which will be in accordance with applicable federal and state statutes and regulations relating to peer review and performance improvement. Neither the Medical Staff nor the Governing Body may unilaterally amend the Medical Staff Bylaws or Rules and Regulations. It is the intention of these Bylaws that the actions of the Medical Staff in conducting such review, including, without limitation, the actions of its officers, representatives, committees and consultants (including persons who are not members of the Medical Staff, but who are requested by a duly authorized officer or committee of the Medical Staff to participate in such review) shall be confidential and afforded immunity from civil liability to the fullest extent permitted by all applicable federal and state statutes and regulations as set forth in Article XII herein.

The Medical Staff shall provide an educational setting that will maintain scientific and medical standards and lead to continued advancement of professional knowledge and skill.

The Medical Staff shall initiate and maintain rules and regulations for governing the Medical Staff that shall be binding on all Members and all Applicants in accordance with these Bylaws, the policies of the Hospital and the Governing Board.

The Medical Staff shall provide a means of communication among Members, the Administrator, and the Governing Board.
ARTICLE II: DEFINITIONS

The following words, terms or phrases contained in these Bylaws shall be defined as follows:

ADMINISTRATOR: The term "Administrator" means the chief administrative officer of the Hospital, or his or her designee.

ADMISSION: The terms "admit," "admitting" and/or "admission" shall refer to those instances in which a Member causes a patient to be assigned to a Hospital room and designated bed number, generally for inpatient care, but not necessarily excluding outpatient care. The requesting of ancillary outpatient services provided by the Hospital specifically does not constitute an admission. In addition, patients treated at the Hospital on an outpatient basis when the patient has not been assigned to a Hospital room and designated bed number does not constitute an admission for the purposes of these Bylaws.

ALLIED HEALTH PROFESSIONALS: The term "Allied Health Professionals" shall have the meaning ascribed to such term in Article XIII.

APPLICANT: The term "Applicant" shall mean any Practitioner who has applied for initial appointment to the Medical Staff or any Member who has applied for reappointment to the Medical Staff, additional clinical privileges or a change in Medical Staff category.

APPLICATION FOR APPOINTMENT OR REAPPOINTMENT TO THE MEDICAL STAFF: The term "application for appointment or reappointment to the Medical Staff" shall refer to an application for appointment or reappointment to the Active Staff, the Courtesy Staff or the Consulting Staff, and as a matter of definition, shall not be construed as having any reference to the Honorary Staff/Emeritus.

BYLAWS: The term "Bylaws" shall refer to these Medical Staff Bylaws and the Medical Staff Rules and Regulations, unless otherwise specified.

COMPLETED APPLICATION: The term "completed application" means and refers to an application for appointment or reappointment to the Medical Staff in such form as the Governing Board may require, plus all documentation required by these Bylaws for consideration of an application for appointment or reappointment to the Medical Staff, including, but not limited to, the documentation set forth in Article V: Section 5.1, 5.2, and 5.3.

CORPORATE BYLAWS: The term "Corporate Bylaws" shall refer to the corporate bylaws of Banner Health.

DELINEATED CLINICAL PRIVILEGES: The term "delineated clinical privileges" shall refer to privileges granted to Members and Practitioners who provide patient care services. These privileges are meant to be complete, but not all inclusive.

DOD: The term "DOD" shall mean the United States Department of Defense.
EXECUTIVE COMMITTEE: The term "Executive Committee" shall refer to the executive committee of the Medical Staff, unless specific reference is made to the Executive Committee of either the Local Board of Trustees or the Governing Board.

GOVERNING BOARD: The term "Governing Board" shall refer to the Governing Board of Banner Health, an Arizona nonprofit corporation, which is the governing board of such corporation, unless specific reference is made to the Local Board of Trustees.

HOSPITAL: The term "Hospital" means Banner Churchill Community Hospital of Fallon, Nevada.

LOCAL BOARD OF TRUSTEES: The term "Local Board of Trustees" shall refer to the Local Board of Trustees of Banner Churchill Community Hospital, Fallon, Nevada, which has been authorized by the Governing Board to act in its behalf in matters of routine governance.

MEDICAL STAFF: The term "Medical Staff" shall be interpreted to include all Practitioners who are formally appointed by the Governing Board as Members, and does not include such Allied Health Professionals or other health care providers who may be granted certain health care privileges within the Hospital, and who are monitored by Members or committees of the Medical Staff, as hereinafter set forth.

MEDICAL STAFF YEAR: The term "Medical Staff Year" means the period from January 1 to and including December 31.

MEMBER: The term "Member" means any Practitioner who has been appointed to membership on the Medical Staff by the Governing Board.

MEMBER-AT-LARGE: The term "Member-at-Large" means the Member who has been elected to hold the position of Member-at-Large of the Executive Committee.

PHYSICIAN: The term "physician" shall refer to a doctor of medicine or a doctor of osteopathy.

PRACTITIONER: The term "Practitioner" shall mean a physician, a doctor of dental medicine, a doctor of dental surgery, or a podiatrist.

STANDARDS REQUIRED BY THESE BYLAWS: The phrase "standards required by these Bylaws" means and refers to standards set forth in these Bylaws; standards adopted by the Executive Committee and approved by the Governing Board, such as those set forth in Article III: Section 3.2.3; and standards required by any policy and/or procedure statement formally adopted by the Governing Board.
ARTICLE III: MEDICAL STAFF MEMBERSHIP

3.1 NATURE OF MEDICAL STAFF MEMBERSHIP

Membership on the Medical Staff is a privilege granted by the Governing Board, which shall be extended only to professionally competent Practitioners who continuously meet the qualifications, standards, and requirements set forth in these Bylaws. Membership on the Medical Staff may be withdrawn at any time, in accordance with these Bylaws, if it is determined that the Member fails to meet the qualifications, standards and requirements of the Medical Staff. No Applicant shall be denied Medical Staff membership on the basis of sex, race, creed, or national origin, or on the basis of any other criterion lacking professional justification. The Medical Staff is not departmentalized.

3.2 QUALIFICATIONS FOR MEMBERSHIP

3.2.1 Only Practitioners licensed to practice in the State of Nevada who can continually document their education, background, experience, training, physical and mental health, professional competence, and clinical judgment in the treatment of patients, participation in Medical Staff affairs, their compliance with these Bylaws and the applicable policies and procedures of the Medical Staff and the Hospital, their use of the Hospital’s facilities for their patients, their adherence to the ethics of their professions, their good reputation, and their ability to work collegially and cooperatively with others for the delivery of quality medical care, shall be qualified for appointment or reappointment to the Medical Staff; provided, however, that members of the Federally Employed Military Staff caring only for DOD patients are not required to be licensed to practice in the State of Nevada if they have a current license to practice in one of the other forty-nine (49) states. A conviction of a felony crime shall be grounds for disqualification from Medical Staff membership. No Practitioner shall be entitled to membership on the Medical Staff, or to the exercise of any particular clinical privilege merely by virtue of the fact that he or she is licensed to practice his or her profession in this or in any other state, or that he or she is a member of any professional organization, or that he or she has ever been granted such privileges at another hospital or health care facility.

3.2.2 An applicant for appointment or reappointment to the Medical Staff shall have the burden of establishing, to the satisfaction of the appropriate committees of the Medical Staff and to the Governing Board, that he or she meets the qualifications, standards and requirements set forth in these Bylaws and the Corporate Bylaws, and that, if granted Medical Staff membership and clinical privileges, he or she would provide quality medical care.

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1 Establishing “standards for Medical Staff membership and for clinical privileges involves an examination of several facets of the Applicant’s education, training, experience, background and personal makeup. The “credentialing” process referred to in Section 3.2 above involves examination of the Applicant’s formal education, training, experience and participation in
3.2.3 In order to qualify for appointment or reappointment to the Medical Staff and to be granted clinical privileges to practice at the Hospital, each Applicant must continually meet all the following standards to assure that any patient treated by him or her will be given quality medical care:

a. He or she must possess such credentials for Medical Staff appointment or reappointment and for the specific clinical privileges requested, as the Executive Committee shall, from time to time, establish, subject to final approval by the Governing Board.

b. At a minimum, he or she must possess the following:

   (1) graduation from a medical school accredited at the date of graduation by the Liaison Committee on Medical Education or the Canadian Medical Association, or from a college of osteopathic medicine approved by the American Osteopathic Association; or graduates of foreign medical schools must have passed parts I and II of the National Board of Medical Examiners’ examination or have a permanent certificate of the Educational Council for Foreign Medical Graduates; or graduation from an appropriately accredited dental school; or graduation from an appropriately accredited school of podiatry;

   (2) a license to practice in the State of Nevada issued by the Nevada Board of Medical Examiners, the Nevada Board of Osteopathic Examiners, the Nevada Board of Dental Examiners, or the Nevada Board of Podiatric Examiners; provided, however, that an Applicant in the Federally Employed Military Staff category who will be caring only for DOD patients is not required to have a license to practice in the State of Nevada if the Applicant hold a current license to practice in one of the other forty-nine (49) states; and

medical societies, associations, groups, or specialty organizations, as well as his or her experience at other hospitals and with licensing authorities. In addition, however, it is recognized by section 3.2 above that an individual practitioner may have received sufficient formal training to “appear on paper” to be qualified for membership on the Medical Staff or to exercise specific clinical privileges and yet, because of other factors, be unable to carefully practice that privilege. For example, certain clinical privileges require continued proficiency and skill with surgical instruments, or specialized equipment for diagnosis and treatment. The committees of the Medical Staff and the Governing Board shall consider an Applicant's ability to perform certain procedures, and practice within certain privileges. Additionally, an Applicant or Member with proper credentials who, under pressure, stress, substance abuse or other personal circumstances, engages in erratic behavior that is dangerous or contrary to good patient care, should not be qualified for continued Medical Staff membership or continued clinical privileges.
(3) for physician Applicants, completion of three (3) years of post-graduate training in a specialty or area corresponding to the privileges requested, secured in a formal training program that has been approved by the Accreditation Council for Graduate Medical Education or by the American Osteopathic Association, or by a comparable accreditation agency, or, demonstration of experience of, as a threshold, ten (10) years of active practice in a specialty or area corresponding to the privileges requested.

c. He or she must possess the requisite physical and mental health status to safely and competently perform the privileges requested.

d. He or she must possess insurance coverage as required by these Bylaws. A member of the Federally Employed Military Staff caring only for DOD patients who has Federal insurance by virtue of his or her employment by the Federal government shall be deemed to satisfy this requirement.

e. He or she must possess a current controlled substance registration certification from the Drug Enforcement Administration ("DEA").

3.2.4 Acceptance of an application for membership on the Medical Staff does not constitute privileges granted; provided, however, that submission of the application is an acknowledgement that the Applicant has read, and understands these Bylaws and shall constitute an agreement that the Applicant will strictly abide by these Bylaws, the Principles of Medical Ethics and Rules of the Judicial Council of the American Medical Association, the Code of Ethics of the American Osteopathic Association, the Code of Ethics of the American Dental Association, or the Code of Ethics of the American Podiatric Association, whichever is applicable, and the Standards for Hospitals as promulgated by the Joint Commission.

3.3 CONDITIONS AND DURATION OF APPOINTMENT

3.3.1 All appointments and reappointments to the Medical Staff shall be made by the Governing Board. The Governing Board shall act on appointments, reappointments, or revocation of appointments only after there has been a recommendation from the Medical Staff as provided in these Bylaws; provided, however, that in the event of unwarranted delay on the part of the Medical Staff and after due notification of appropriate committees of the Medical Staff and the Chief of Staff, the Governing Board may act without such recommendation on the basis of documented evidence of the Applicant's professional and ethical qualifications obtained from reliable sources. Prior to taking such action, however, the Governing Board shall notify the Medical Staff of its intent, and shall designate an action date prior to which the Medical Staff may still fulfill its responsibility.
3.3.2 Initial appointments shall be "provisional" in nature and shall be governed by the provisions of Article IV: Section 4.2. This "provisional" appointment shall not be applicable for the Honorary Staff category or for practitioners without clinical privileges. Reappointments shall be for a period not exceeding twenty-four (24) months, and shall be determined in accordance with Article V: Section 5.3 of these Bylaws.

3.3.3 Appointment to the Medical Staff shall confer on the Member only such clinical privileges as have been granted by the Governing Board in accordance with these Bylaws.

3.3.4 As a condition to membership on the Medical Staff, each Member shall acknowledge his or her obligation to provide continuous care and supervision of his or her patients, to accept medically appropriate consultation assignments that are not in conflict with the personal beliefs of the consultant to acknowledge his or her obligation to participate in the Emergency Room "back-up call" in accordance with these Bylaws and established policies, and to supply any documentation required to meet state and federal laws or regulations.

3.3.5 It shall be a condition of membership of the Medical Staff, and a condition to the exercise of any delineated clinical privilege, that the Member shall have in full force and effect a policy or policies of professional liability insurance that is or are acceptable in form and amount to the Governing Board (as specified in the most current policy directive from the Governing Board dealing with this issue), and that the Member has on file with the Administrator a certificate(s) of insurance issued by an acceptable insurance carrier(s) specifying the terms of coverage, the policy period in effect, and the limits of coverage available. This condition shall not be applicable to the Honorary Staff category. Notice shall be given to the Administrator of any termination, cancellation, revocation or lapse of any of said policies of insurance. A member of the Federally Employed Military Staff caring only for DOD patients who has Federal insurance by virtue of his or her employment by the Federal government shall be deemed to satisfy this requirement.

3.3.6 All initial applications shall be accompanied by a non-refundable processing fee in an amount established by the Hospital. In addition, all initial applications and applications for reappointment, with the exception of Honorary Staff/ Emeritus members, shall be accompanied by a membership fee in an amount established by the Executive Committee.

3.4 RIGHTS AND RESPONSIBILITIES OF EACH MEMBER

3.4.1 Responsibilities of Each Member
   a. Each Member shall provide appropriate, timely, and continuous care of his or her patients. He or she is not responsible for the actions of other
Members, Allied Health Professionals (unless under his or her sponsorship), or Hospital employees.

b. Each Member shall participate, if assigned, in relevant quality/performance improvement activities and in discharging other Medical Staff functions as may be required from time to time.

c. Each Member shall participate in the on-call coverage of the Emergency Department and other coverage programs as determined by the Executive Committee or, if necessary, the Administrator.

d. Each Member shall abide by these Bylaws, including the Medical Staff Rules and Regulations, and the applicable bylaws, rules, regulations, policies and procedures of the Hospital.

e. Each Member shall prepare and complete, in a timely fashion, according to these Bylaws and the Hospital's policies, the medical and other required records for all patients to whom the Member provides care in the Hospital, or within its facilities, services or departments.

f. Each physician or Allied Health Professional who is approved by the medical staff to perform admission history and physical examinations shall complete an appropriate history and physical (H&P) examination as delineated in Article XVI: Section 16.5.3, on all admissions, as well as all patients undergoing ambulatory surgeries, and placed in the patient’s medical record within twenty-four (24) hours after admission. The completed H&P must be on the medical record prior to surgery or invasive procedures, or any procedure in which anesthesia or procedural/moderate sedation will be administered or the case will be cancelled unless the responsible physician documents in writing that such delay would constitute a hazard to the patient. A legible history and physical performed within 7 days prior to admission is acceptable with an updated medical record entry documenting an examination for any changes in the patient’s condition. The contents of a complete H&P shall include, but not limited to, documentation of date, of admission, identification, data, chief complaint, allergies, details of present illness, pertinent past/social/family history, pertinent psychosocial needs, medications and a review of body systems. A physical exam must reflect a comprehensive physical assessment and be authenticated by the physician or Allied Health Professional. A statement of the conclusion or impression (provisional diagnosis) drawn from the admission H&P and a course of action planned for the patient must be documented Further details regarding the H&P are delineated in the Medical Staff Rules and Regulations and in the Documentation Requirements for the Medical Record Policy.
g. Each Member shall act in an ethical and professional manner, abiding by the principles and standards of ethics established by the applicable national professional association(s), including arranging for appropriate and timely medical coverage and caring for patients for whom he/she is responsible and obtaining consultation when necessary for the safety of those patients.

h. Each Member shall treat as confidential, any information discussed in executive session and use confidential information only as necessary for treatment, payment and healthcare operations in accordance with the requirements of the Health Insurance Portability and Accountability Act of 1996, as amended, to conduct authorized research activities, or to perform Medical Staff responsibilities. For purposes of these Bylaws, confidential information means patient information, peer review information, and the Hospital's business information that is designated as confidential by the Hospital or its representatives prior to disclosure.

i. Each Member shall refrain from disclosing confidential information to anyone unless authorized to do so.

j. Each Member shall protect access codes and computer passwords and to ensure confidential information is not disclosed.

k. Each Member shall treat Hospital employees, patients, visitors and other Members in a dignified and courteous manner.

l. Each Member shall demonstrate the ability to work cooperatively and professionally with the Hospital, Hospital staff, and other Members and shall refrain from disruptive behavior that has interfered or could interfere with patient care or the operation of the Hospital and/or the Medical Staff.

m. Each Member shall comply with a request from the Chief of Staff or the Administrator to confirm current physical and mental capacity to practice medicine and his/her freedom from, or adequate control of, any physical, mental, or behavioral impairment, including substance and alcohol abuse.

n. Each Member shall promptly notify the Administrator of any change in the status of liability coverage, licensure, DEA registration, or any other information on the application form.

o. Each Member shall immediately notify the Administrator of his/her denial or loss of staff membership or denial, loss, curtailment, restriction of privileges at any hospital or other healthcare institution, of any adverse determination by a peer review organization concerning his/her quality of care; of the commencement of a formal investigation or the filing of charges by the United States Department of Health and Human Services,
any law enforcement agency, any regulatory agency of the United States, the State of Nevada, or any other state, or of the denial or loss of his/her right to participate in any federal or state program, including the Medicare and Medicaid programs.

p. Failure to meet these obligations may result in non-reappointment or the imposition of corrective action as provided in Article VII.

3.4.2 Rights of Each Member

a. Each Member has the right to an audience with the Executive Committee. In the event a Member is unable to resolve a difficulty working with the Chair of his/her Committee, the Member may, upon presentation of a written notice, meet with the Executive Committee to discuss the issue.

b. Each Member has the right to initiate a recall election of a Medical Staff officer. A petition for such recall must be presented to the Executive Committee and be signed by at least ten percent (10%) of the Active Staff. Upon presentation of a valid petition, the Executive Committee shall schedule a special meeting of the Medical Staff for the purpose of discussing the issue and, if appropriate, shall entertain a no confidence vote, followed by the removal of such Medical Staff officer from office, if appropriate.

c. Each Member has the right to initiate a call for a meeting of the Medical Staff. Upon presentation of a petition signed by ten percent (10%) of the Active Staff, the Executive Committee shall schedule a meeting of the Medical Staff for the specific purpose(s) addressed by the petitioners. No business other than that in the petition may be transacted.

d. Each Member has the right to initiate a challenge to any Medical Staff rule or policy established by the Executive Committee. In the event any Medical Staff rule or policy is felt to be inappropriate, any Member may submit a petition signed by ten percent (10%) of the Active Staff.

(1) The petition should clearly state the basis of the disagreement and may include any other information by way of additional explanation to Medical Staff members. The petitioner must acknowledge that he/she has read the petition and all attachments, if any, in order for his/her signature to be considered valid.

(2) The Executive Committee will consider the challenge at its next meeting and will determine what changes will be made to the Medical Staff rule or policy or will appoint a subcommittee to review and challenge and recommend potential changes.
to address the concerns. The Executive Committee will review subcommittee recommendations and take final action on the rule or policy. The Executive Committee will communicate all changes to the Medical Staff.

(3) Should the parties fail to reach resolution, or if the voting members do not approve any proposed solution agreed to by the petitioners and the Executive Committee, the petition and all accompanying materials will be forwarded to the Board for its review and consideration. The decision of the Board shall be final.

(4) If, on the other hand, the voting members accept the conflict resolution as proposed by the petitioners and the Executive Committee, the resolution, the initial petition and all accompanying materials shall be forwarded to the Board for its review and consideration. The decision of the Board shall be final.

(5) Nothing under this section precludes direct communication between an individual member and the Board regarding any rule, regulation or policy already adopted by the Medical Staff or the Executive Committee.

(6) Such communication shall be forwarded to the Executive Committee of the Board through the Chief Executive Officer of the Hospital and to the Executive Committee through the Chief of Staff. The Chair of the Board shall determine the manner and method of responding to any physician(s) communicating to the Board under this Article.

3.5 MEDICAL DIRECTOR ROLE

3.5.1 A medical director is a Member engaged by the Hospital or the Medical Staff, either full or part-time, in an administrative capacity, whose activities may include clinical responsibilities such as direct patient care, research or supervision of the patient care activities of other Members under the medical director’s direction.

3.5.2 When provided for by contract, a medical director’s responsibilities shall include assisting the Medical Staff and/or Banner Health’s Care Management Council to carry out its peer review and quality improvement activities. Such medical director may serve as an ex-officio member of all committees of the Medical Staff, without vote, consistent with the scope of his/her responsibility.
3.6 COOPERATIVENESS

Demonstrated ability to work with, and relate to, others in a cooperative, professional manner is essential for maintaining an environment appropriate to quality and efficient patient care. It is the policy of the Hospital and the Medical Staff, that all individuals within its facility be treated courteously, respectfully, and with dignity. The Medical Staff prohibits and shall not tolerate abuse or harassment by Members or Allied Health Professionals. This includes verbal or physical behavior that a reasonable person would regard as hostile, intimidating, disrespectful, or offensive. Should claims about such behavior occur, the situation shall be investigated. If inappropriate behavior is determined to have occurred, the situation shall be judged on the nature and severity of the behavior, as well as patterns of behavior.

In order to effectively and expeditiously address complaints from Hospital staff concerning Member conduct and/or behavior (other than quality of care issues), each complaint shall be submitted, and shall be processed, in accordance with the Medical Staff disruptive practitioner policy. The Medical Staff and the Hospital shall, to the extent permitted by law, protect the identity of complainants and the confidentiality of the information, ensuring an environment of fairness for all involved.

As appropriate, Hospital administration shall adopt policies and procedures consistent with the policy and these Bylaws, to inform Hospital personnel about the mechanisms and processes for lodging complaints about Member conduct.

Complaints of sexual harassment also shall be handled in accordance with the Banner Health Sexual Harassment Policy and Procedure.
ARTICLE IV: CATEGORIES OF THE MEDICAL STAFF

4.1 STAFF CATEGORIES

The Medical Staff shall be divided into the following categories: Active Staff, Courtesy Staff, Consulting Staff, Honorary Staff/Emeritus and Federally Employed Military Staff.

For the purposes of this Article IV, the following interpretations shall apply:

Physician Members may admit inpatients and/or ambulatory surgery patients as provided in these Bylaws. Dentist and podiatrist Members may admit inpatients and/or ambulatory surgery patients provided it is demonstrated, at the time of admission, that a specified physician Member concurs with the admission and agrees to assume responsibility for the basic medical appraisal of the patient, and for the care of any medical problems that may be present or may arise during the admission, as specified in the Medical Staff Rules and Regulations.

4.1.1 Active Staff: The Active Staff shall consist of:

a. those Practitioners who have demonstrated a special interest in the Hospital by applying for, and being granted, Medical Staff membership in the Active Staff category, regularly admitting, treating and/or performing consultations for patients cared for at the Hospital, or are regularly involved in medical staff functions, as determined by the Executive Committee, such that the Medical Staff is afforded adequate opportunity to assure the quality of the member’s judgment and/or clinical practice in an acute care setting, locating his or her office and residence in such proximity to the Hospital as to be readily available to Hospital patients for continuous and emergency care, taking an active role in Medical Staff affairs by accepting and fulfilling committee assignments, service as Medical Staff officers, and otherwise contributing to accomplishment of the Medical Staff purposes;

b. the Physician Director of the Department of Radiology, the Physician Director of the Department of Pathology, and the Physician Director of the Emergency Department, Hospitalists; and

c. those physician Members who work full-time (eight shifts per month) in the Emergency Department and who request membership on the Active Staff.

d. Members of the Active Staff shall have delineated clinical privileges, shall be eligible to serve on Medical Staff committees, to vote, and to hold office, provided, however, that dentist and podiatrist members of the Active Staff may not vote on specified matters for which medical education, training and experience, beyond which dentists and podiatrist
can demonstrate, are deemed prerequisites for making an informed judgment thereon.

e. Active Staff members are required to attend a minimum of fifty percent (50%) of general Medical Staff meetings with the exception of the Active Staff members listed in Paragraphs 4.1.1 b. and c above, in addition to any rotating/contracted members (Emergency Medicine, Hospitalist, Radiologist, Pathologist).

f. Failure of an Active Staff member to satisfy the qualifications or obligations of the Active Staff category at time of Reappointment may result in re-assignment by the Executive Committee to another staff category.

4.1.2 Courtesy Staff:
   a. The Courtesy Staff shall consist of those Practitioners who apply for, and are granted, Medical Staff membership in the Courtesy Staff category, whose office and/or residence is at a location in relation to the Hospital such that the Member is generally not readily available to Hospital patients for continuous and emergency care, or whose annual total admissions number less than fifteen (15), excluding the Physician Director of the Department of Radiology, the Physician Director of the Department of Pathology, the Physician Director of the Emergency Department and Hospitalists who are granted Active Staff status as described in Article IV: Section 4.1.1(b), and those Members granted Active Staff status as described in Article IV: Section 4.1.1(c).

   b. Members of the Courtesy Staff shall have delineated clinical privileges, shall be eligible to serve on Medical Staff committees, shall not be eligible to vote, and shall not be eligible to hold office.

   c. Failure of a Courtesy Staff member to satisfy the qualifications or obligations of the Courtesy Staff category at time of Reappointment may result in re-assignment by the Executive Committee to another staff category.

4.1.3 Consulting Staff: The Consulting Staff shall consist of Practitioners who are not otherwise members of the Active Staff, the Courtesy Staff, the Honorary Staff/Emeritus or the Federally Employed Military Staff, and are interested in the Hospital but do not wish to have Active Staff or Courtesy Staff obligations. Members of the Consulting Staff may not admit patients, and shall have only the delineated clinical privileges of: assessment of patients, differential diagnosis, lab or other diagnostic test interpretation. They shall not be eligible to serve on Medical Staff committees, shall not be eligible to vote, and shall not be eligible to hold office.
4.1.4 Honorary Staff/Emeritus: Honorary Staff/Emeritus shall consist of Practitioners not active in Hospital practice but who, because of outstanding service, years of service, reputation or recognition, may be appointed to the Honorary Staff/Emeritus. They shall not be eligible to serve on Medical Staff committees, shall not be eligible to vote, and shall not be eligible to hold office.

4.1.5 Federally Employed Military Staff: The Federally Employed Military Staff shall consist of physicians and dentists who meet the requirements of, and hold privileges and responsibilities identical to, Active Staff membership, with the following exceptions:

a. Federally Employed Military Staff shall not be required to have a license to practice in the State of Nevada if the Member has a current license to practice in one of other forty-nine (49) states.

b. Federally Employed Military Staff must be members in good standing of the active, associate, or provisional medical staff of other Federal military facilities with which the Medical Staff has a Memorandum of Understanding.

c. Federally Employed Military Staff members are not required to serve on Medical Staff committees. They shall not be eligible to vote or hold office in the Medical Staff. The Chief of Staff shall appoint one physician representative from the Federally Employed Military Staff to serve on the Quality Improvement Committee and the Executive Committee and to attend general Staff Meetings. The same physician may not serve than two (2) consecutive years as the representative of the Federally Employed Military Staff.

d. Federally Employed Military Staff are restricted to the care of patients who are eligible for care at military health care facilities.

e. Federally Employed Military Staff who wish to care for other patients must apply for membership on the Active Staff.

f. Federally Employed Military Staff are not required to participate in Emergency Department back-up call.

Specific operation criteria are detailed in the current Memorandum of Understanding between Fallon Naval Air Station Branch Clinic and the Medical Staff.

4.2 PROVISIONAL NATURE OF INITIAL APPOINTMENT – INITIAL FOCUSED PROFESSIONAL PRACTICE EVALUATION PERIOD

All initial appointments (excluding the Honorary Staff category) are provisional in nature and shall be placed into an Initial Focused Professional Practice Evaluation (FPPE)
review period as per the System Focused Professional Practice Evaluation (FPPE) policy and procedure and these Members are subject to the following conditions:

4.2.1 The initial FPPE period shall be for six (6) months following the date on which clinical privileges were granted by the Governing Board.

4.2.2 During the initial FPPE period, the Member shall be entitled to admit patients to the Hospital and exercise the clinical privileges granted by the Governing Board.

4.2.3 During the initial FPPE period, the Member may be proctored by the chair of the appropriate clinical committee or a Member appointed by the Chief of Staff or designee for the initial performance of admissions and/or procedures as deemed necessary by the Executive Committee and/or Medical Quality Improvement Committee.

4.2.4 Upon successful completion of the initial FPPE period, the Executive Committee shall review a summary of the Member’s patient care activity at the Hospital and the written reports of the monitor/proctor(s). Following review of the Member’s patient care activity and monitored/proctored cases, the Executive Committee shall make recommendations to the Governing Board regarding advancement from the provisional status. Upon approval by the Governing Board, the new Member shall function as a non-provisional Member of the Medical Staff category to which he/she has been assigned and shall be reappointed in accordance with the provisions of these Bylaws. In the event of concerns regarding the Member’s patient care activity or the monitored/proctored cases, the Executive Committee shall determine whether any action under these Bylaws, such as correction action or further monitoring/proctoring, is warranted.

4.2.5 The initial FPPE period may be extended for additional periods of six (6) months each for as many times as deemed necessary, but advancement must occur prior to completion of twenty-four (24) months of membership. Failure to complete the initial FPPE period and advance from provisional status at the end of twenty (24) months shall result in automatic termination of the Member's initial appointment and Medical Staff membership.
ARTICLE V: PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

5.1. RESPONSIBILITIES OF APPLICANT

5.1.1 It shall be the responsibility of each Applicant to supply all information reasonably required by the Medical Staff committees and the Governing Board in order to make an informed judgment as to the Applicant's qualifications and compliance with the standards required by these Bylaws. To that end, it shall be the responsibility of the Applicant to supply all information requested by the appropriate committees of the Medical Staff, the officers of the Medical Staff, the Administrator, and/or the Governing Board, and the Applicant's duty to supply such information is not necessarily fulfilled simply by completing the application form. The Applicant shall have the burden of establishing to the satisfaction of the appropriate Medical Staff committees and to the Governing Board that he or she meets the standards required by these Bylaws and any applicable policies and procedures of the Hospital and the Governing Board. In the event that the information supplied by the Applicant to the committees of the Medical Staff and the Governing Board is not sufficient to permit an informed decision on the matter, then the application for appointment to the Medical Staff and for clinical privileges will be deemed incomplete. If any requested information is not obtained from the Applicant within sixty (60) days after written to the Applicant of the request for same, the subject application shall be deemed withdrawn from consideration and no further action will be taken on it. In the event that the information supplied by the Applicant to the committees of the Medical Staff or the Governing Board has been falsified, or contains material omissions, the application for appointment to the Medical Staff and for clinical privileges will be denied as defined in these Bylaws regarding ethical conduct.

5.1.2 All Applicants shall complete, sign and file with the Administrator such application or reappointment form as the Governing Board may require. Such forms shall require full and complete disclosure by the Applicant of all information required by Article V: Section 5.1.1, including, without limitation, the following matters:

a. Education - All institutions of higher learning attended by the Applicant (meaning all institutions attended after graduation from high school), including dates of attendance, areas of study and degrees awarded.

b. Training - All training programs of every type or description that are medically or health care related, in which the Applicant has participated, and for those programs completed by the Applicant, the date(s) of completion.

c. Professional Qualifications - All factors bearing upon the Applicant's professional qualifications, including a listing of at least three (3) professional references (physicians, dentists or podiatrists, as applicable),
who are personally acquainted with the Applicant. At least two (2) of these professional references must have extensive experience in observing and working with the Applicant, and be in a position to provide adequate references pertaining to the Applicant's professional competence, ethical character and compliance with the standards required for the appointment as set forth in Article V: Section 5.1.1. The form shall require the Applicant to identify all specialty boards to which he or she has applied for certification and dates of certification, if any. As to those Applicants who are not Board certified in any specialized field of medical practice, but who consider themselves to be "Board eligible," the Applicant shall provide information concerning the date upon which he or she first became "Board eligible" and the basis upon which "Board eligibility" is claimed.

d. Organizational Experience - All medical, surgical and/or health related organizations to which the Applicant has ever belonged or applied for membership and the current status of the Applicant's membership, including not only specialty organizations, but also professional societies and other professional organizations of every type.

e. Hospital Experience - Every hospital facility, or other acute care facility, including governmentally owned or operated facilities, at which the Applicant has applied for, and/or received Medical Staff appointment and/or other patient care privileges

f. Peer Review Information - Any pending or completed action or recommendation to deny, revoke, suspend, reduce, limit, impose supervision or consultation requirements; any refusal to process or withdrawal of an application; any voluntary or involuntary relinquishment (by resignation, expiration or otherwise); and/or any imposition of probation, letter of censure, letter or concern or other warning of or by or relating to medical staff membership status, prerogatives, or clinical privileges at any hospital or health care institution; specialty or subspecialty board certification or eligibility; and/or any professional society and other professional organization.

g. Insurance Experience - The Applicant's insurance and malpractice claims experience, including a certificate of insurance by a reliable insurance carrier indicating that the Applicant has, in full force and effect, valid and collectible insurance with coverage and policy limits in such amounts as the Governing Board may from time to time, determine. The Applicant shall disclose all claims made against the Applicant involving allegations of professional negligence or malpractice, and shall identify the person making the claim, the current status of all pending claims and the ultimate disposition of all closed claims.
h. Licensing Experience - The Applicant's experience with regard to any licensing agency of federal, state or local government, including all licenses granted, denied, suspended or revoked relating to the privilege of practicing any health care profession, including, but not limited to, the practice of medicine, osteopathy, dentistry or podiatry.

i. Felony Information - Any current felony criminal charges pending against the Applicant and any past charges including their resolution.

j. Exclusion Information - Any pending or current action against the Applicant that may exclude him or her from participation in Medicare and/or any other federally-supported healthcare program.

k. Health Status - Any physical or mental impairment (including alcohol and/or drug dependencies) which could affect the Applicant’s ability to exercise the clinical privileges requested or would require an accommodation in order for the Applicant to exercise the privileges requested safely and competently. Regardless of the nature of the Applicant's response, the application will be processed in the usual manner. If the Applicant answers this question affirmatively and is found to be professionally qualified for Medical Staff appointment and the clinical privileges requested, the Applicant will be given an opportunity to meet with the Executive Committee to determine what accommodations may be necessary or feasible to allow the Applicant to practice safely.

l. Continuing Education – Participation in continuing medical education related to the clinical privileges to be exercised by the Applicant and as required by the Applicant’s state license.

5.1.3 By making application for appointment or reappointment to the Medical Staff, the Applicant acknowledges his or her responsibility to give full, complete and accurate information, and to update any information or changes relating to the appointment or reappointment process on an ongoing basis. Any failure to give true, complete and accurate information concerning the matters required by these Bylaws, including the making of untrue statements in the application for appointment, or the failure to make materially true statements in said application, shall be sufficient grounds for denial of the application for appointment, or for automatic suspension of privileges already granted.

5.1.4 By making application for appointment or reappointment to the Medical Staff, the Applicant authorizes the release of all information required for making an informed judgment concerning the Applicant's compliance with the standards required by these Bylaws. Without limiting the foregoing, the Applicant authorizes the release of:

a. medical records and information relating to any physical or mental impairment which could affect the Applicant's ability to exercise the
clinical privileges requested or would require an accommodation in order for the Applicant to exercise the privileges requested safely and competently.

b. peer review information by all other hospitals or other health care organizations at which the Applicant has ever applied for or received Medical Staff privileges, even though said peer review records might be deemed "confidential" or "privileged."²

5.1.5 By making application for appointment or reappointment, the Applicant agrees to submit to such physical or mental examination(s), solely at Applicant's expense, as the Executive Committee or the Governing Board may require. In addition, by making application for appointment to the Medical Staff, the Applicant releases from civil liability the agents, attorneys, employees and representatives of the Hospital and Banner Health, as well as the agents, attorneys and representatives of the hospitals and other health care organizations to which inquiries are directed under these Bylaws, for all acts taken in good faith by said individuals in supplying information concerning the Applicant.

5.1.6 The forms shall include a statement that the Applicant has received and read these Bylaws and that he or she agrees to be bound by the terms thereof without regard to whether or not he or she is granted membership and clinical privileges.

5.1.7 The forms shall include a statement that the Applicant pledges to preserve the confidentiality of credentialing, peer review, and quality assurance information and activities.

5.1.8 The forms shall include a statement that the Applicant authorizes review and discussion of his or her application and all associated documentation by the Executive Committee and the Governing Board.

5.1.9 Qualified applicants in administrative positions who desire Medical Staff membership or clinical privileges are subject to the same procedures as all other Applicants for membership or privileges.

² It is recognized that certain documentation which would be of assistance in evaluating the Applicant’s compliance with standards required by these Bylaws, might otherwise be protected from disclosure because of a “privilege” that can be waived by the Applicant. Nothing contained in these Bylaws shall permit, or require, the improper or illegal disclosure of information relating to patients of the Applicant. If such patient care records are requested, care shall be taken to protect against disclosure of the patient’s identity or other matters protected by law from disclosure. However, by making application for appointment or reappointment to the Medical Staff, the Applicant authorizes and consents to release, as provided in these Bylaws, privileged or confidential information and records pertaining to his or her own physical or mental health status.
5.2 APPOINTMENT PROCESS

Upon receipt of an application and the applicable membership fees, as set forth in Article III: Section 3.3.6, the application for appointment to the Medical Staff shall be processed in the following manner:

5.2.1 Review and evaluation of an application by the Executive Committee for appointment to the Medical Staff shall not commence until the following information/documentation has been received and/or verified by the Hospital and/or its authorized agent. The information/documentation shall include but not limited to the following:

a. A completed application form;
b. A completed clinical privilege application;
c. Primary Source Verification of:
   (1) Medical Education (M.D, D.O., DDS or DPM);
   (2) Post-graduate education (internship, residency, and fellowship if any); and
   (3) Board certification certificate, if applicable;
d. Primary Source Verification of Nevada License, or current state license if the Applicant is applying in the Federally Employed Military Staff category, DEA and State Board of Pharmacy registration;
e. Copy of current certificate of malpractice insurance;
f. Three (3) professional reference letters;
g. Hospital affiliation verifications;
h. National Practitioner Data Bank Continuous Query Enrollment;
i. Responses to letters of inquiry and any other information that may be requested by the Hospital to complete the application process and is within the scope of the provisions of Article V: Section 5.1.
j. Other additional information that may be required by Medical Staff or Governing Board that would be relevant to making an informed decision.

Upon receipt by Medical Staff Services of all of the foregoing documentation, review and evaluation of the application shall commence within a timely manner. For purposes of these Bylaws, all of the documentation referred to in this Article V: Section 5.2.1 and Article V: Section 5.1 shall be referred to as "the completed application."

5.2.2 The completed application shall be reviewed and evaluated by the Medical Staff in accordance with this Article V: Section 5.2.2 within one hundred eighty (180) days. Such time period is a guideline and does not create any right to have an application processed within a specified period of time. The Medical Staff shall formulate recommendations to the Governing Board concerning the Applicant's compliance with the standards required by these Bylaws.
a. The completed application shall be referred to the Executive Committee. The Executive Committee shall review the Applicant's qualifications and measure them against the standards required by these Bylaws, and may conduct an interview.

In special situations where there are no Members on the Executive Committee with the expertise and/or experience to review the Applicant's qualifications and formulate recommendations regarding appointment and the requested privileges, the Chief of Staff may appoint one or more individuals from the Medical Staff, if possible, or from outside of the Medical Staff, if necessary, to advise the Executive Committee for the specific purpose of helping the Executive Committee make a recommendation on the Applicant.

b. Upon completion of its initial review, the Executive Committee shall make a recommendation concerning the appointment of the Applicant to the Medical Staff or shall defer taking action on the application pending further consideration or receipt of additional information. The forms of recommendation available to the Executive Committee shall include:

1. formulation of a recommendation to the Governing Board concerning the granting of Medical Staff membership and delineated clinical privileges; or

2. recommendation against appointment to the Medical Staff and/or recommendation against granting of any or all of the clinical privileges requested by the Applicant.

c. The effect of the Executive Committee's actions shall be as follows:

1. Favorable Recommendation

A recommendation of the Executive Committee that is favorable to the Applicant in all respects shall be promptly forwarded to the Governing Board.

2. Adverse Recommendation

An adverse recommendation of the Executive Committee shall entitle the Applicant to the procedural rights provided in these Bylaws, including Article XIV.

3. Deferral

An action by the Executive Committee to defer the application for further consideration or receipt of additional information shall be
followed up at its next regular meeting or upon receipt of adequate information with its recommendations as to approval or denial of, or any special limitations on, Medical Staff appointment, Medical Staff category, prerogatives, department and section affiliation, and scope of clinical privileges.

d. Upon approval of the Applicant by the Executive Committee, the Applicant may request temporary privileges as provided in Article VI: Section 6.2 of these Bylaws.

e. At its next regularly scheduled meeting, the Governing Board may adopt or reject, in whole or in part, a recommendation of the Executive Committee or refer the recommendation back to the Executive Committee for further consideration stating the reasons for such referral. Favorable action by the Governing Board is effective as its final decision. If the Governing Board's action is adverse to the Applicant in any respect, the Administrator promptly so informs the Applicant in writing who is then entitled to the procedural rights provided in these Bylaws, including Article XIV. Governing Board action after completion of the procedural rights provided in these Bylaws, including Article XIV, or after waiver of these rights is effective as the final decision of the Governing Board.

f. The Administrator shall notify the Applicant within thirty (30) days of the Governing Board’s decision to grant, limit, or deny membership.

5.3 REAPPOINTMENT PROCESS

5.3.1 In order to be granted continuing Medical Staff membership and clinical privileges, it shall be the responsibility of the Applicant to supply the appropriate committees of the Medical Staff and the Governing Board, with all of the current information required to the Medical Staff under the provisions of Article V: Section 5.1, in addition to, but not limited to, the number of successful procedures performed in the previous two (2) year period to include requested special delineated clinical privileges and/or additional updated training, as outlined in the reappointment criteria. After submission of such information, the committees of the Medical Staff and the Governing Board shall determine whether the Applicant continues to meet criteria of Medical Staff membership and clinical privileges. The Applicant must complete, sign and file with the Hospital, an application for reappointment in such form as the Governing Board may require. It shall also be the responsibility of the Applicant to supply such other data as may be reasonably requested by representatives of the Medical Staff and/or the Governing Board, within thirty (30) days of request therefore, in order that each may make an informed judgment as to the Applicant’s compliance with the standards required by these Bylaws. If any requested information is not obtained from the Applicant within sixty (60) days after written notice to the Applicant of the request for same,
the subject application shall be deemed withdrawn from consideration and no further action shall be taken on such application.

5.3.2 The reappointment process shall be commenced prior to the expiration of the Member's Medical Staff appointment as follows:

a. The Administrator shall cause to be mailed an application for reappointment and clinical privileges at least one hundred twenty (120) days prior to expiration date of privileges, to the Member at the most recent business address found in the Hospital's records.

b. The Applicant shall complete, sign, date, and return the application to the Administrator in a timely manner.

c. Review and evaluation of a reappointment application by the Executive Committee for reappointment to the Medical Staff shall not commence until the following information/documentation has been received and/or verified by the Hospital and/or its authorized agent. The information/documentation shall include but not limited to the following:

(1) A completed reappointment application form;
(2) A completed clinical privilege application;
(3) Primary Source Verification of:
   i. Board certification certificate, if applicable;
   ii. Nevada State License, or current state license if the Applicant is applying in the Federally Employed Military Staff category;
   iii. DEA registration;
   iv. State Board of Pharmacy registration;
   v. Current primary hospital affiliation verification;
   vi. OIG Sanction check;
(4) Copy of current certificate of malpractice insurance;
(5) One (1) professional reference letter;
(6) National Practitioner Data Bank Continuous Query Report;
(7) Continuing Medical Education (CME) hours as required by State License;
(8) Responses to letters of inquiry and any other information that may be requested by the Hospital to complete the application process and is within the scope of the provisions of Article V: Section 5.1; and
(9) Such other additional information that may be required by Medical Staff or Governing Board that would be relevant to making an informed decision.

d. The completed application for reappointment form and privileges, and such other information as may be requested by the Medical Staff or the
Governing Board as set forth in Article V: Section 5.3.2 (c) above, shall be forwarded to the Executive Committee.

In special circumstance where there are no individuals on the Executive Committee with the appropriate qualifications to review the Applicant's reapplication form, the Chief of Staff may appoint one (1) or more Members, if possible, or one or more Practitioners from outside of the Medical Staff as necessary, to serve on the Executive Committee, for the specific purpose of helping the Executive Committee make a recommendation on the Applicant.

5.3.3 The Executive Committee shall review the Applicant's file, and any other relevant information available to it and either make a recommendation for reappointment or non-reappointment and for Medical Staff category, department and section assignment, and clinical privileges, or defer action for further consideration.

5.3.4 Final processing of reappointments shall follow the procedure set forth in Article V: Section 5.2.2(c) and Article V: Section 5.2.2(e) above.

5.4 LEAVE OF ABSENCE

5.4.1 Request for Leave of Absence

a. A Member may, for good cause, be granted a voluntary leave of absence by the Chief of Staff and the Administrator, subject to the approval of the Governing Board, for a definitely stated period of time, not to exceed two (2) years, except for military service. Absence for longer than the period of time granted shall constitute voluntary resignation of Medical Staff membership and clinical privileges unless an exception is made by the Governing Board upon recommendation by the Executive Committee. A Member may be granted a leave of absence for an additional period of time so long as the total duration of the leave of absence does not exceed two (2) years. Such extensions shall be considered only in extraordinary cases where the additional period of time for the leave of absence would be in the best interest of the Hospital.

b. Requests for leaves of absence shall be sent, in writing, to the Administrator. The request shall include the reasons for the leave of absence, the proposed commencement date of the leave of absence and the proposed duration of the leave of absence. The Chief of Staff and the Administrator shall forward the request, together with their recommendations, to the Executive Committee for transmittal to the Governing Board.
c. During the duration of a leave of absence, the clinical privileges, prerogatives, and responsibilities of the Member who has been granted such leave of absence shall be suspended.

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

5.4.2 Reinstatement

a. A Member who has been granted a leave of absence may request reinstatement of Medical Staff status and clinical privileges at the conclusion of the leave of absence or at any time prior to the defined ending date of the leave of absence. Such request for reinstatement shall be submitted, in writing, to the Administrator and shall include a summary of all professional activities undertaken during the leave of absence as well as evidence of current licensure, DEA registration, if applicable, and liability insurance coverage. If the leave of absence extended beyond the Member's current appointment term, then, the Member also shall be required to complete an application for reappointment to the Medical Staff.

b. The Chief of Staff and the Administrator shall forward the request for reinstatement, together with their recommendations, to the Executive Committee for further consideration. The Member who is requesting reinstatement also shall provide such other information as may be requested by the Executive Committee at such time.

c. If the leave of absence was for medical reasons, the Member who is requesting reinstatement shall submit a report from his or her Practitioner indicating that the Member is physically and mentally capable of exercising the clinical privileges requested. The Member also shall provide such other information as may be requested by the Executive Committee at such time.

d. After considering all relevant information, the Executive Committee shall make its recommendation on the request for reinstatement to the Governing Board. The Executive Committee may approve reinstatement either to the same or a different Medical Staff category and may limit or modify the clinical privileges to be extended to the Member upon reinstatement. If the recommendation of the Executive Committee or the Governing Board is adverse to the Member seeking reinstatement, such recommendation shall be processed in accordance with Article XIV.
5.5 REQUESTS FOR MODIFICATION OF APPOINTMENT

A Member may, either in connection with reappointment or at any other time, request modification of his or her Medical Staff category or clinical privileges by submitting an appropriate request form to the Administrator completing the relevant sections. Such application shall be processed in substantially the same manner as for reappointment as provided in Article V: Section 5.3.
ARTICLE VI: CLINICAL PRIVILEGES

6.1 CLINICAL PRIVILEGES RESTRICTED

6.1.1 Every Member shall be entitled to exercise only those clinical privileges specifically granted to him or her by the Governing Board, except as provided in Article VI: Section 6.2, Article VI: Section 6.3 and Article VI: Section 6.4.

a. Every application for Medical Staff appointment or reappointment must contain a request for specific clinical privileges desired by the Applicant on such form as the Governing Board may require. The evaluation of such requests shall be based upon the Applicant's compliance with the standards required by these Bylaws. The Applicant shall have the burden of establishing his or her qualifications and competency in the clinical privileges requested.

b. Privileges granted to dentists and podiatrists shall be based on their training, experience and demonstrated competence and judgment. The scope and extent of surgical procedures, if any, that each dentist or podiatrist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by dentists or podiatrists shall be under the overall supervision of the Chief of Staff or his or her designee. All dental or podiatric patients shall receive the same basic medical appraisal as patients admitted to other surgical services. A physician Member shall be responsible for a current (less than seven (7) days old) history and physical, and for the care of any medical problem that may be present at the time of admission, or that may arise during the procedure or hospitalization.

6.1.2 The following must be successfully completed, as applicable, prior to exercising clinical privileges at the Hospital:

a. Banner Health’s electronic medical record/computerized physician order entry (CPOE) training as provided by Article XVI Section 16.10.3 of the Rules and Regulations; and


c. Exceptions may be made for Practitioners granted temporary or disaster privileges.
6.2 TEMPORARY PRIVILEGES

6.2.1 Upon receipt of a completed application for Medical Staff membership from an appropriately licensed Applicant, after receipt of a copy of current Nevada license (or other state license in the case of an Applicant in the Federally Employed Military Staff category), after verification of such license by the Hospital, with all of the current information required for initial appointment to the Medical Staff under the provisions of Article V: Section 5.1, and with the approval of the Chief of Staff, acting on behalf of the Executive Committee, the Administrator may grant temporary admitting and clinical privileges to the Applicant for up to sixty (60) days to allow for completion of the Governing Board’s approval of the Applicant; provided, however, that in exercising such privileges, the Applicant shall act under the supervision of the Member(s) that the Chief of Staff assigns to monitor his or her practice.

6.2.2 Temporary clinical privileges may also be granted by the Administrator to Practitioners who do not intend to become Members for the care of a specific patient(s) in order to provide specialized services/care not otherwise provided by Members under the following terms and conditions:

a. The Applicant for temporary clinical privileges shall advise the Chief of Staff, or his or her designee, of his or her qualifications and the extent to which he or she complies with the standards required by these Bylaws; and

b. The Applicant shall furnish proof of licensure, which must be verified by Hospital and/or its authorized agent, and proof of adequate professional liability insurance coverage.

Under such circumstances, and upon the recommendation of the Chief of Staff or his or her designee, the Administrator may grant temporary clinical privileges. Such temporary privileges shall be restricted to the treatment of not more than two (2) patients in any twelve (12) month period.

6.2.3 A Practitioner may be permitted to serve as locum tenens Practitioner for a Member or for an urgent patient care need, under the following conditions:

a. The Member desiring to utilize a locum tenens Practitioner for coverage of his or her practice shall advise the Administrator of the name and address of the proposed locum tenens Practitioner, and the planned dates of service at the Hospital. It is the responsibility of the Member to insure that the proposed locum tenens Practitioner complies, in all respects, with the provisions of these Bylaws.

b. The locum tenens Practitioner shall complete and sign an application for appointment to the Medical Staff. The application will not be processed
for review, but will be used as a source of information concerning the qualifications of the Practitioner, and by signing the application, the locum tenens Practitioner agrees to be bound by these Bylaws.

Upon receipt of a completed application, and after verifications as detailed below by the Hospital and/or its authorized agent, and upon review and approval of privileges, an appropriately licensed Practitioner who is serving as a locum tenens may, without applying for membership on the Medical Staff, be granted temporary privileges which may not exceed a total of one hundred twenty (120) cumulative days within any twelve (12) month period. If a locum tenens Practitioner has been granted limited temporary privileges for more than one hundred twenty (120) days in any twelve (12) month period, such locum tenens Practitioner shall be required to apply for Medical Staff membership.

c. Locum Tenens privileges will not be granted until the following information/documentation has been received and/or verified by the Hospital and/or its authorized agent. The information/documentation shall include but not limited to the following:

(1) A completed application form;
(2) A completed clinical privilege application;
(3) Primary Source Verification of:
   i. Nevada State License, or current state license if the Applicant is applying in the Federally Employed Military Staff category;
   ii. All other State License listed on application;
   iii. Medical Education
   iv. Post-graduate education
   v. ECFMG, if applicable
   vi. Board certification, if applicable
   vii. DEA registration;
   viii. State Board of Pharmacy registration;
   ix. Current primary hospital affiliation verification;
   x. OIG Sanction check;
   xi. NPI;
   xii. PECOS
(4) Copy of current certificate of malpractice insurance;
(5) One (1) professional reference letter;
(6) National Practitioner Data Bank Continuous Query Report;
(7) Continuing Medical Education (CME) hours are required by State License;
(8) Procedure Log;
(9) Responses to letters of inquiry and any other information that may be requested by the Hospital to complete the application process and is within the scope of the provisions of Article V: Section 5.1; and
(10) Such other additional information that may be required by the Hospital that would be relevant to making an informed decision.

d. The Administrator may permit the locum tenens Practitioner to care for patients in the Hospital only with the approval of the Chief of Staff.

6.2.4 Special requirements or conditions may be imposed by the Chief of Staff or Administrator on any Practitioner granted temporary privileges. Before temporary privileges are granted the Practitioner must acknowledge in writing that he or she has received and read these Bylaws, and that he or she agrees to be bound by the terms thereof in all matters relating to his or her temporary privileges.

6.2.5 The Administrator may, at any time, and without notice, revoke temporary privileges and he or she shall revoke the temporary privileges of a Practitioner when requested to do so in writing by the Chief of Staff. On the discovery of any information pertinent to a Practitioner’s qualifications or ability to exercise any or all of the temporary privileges granted, or the occurrence of any event of a professionally questionable nature, the Chief of Staff, or the Administrator, after consultation with the Chief of Staff, may terminate any or all of such Practitioner’s temporary privileges, provided that where the life or well-being of a patient is determined to be endangered by continued treatment by the Practitioner, the termination may be effected by any person entitled to impose precautionary suspensions under Article VII.

6.2.6 Revocation of temporary privileges shall not be subject to review by any committee of the Medical Staff or the Governing Board; nor shall such termination be the subject of any proceedings under Article XIV. Where appropriate or necessary, the Chief of Staff shall arrange for the continued care of patients who have been admitted by a Practitioner whose temporary privileges have been terminated. The wishes of the patient shall be considered, where feasible, in choosing a substitute Member. The Practitioner whose temporary privileges have been terminated shall confer with the substitute Member to the extent necessary to safeguard the patient.

6.3 EMERGENCY MEDICAL SITUATIONS

In the event of a medical emergency, any Member, to the degree permitted by his or her license and regardless of Medical Staff category, shall be permitted to do everything reasonably possible to save the life of a patient, using every available facility of the Hospital. When such emergency situation no longer exists, such Member must request the privileges necessary to continue to treat the patient. In the event such privileges are denied, or he or she desires not to request such privileges, the patient shall be assigned to an appropriate Member by the Chief of Staff. For the purposes of this Article VI: Section 6.3, an "emergency" is defined as a condition in which serious permanent harm or death would result to a patient and any delay in administering treatment would add to that risk.
6.4 DISASTER MANAGEMENT

In the event of a disaster situation, the Administrator or the Chief of Staff, or their respective designee(s), may grant temporary emergency privileges to a volunteer licensed Practitioner (LIP) who is not then a Member, but only after the identity of the volunteer LIP has been verified. The minimum acceptable sources of identification for the volunteer LIP providing emergency care shall include a valid government-issued photo identification (i.e. a driver’s license or passport) and at least one of the following:

a. A current picture identification card from a health care organization that clearly identifies professional designation;

b. A current license to practice in any state in the United States;

c. Identification indicating that the volunteer LIP is a member of a Disaster Medical Assistance Team (DMAT), of the Medical Reserve Corps (MRC), or the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP); or other recognized state or federal response organization or group;

d. Identification indicating that the volunteer LIP has been granted authority by a government entity to render patient care, treatment, and services in disaster circumstances; or

e. Verification of the volunteer LIP’s identity by a current Hospital employee or a current Member with personal knowledge of the volunteer LIP’s ability to act as a licensed independent practitioner during a disaster.

Volunteer LIPs will be identified by a name badge provided by the Hospital. The badge will include the name and professional designation of the volunteer LIP as well as the notation that the individual is a volunteer. The volunteer LIP will be required to wear the badge at all times while performing in that role/capacity.

Such temporary privileges shall last for the duration of the disaster or for ninety (90) days, whichever occurs first. Medical Staff Services will begin the verification process of the credentials of each volunteer LIP who receives disaster privileges as soon as the immediate situation is under control, and such verification process shall be completed within seventy-two (72) hours from the time the volunteer LIP presents to the Hospital, if possible. If extraordinary circumstances, such as lack of communication means or resources, prevent the primary source verification from being completed within seventy-two (72) hours, Medical Staff Services shall document the reason for the delay, evidence of a demonstrated ability on the part of the volunteer LIP to provide adequate care, treatment and services, and all attempts to rectify the situation as soon as possible.

The Hospital shall make a decision, based on the information obtained regarding the professional practice of the volunteer LIP within seventy-two (72) hours related to the continuation of the disaster privileges initially granted to such volunteer LIP. The
verification process will be the same as described in Article V: Section 5.2 of these Bylaws.

The Administrator or the Chief of Staff, or their respective designee(s), will pair the volunteer LIP who is granted disaster management privileges with a Member for the duration of such temporary privileges. Whenever possible, the volunteer LIP will be paired with a Member who is in a similar specialty/practice. The Member will serve as a mentor and resource for the volunteer LIP. The Member will be responsible for overseeing the professional performance of the volunteer LIP. This may be accomplished by:

a. Direct observation; or


Furthermore, notwithstanding any existing delineation of privileges or scope of authority, Members, Hospital employees and volunteers are authorized to take whatever steps they reasonably believe are necessary to save or preserve the life or health of patients or the public health during a mass disaster.

6.5 TELEMEDICINE PRIVILEGES

6.5.1 “Telemedicine Privileges” means the authorization granted to a Practitioner by the Governing Board to render a diagnosis of a patient at the Hospital through the use of electronic communication or other communications technologies. The Practitioner will not be a Member and may not provide direct patient care.

6.5.2 Any Practitioner who wishes to be considered for Telemedicine Privileges will provide the following documentation to Medical Staff Services or its designee:

a. Signed consent and release/authorization form;

b. Current Nevada license to practice medicine;

c. Curriculum Vitae;

d. Current copy of DEA and state controlled substance certificate, if applicable;

e. Current copy of professional liability insurance coverage certificate in such minimum amount as may be required by the Hospital;

f. Evidence of no exclusion from any federal health care program;
g. Evidence of medical staff appointment and clinical privileges in good standing at another Joint Commission accredited or equivalent hospital/organization;

h. The application fee; and

i. Such additional information as may be requested by the Hospital.

6.5.3 The following verifications will be completed by Medical Staff Services or its designee:

a. Query to the National Practitioner Data Bank;

b. Query to determine that the Practitioner has not been excluded from any federal health care program;

c. Verification of the Practitioner’s medical staff status at the Practitioner's primary Joint Commission accredited or equivalent hospital/organization;

d. Verification of the Practitioner's medical license(s) in the Practitioner’s primary state and the state in which telemedicine services will be provided (when applicable); and

e. Verification of the Practitioner's current DEA status, when applicable; and verification of the Practitioner's current board status (when applicable).

6.5.4 The Executive Committee will confer with the Physician Director of the applicable Department or the chair of the applicable committee regarding the clinical services that may be offered through telemedicine.

The Administrator, with input from the Executive Committee, will determine the specific services to be provided at the Hospital via telemedicine.

The Executive Committee will make a recommendation to the Governing Board regarding whether the Practitioner's request for Telemedicine Privileges should be granted. The decision of the Governing Board will be final.

6.5.5 Practitioners may be granted Telemedicine Privileges for a period not to exceed two (2) years and will be required to submit an application for reappointment prior to the expiration of his or her Telemedicine Privileges.

6.5.6 A Practitioner who has been granted Telemedicine Privileges will immediately report to the Administrator the loss or suspension of any license, certificate or authorization described in Article III: Section 3.4.1(m) above. Such loss or suspension will result in the immediate and automatic relinquishment of any and
all Telemedicine Privileges with no right to a hearing or an appeal as outlined in these Bylaws.

If telemedicine services are being provided at the Hospital through a contracted group, it will be the responsibility of the contracted group to notify Medical Staff Services or its designee of any Practitioner who requires Telemedicine Privileges and of any Practitioner who no longer needs to maintain Telemedicine Privileges.

6.5.7 If any Practitioner who has been granted Telemedicine Privileges intends to direct patient care or to provide “hands-on” patient care, such Practitioner will be required to apply for Medical Staff membership and clinical privileges at the Hospital prior to the provision of any such direct patient care.
ARTICLE VII: PROFESSIONAL REVIEW PROCEDURES & CORRECTIVE ACTION

7.1 NATURE OF PROFESSIONAL REVIEW PROCEDURES

7.1.1 Resolution of any controversy or request for an investigation regarding a Member's compliance with these Bylaws, shall, if possible, be accomplished by an informal professional review procedure by the appropriate Medical Staff Committee.

7.1.2 Initiation of Professional Review Procedures

a. Whenever a matter that alleges grounds for an investigation comes to the attention of any Member, the Administrator, or the Governing Board, a written request for a professional review procedure shall be made to the Chief of Staff, or in his or her absence or inability to act, the Vice-Chief of Staff. The allegations shall be supported by reference to specific activities or conduct that would be grounds for an investigation. No anonymous or oral requests shall be considered.

b. The Chief of Staff (or the Vice-Chief of Staff) shall arrange for a confidential investigation of the matters alleged in the request, by an investigating committee of not less than two (2) Members. The Chief of Staff also shall notify the Administrator of the investigation. If possible, the members of the investigating committee shall not be in direct economic competition with the Member in question.

c. If preliminary investigation by the committee indicates that the matter does not merit serious attention, the committee shall report to the Chief of Staff through written recommendation and the investigation shall be closed without further action. A copy of this report shall be retained in the quality/peer review file of the Member in question.

d. If preliminary investigation indicates that the matter merits more detailed investigation, the Chief of Staff shall promptly notify the Member and give the Member an opportunity to meet informally with the investigation committee before it makes its report. At this meeting (but not, as a matter of right, in advance of it) the Member shall be informed of the general nature of the evidence supporting the investigation requested and shall be invited to discuss, explain, or refute it. The Member may also be allowed to present any written information he or she feels is relevant for the ad hoc committee to review. This interview shall not constitute a hearing and none of the procedural rules provided in these Bylaws shall apply. If the matter can be resolved to the satisfaction of the investigation committee, it shall be dismissed with an appropriate notation made in the committee
records. A copy of the documentation also shall be retained in the quality/peer review file of the Member in question.

e. If the investigating committee and/or Chief of Staff recommends that corrective action be initiated at any time during these procedures, the recommendation shall be in the form of a written report that is forwarded to the Executive Committee, along with supporting documentation.

f. An investigation is not a prerequisite to initiating a corrective action, but is encouraged when appropriate. At any time during the corrective action, if it is deemed appropriate to initiate an investigation, one may be requested pursuant to this Article VII.

7.1.3 Administrator’s Option

When the Executive Committee has rejected a request for corrective action as set forth in Article VII: Section 7.2.3, the Administrator may either appoint an ad hoc investigating committee, or direct the appropriate committee chairman to appoint an investigating committee, to investigate further the activities or conduct, and to submit a written report of the investigation to him. Such report shall be submitted by the Administrator to the Executive Committee for action in accordance with Article VII: Section 7.2.

7.1.4 Governing Board Option

When the Executive Committee, after review of a report of investigation, or after review of precautionary suspension imposed pursuant to Article VII: Section 7.4, determines that no corrective action be taken, the Administrator shall report such determination to the Governing Board. The Governing Board, in its discretion, may appoint a committee to conduct an investigation of the conduct that served as the basis for the request for corrective action and, after receipt of the report of the investigation, take any such action as is set forth in Article VII: Section 7.2.

7.1.5 If, after an investigation is completed and the Executive Committee has recommended corrective action, or at any other time a corrective action is initiated, the Member shall be entitled to the procedural rights as provided for in these Bylaws, including Article XIV, and the matter shall be processed in accordance with these Bylaws, including Article XIV.

7.2 CORRECTIVE ACTION

7.2.1 If it appears that a Member does not meet the standards required by these Bylaws for Medical Staff membership, or for specific clinical privileges that have been granted, or otherwise appears to have engaged in a course of conduct or practice that is, or may be, detrimental to patient safety, or a substantial hindrance to the delivery of quality patient care by others, is disruptive to the Hospital's
operations, or is an impairment to the community’s confidence in the Hospital or
the Medical Staff, a corrective action proceeding may be initiated by any of the
following persons: any officer of the Medical Staff, the chair of any standing
committee of the Medical Staff, the Administrator, or the Governing Board.

7.2.2 A corrective action proceeding may be initiated only in the following manner:

a. A written request for corrective action must be submitted to the Chief of
Staff, or in his or her absence or inability to act, the Vice-Chief of Staff. A
copy of such request shall also be submitted to the Administrator.

b. The above request for corrective action must specify the type of action
requested and shall give a general description of the basis upon which this
corrective action has been requested.

7.2.3 Decision and course of action by the Executive Committee

a. All requests for corrective action shall be reviewed by the Executive
Committee within thirty (30) days of receipt.

b. The Executive Committee may:

(1) Determine that the request is without merit and recommend no
action be taken.

(2) Determine that more information is needed and request an
investigation pursuant to Article VII: Section 7.1 above.

(3) Determine that sufficient information exists to make a
recommendation for corrective action.

7.2.4 Notice to the Member

a. If a recommendation for corrective action is made by the Executive
Committee, the Administrator shall send to the Member, a written
preliminary statement of the general nature of the charges, the
recommendation, and a course of action to be followed.

b. If the recommendation for corrective action is non-reviewable, the
Executive Committee shall consider its implementation and so advise the
Member in writing.

c. If the recommendation for corrective action is reviewable, the Member
shall be informed in writing of his or her rights to a hearing and shall be
provided a copy of these Bylaws, including Article XIV.
7.2.5 The various time periods within which to hold hearings or render decisions shall be subject to practical considerations. Reasonable variances may be necessary and will not amount to a violation of the terms of these Bylaws.

7.3 NON-REVIEWABLE FORMS OF CORRECTIVE ACTION

7.3.1 Not every form of requested corrective action entitles a Member to a formal hearing and/or appeal pursuant to Article XIV before the corrective action is implemented. For example, precautionary suspension may be implemented immediately under the terms set forth in Article VII: Section 7.4. In addition, the following types of corrective action are not deemed to be a reduction, suspension or revocation of clinical privileges or Medical Staff membership and therefore may be imposed by the Executive Committee without affording the Member the procedural steps provided for in Article XIV:

a. imposition of a program of individual monitoring of professional practices, with retrospective review of practice but without special requirements of consultation or supervision;

b. the requirement of additional formal, practical, clinical or other training or education;

c. the issuance of warning or letter of admonition;

d. the issuance of a letter of reprimand; or

e. the granting of conditional appointment or appointment of a limited duration to the Medical Staff; or

f. the re-assignment of Medical Staff category at the time of reappointment.

7.3.2 The inability of a Member to exercise clinical privileges and/or the rights and prerogatives of Medical Staff membership as a result of (a) Hospital's decision to enter into, to terminate, or to modify an exclusive arrangement with a single Practitioner or provider group to provide certain clinical services, or (b) the termination or modification of the Member's relationship with the exclusive provider shall not constitute a reduction, suspension or revocation of such clinical privileges and/or Medical Staff membership such that the affected Member would be afforded any of the rights set forth in Article XIV.

7.3.3 The determination that an Applicant is ineligible to apply for initial appointment or reappointment to the Medical Staff and for clinical privileges as a result of the Hospital's decision to enter into an exclusive arrangement with a single Practitioner or provider group to provide certain clinical services shall not constitute a reviewable action.
7.3.4 The forms of corrective action that, when requested, entitle a Member to hearing and review are set forth in Article XIV: Section 14.2.1.

7.3.5 If the corrective action recommended by the Executive Committee constitutes a reviewable adverse action against the Member's clinical privileges or Medical Staff membership, then the Member is afforded all the rights set forth in Article XIV. All parties shall abide by the procedure set forth in Article XIV, if such a recommendation is made by the Executive Committee.

7.4 PRECAUTIONARY SUSPENSION

7.4.1 Precautionary suspension of all or any portion of the clinical privileges of a Member may be imposed whenever such action must be taken immediately in the best interest of patient care. Any one of the following shall have the authority to impose precautionary suspension: the Chief of Staff, the Executive Committee, the Administrator, or the Governing Board. Precautionary suspension shall become effective immediately upon giving notice thereof to the affected Member. Such notice must be written and shall, if practical, be given by the Administrator, or in the event of his or her unavailability, shall be given by the Chief of Staff or member of the Executive Committee.

7.4.2 Executive Committee Action

Upon the written request of the suspended Member, a meeting of the Executive Committee shall be convened as soon as reasonably possible after the imposition of the precautionary suspension to review and consider the action taken. Otherwise, the review and consideration shall take place at the next regularly scheduled meeting of the Executive Committee. The Executive Committee shall recommend to the Governing Board modification, continuation or termination of the terms of the precautionary suspension and the action, if any, to be taken by the affected Member to have the suspension lifted.

7.4.3 Procedural Rights

a. Unless the Executive Committee recommends termination of the suspension and cessation of all other corrective action, the Member shall be entitled to the procedural rights as provided for in these Bylaws, including Article XIV. If the Executive Committee recommends termination of the suspension, the suspension shall be lifted until the Governing Board has reviewed the recommendation and taken action.

b. If the Governing Board decides to continue the suspension, the suspension shall remain in effect or be reinstated and the Member shall be entitled to the procedural rights as provided for in these Bylaws, including Article XIV.
c. If the Executive Committee recommends less restrictive terms of suspension, the original suspension shall remain in effect until the Governing Board has reviewed the recommendation and taken action to modify or terminate the suspension. If the suspension is continued, either as originally imposed or as modified, the Member shall be entitled to the procedural rights as provided for in these Bylaws, including Article XIV.

7.5 AUTOMATIC SUSPENSION

7.5.1 A temporary suspension of a Member's clinical privileges effective until medical records are completed shall be imposed automatically for failure to complete medical records within the time period specified in the Medical Staff Rules and Regulations and in the Documentation Requirements for the Medical Record Policy. While on suspension, the Member may not admit patients or schedule inpatient or outpatient procedures. This suspension does not include Emergency Department admission while on Emergency Department back-up call. Members shall not be suspended while on vacation or out of town.

7.5.2 If a Member's license to practice his or her profession in the State of Nevada is revoked or suspended, or the licensing agency imposes terms of probation or limitation of practice on the Member, such Member shall immediately and automatically be suspended from practicing in the Hospital.

7.5.3 Final action taken by the Nevada Board of Medical Examiners, the Nevada Board of Osteopathic Examiners, the Nevada Board of Dental Examiners, or the Nevada Board of Podiatric Examiners, placing a Member on probation may be cause for automatic suspension of all of his or her Hospital privileges, or other corrective action, in accordance with the provisions of Article VII: Section 7.2.

7.5.4 Termination of a Member’s malpractice insurance coverage shall result in an automatic suspension of the Member’s Medical Staff membership and clinical privileges. An affected Member may request reinstatement during a period of sixty (60) calendar days following suspension, upon presentation of proof of adequate insurance. Thereafter, such Member shall be deemed to have voluntarily resigned from the Medical Staff and must reapply for Medical Staff membership and clinical privileges.

7.5.5 By making application for appointment or reappointment to the Medical Staff, the Applicant acknowledges his or her responsibility to give full, complete and accurate information. Any failure to give true, complete and accurate information, including the making of untrue statements or failure to make materially true statements shall be sufficient grounds for automatic suspension of privileges already given or other corrective action, in accordance with the provisions of Article VII: Section 7.2.
7.5.6 Conviction of a felony may be cause for automatic suspension of all of a Member's Hospital privileges.

7.5.7 A Member whose DEA registration is revoked, suspended or voluntarily relinquished shall immediately and automatically be divested of his or her right to prescribe medications covered by such registration. The Executive Committee shall treat the matter as a request for corrective action and the procedures for such shall be followed.

7.5.8 The clinical privileges of any Member who has been excluded from participation in the Medicare/State programs shall be automatically suspended to ensure that the excluded Member does not provide or order items or services for patients enrolled in Medicare/State programs.

7.5.9 Procedural Rights

a. As soon as practicable after the Member's license is suspended, restricted or placed on probation, the Executive Committee shall convene to review and consider the facts under which the action was taken. The Executive Committee may then recommend such further corrective action as is appropriate to the facts disclosed in the investigation including limitation of privileges.

b. Thereafter, the applicable corrective action process set forth in these Bylaws is followed.

7.6 ENFORCEMENT AND CONTINUITY OF PATIENT CARE DURING A SUSPENSION

7.6.1 The Chief of Staff shall provide for alternative coverage for the Hospital patients of a Member suspended pursuant to a precautionary or an automatic suspension. The wishes of the patients shall be considered, where feasible, in choosing a substitute Member. The suspended Member shall confer with the substitute Member to the extent necessary to provide safe, competent care for the patient(s).

7.6.2 It shall be the duty of the Chief of Staff to cooperate with the Administrator in enforcing all automatic suspensions.

7.7 CONFIDENTIALITY

7.7.1 All proceedings conducted pursuant to this Article VII shall be privileged and confidential pursuant to applicable federal and state laws, rules and regulations. Such proceedings and final action by the Governing Board pursuant to these Bylaws, including Article XIV, shall not be disclosed except in accordance with reporting requirements imposed by applicable federal and state laws, rules and regulations.
7.7.2 All Members participating in the proceedings outlined in this Article VII acknowledge that confidentiality is required.

7.8 REPORTING

7.8.1 Precautionary and automatic suspensions that exceed thirty (30) days shall be reported as required by law to the National Practitioner Data Bank and, if required, to the Member’s licensing board.

7.8.2 Any final action imposed by the Governing Board, after the exhaustion of all appeal rights, shall also be reported as required by law to the National Practitioner Data Bank and, if required, to the Member’s licensing board.
ARTICLE VIII: OFFICERS OF THE MEDICAL STAFF

8.1 CATEGORIES OF OFFICERS

The officers of the Medical Staff shall be:

8.1.1 The Chief of Staff;

8.1.2 The Vice-Chief of Staff; and

8.1.3 The Secretary-Treasurer.

8.2 QUALIFICATIONS OF OFFICERS

Officers must be members of the Active Staff at the time of nomination and election, and as a condition of holding office, must remain members of the Active Staff, regularly admitting, treating and/or performing consultations for patients cared for at the Hospital, or are regularly involved in medical staff functions, as determined by the Executive Committee, such that the Medical Staff is afforded adequate opportunity to assure the quality of the member’s judgment and/or clinical practice in an acute care setting, and remain in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

8.3 ELECTION OF OFFICERS

Each officer shall be elected every two (2) years at the annual meeting of the Medical Staff by the members of the Active Staff in accordance with Article XI of these Bylaws.

8.4 TERMS OF OFFICE

The term of office for all officers of the Medical Staff shall be for a period of two (2) years commencing with the first day of the Medical Staff Year following the officer's election, and continuing for two (2) years thereafter or until a successor is qualified and elected, unless that officer shall sooner resign or be removed from office. No officer of the Medical Staff shall be permitted to serve more than two (2) consecutive elected terms in the same office.

8.5 VACANCIES IN OFFICE

8.5.1 An office of the Medical Staff shall be deemed "vacant" if the person elected to the office:

a. resigns from membership on the Medical Staff;

b. Resigns from office;
c. assumes a Medical Staff category other than Active Staff during the term of office;

d. is removed from membership on the Medical Staff;

e. requests and is granted a leave of absence from the Medical Staff;

f. becomes disabled to the extent that the duties of the office cannot be fulfilled;

g. is removed from office pursuant to Article VIII: Section 8.7; or

h. dies.

8.5.2 Any vacancy in office shall be filled by appointment by the Executive Committee, with the following exceptions:

a. vacancy in the office of the Chief of Staff, for whatever reason, will automatically be filled by the Vice-Chief of Staff who shall then serve out the remaining term; and

a. vacancy in the office of the Vice-Chief of Staff for whatever reason, will automatically be filled by the Secretary/Treasurer who shall then serve out the remaining term.

8.6 DUTIES OF OFFICERS

8.6.1 The Chief of Staff shall serve as the highest elected officer of the Medical Staff to do the following:

a. call, preside at, and be responsible for the agenda of all regular, annual and special meetings of the Medical Staff;

b. call, serve as a member of, preside at, and be responsible for the agenda of all meetings of the Executive Committee;

c. serve as ex-officio member, without vote, of all other Medical Staff committees;

d. appoint from the Medical Staff those Members that are needed to fill Medical Staff positions on Hospital committee(s) as requested by the Administrator, with all appointments, including the chair and members to Medical Staff committees being subject to approval by the Executive Committee;

e. be responsible for:
(1) the enforcement of these Bylaws;

(2) the enforcement of the Medical Staff Rules and Regulations;

(3) the implementation of sanctions where these are indicated; and

(4) the Medical Staff’s compliance with procedural safeguards in all instances where corrective action has been requested;

f. represent the views, policies, needs and grievances of the Medical Staff to the Administrator and to the Governing Board;

g. act in coordination and cooperation with the Administrator in all matters of mutual concern to the Medical Staff and the Hospital;

h. receive and interpret the policies and requests of the Governing Board to the Medical Staff and report to the Governing Board on the performance and maintenance of quality with respect to the Medical Staff’s delegated responsibility to provide medical care, and

i. be the spokesman for the Medical Staff in its external professional and public relations.

8.6.2 The Vice-Chief of Staff shall:

a. assume all of the duties and authority of the Chief of Staff in the Chief of Staff’s absence or inability to act;

b. automatically succeed the Chief of Staff in the office of the Chief of Staff should it become vacant for any reason; and

c. serve as a member of the Executive Committee.

8.6.3 The Secretary-Treasurer shall:

a. serve as a member of the Executive Committee;

b. perform such other duties as assigned by Chief of Staff and/or Executive Committee; and

c. automatically succeed the Vice-Chief of Staff in the office of the Vice-Chief of Staff should it become vacant for any reason.
8.7  REMOVAL OF MEDICAL STAFF OFFICERS

8.7.1  Any officer of the Medical Staff may be removed, prior to the expiration of the term of office, in the following manner. A special meeting of the Active Staff shall be called as provided in Article X: Section 10.3 for the purpose of considering and acting upon a written request, that any one or more officers of the Medical Staff be removed. In order to be effective, the notice of said special meeting must state that the purpose of said special meeting is to consider and act upon a request for removal of one or more designated officer(s) of the Medical Staff. Fifty percent (50%) of the members of the Active Staff shall constitute a quorum for the purpose of conduction of a special meeting held pursuant to the provisions of this Article VIII: Section 8.7. Upon the vote of two-thirds (2/3) of those members of the Active Staff in attendance at said special meeting, any designated officer of the Medical Staff may be removed. Removal of a Medical Staff officer shall be effective upon the vote of the members of the Active Staff. Upon the creation of a Medical Staff office vacancy, the provisions of Article VIII: Section 8.5 shall provide for filling said vacancy.

8.7.2  Reasons for removal of a Medical Staff officer include, but are not limited to:

a. Loss, suspension or restriction of Medical Staff membership or clinical privileges;

b. Loss, suspension or restriction of licensure;

c. Failure to carry out the duties of the office; or

d. Professional misconduct, incompetence or impairment, or disruptive behavior.
ARTICLE IX: COMMITTEES OF THE MEDICAL STAFF

The Medical Staff, acting as a whole, shall have the Executive Committee as a standing committee. The Executive Committee’s functions, size and composition shall be determined by the Medical Staff, as approved by the Governing Board. The Medical Staff delegates to the Executive Committee broad authority to oversee the operations of the Medical Staff. The Chief of Staff, or his or her designee, shall be an ex-officio member of all Medical Staff committees, unless otherwise specifically designated as a committee member. In addition, the Administrator, or his or her designee, shall be an ex-officio member without voting privileges of all Medical Staff committees, unless otherwise specifically designated as a committee member. Active Staff members are required to attend a minimum of fifty percent (50%) of general Medical Staff meetings unless excepted from this requirement as provided in Article IV, Section 4.1.1. (d).

9.1 DISCLOSURE CONFLICT OF INTEREST

All nominees for election or appointment to Medical Staff offices or Committee chairmanship, shall, disclose in writing to the Executive Committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff.

9.2 EXECUTIVE COMMITTEE

9.2.1 The Executive Committee shall be composed of the Chief of Staff (committee chair), the Vice-Chief of Staff, the Secretary-Treasurer, the immediate past Chief of Staff, and the Member-at-Large. In addition, the Administrator or his/her designee, shall be an ex-officio member without voting privileges, unless otherwise specifically designated as a committee member. The Executive Committee includes physicians and may include other licensed independent practitioners and any other individuals, as determined by the Medical Staff. The Executive Committee may act on behalf of the Medical Staff between meetings of the Medical Staff within the scope of its authority as set forth in the Bylaws.

9.2.2 Member-at-Large

a. The Member-at-Large must be a member of the Active Staff (dentist and podiatrist Members may not serve as the Member-at-Large) at the time of nomination and election, and as a condition of holding the position of Member-at-Large, must remain a member of the Active Staff in good standing. Failure to maintain such status shall immediately create a vacancy in the position of Member-at-Large.

b. The Member-at-Large shall be elected at the annual meeting of the Medical Staff by the members of the Active Staff in accordance with Article XI of these Bylaws.
c. The term of office for the Member-at-Large shall be a period of two (2) years commencing with the first day of the Medical Staff Year following the Member-at-Large's election, and continuing for two (2) years thereafter or until a successor is qualified and elected.

d. The position of Member-at-Large shall be deemed "vacant" if the person elected as the Member-at-Large:

1. resigns from membership on the Medical Staff;
2. resigns from the position of Member-Large;
3. assumes a Medical Staff category other than Active Staff;
4. is removed from membership on the Medical Staff;
5. requests and is granted a leave of absence from the Medical Staff;
6. becomes disabled to the extent that the duties of the position of Member-at-Large cannot be fulfilled;
7. is removed from office pursuant to Article IX. Section 9.1.2(f); or
8. dies.

e. Any vacancy in the position of Member-at-Large shall be filled by appointment by the Executive Committee.

f. The Member-at-Large may be removed, prior to the expiration of the Member-at-Large's term, in the following manner. A special meeting of the Active Staff shall be called as provided in Article X: Section 10.3 for the purpose of considering and acting upon a written request, that the Member-at-Large be removed. In order to be effective, the notice of said special meeting must state that the purpose of said special meeting is to consider and act upon a request for removal of the Member-at-Large. Fifty percent (50%) of the members of the Active Staff shall constitute a quorum for the purpose of conduction of a special meeting held pursuant to the provisions of this Article IX. Section 9.2(f). Upon the vote of two-thirds (2/3) of those members of the Active Staff in attendance at said special meeting, the Member-at-Large may be removed. Removal of the Member-at-Large shall be effective upon the vote of the members of the Active Staff. Upon the creation of a vacancy in the position of Member-at-Large, the provisions of Article IX. Section 9.1.2(e) shall provide for filling said vacancy.
Reasons for removal of the Member-at-Large include, but are not limited to:

(1) Loss, suspension or restriction of Medical Staff membership or clinical privileges;

(2) Loss, suspension or restriction of licensure;

(3) Failure to carry out the duties of the position of Member-at-Large; or

(4) Professional misconduct, incompetence or impairment, or disruptive behavior.

9.2.3 The duties of the Executive Committee shall include:

a. Reviewing and evaluating the qualifications of each Applicant for initial appointment, reappointment, or modification of appointment and for clinical privileges;

b. Submitting reports, in accordance with Articles V and VI on the qualifications of each Applicant for Medical Staff membership or particular clinical privileges, which reports shall include recommendations with respect to appointment, Medical Staff category, clinical privileges, and special conditions attached thereto;

c. Reviewing and evaluating all applications and requests for clinical privileges for Allied Health Professionals, and submitting recommendations to the Governing Board regarding same;

d. Submitting reports to the Governing Board regarding the status of pending applications and any problems in processing applications or requests;

e. Investigating, reviewing and reporting on matters, including the clinical or ethical conduct of any Member assigned or referred to it by: (1) the Chief of Staff, (2) the Medical Quality Improvement Committee, (3) the Governing Board or (4) the quality/risk management programs of the Hospital;

f. Receiving and acting upon records and recommendations from the committees and officers of the Medical Staff concerning patient care quality and appropriateness reviews, evaluation and monitoring functions and the discharge of their delegated administrative responsibilities, and recommending to the Governing Board specific programs and systems to implement these functions;
g. Developing, implementing and enforcing Medical Staff policies;

h. Making recommendations to the Administrator on medico-administrative matters and advising the Administrator concerning the implementation of new services;

i. Participating in the identification of community health needs;

j. Representing, and taking action on behalf of, the Medical Staff, subject to such limitations as may be imposed by these Bylaws;

k. Formulating the Medical Staff Rules and Regulations.

l. Representing, and acting on behalf of, the Medical Staff, in accordance with the duties and powers granted by the Medical Staff and these Bylaws;

m. Receiving and acting upon Medical Staff committee concerns;

n. Filling the Medical Staff’s accountability to the Governing Board for the medical care rendered to patients in the Hospital;

o. Being a liaison among the Medical Staff, the Administrator, and the Governing Board by making recommendations on Hospital management matters (for example, long-range planning, operational issues, equipment needs, and the strategic planning process) to the Administrator and the Governing Board;

p. Coordinating participation of the Medical Staff in organizational performance improvement activities;

q. Reviewing, at least annually or more often as needed, these Bylaws for consideration of revisions and amendments, acting upon written proposals for revisions and/or amendments that may originate from the chair of any Medical Staff committee, and making recommendations to the Governing Board as needed pursuant to the requirements of Article XIV of these Bylaws.

r. Absent a documented need for urgent action, before acting, the Executive Committee will communicate to the Active Staff proposed changes to any polices, rules and procedures. In cases of a documented need for urgent amendment, the Executive Committee and Board may provisionally adopt the urgent amendment without prior notification of the Medical Staff. The Executive Committee will immediately notify the Medical Staff of the amendment and provide an opportunity for comment. If there is no comment within 30 days, the amendment stands. If there is a conflict and one-third (1/3) of the Active Staff oppose the amendment, the Executive
Committee will utilize the conflict resolution process set forth in Article XV, Section 15.1.2. If necessary, a revised amendment will be submitted to the Medical Staff, and if approved, to the Board for action.

9.2.4 Meetings shall be held as needed, but not less than quarterly.

9.3 OTHER MEDICAL STAFF COMMITTEES

Medical Staff committees and/or interdisciplinary teams are established to plan and improve important patient-focused functions and organization functions. In addition, new or special committees may be created by the Executive Committee for a specific purpose(s) or on an ad hoc basis to perform special tasks. The existence of such committees shall terminate at the end of the project or every two (2) years of the Medical Staff Year, as applicable, unless renewed by the Executive Committee. The Chief of Staff, subject to the Executive Committee's approval, shall appoint the members of all new and special committees. All chairpersons of the Medical Staff committees shall report committee activity by forwarding a report to the general Medical Staff. A permanent file of the minutes and reports of each meeting shall be maintained in the Medical Staff Services Department.

There is no requirement in these Bylaws, implied or stated, that each Member must serve on one (1) of the following Medical Staff committees each Medical Staff Year. The members of the following Medical Staff committees are appointed by the Chief of Staff and approved by the Executive Committee. Chairpersons shall be elected by majority vote of the committee members, and in the event of a tie vote, shall be determined by the Chief of Staff.

The Chief of Staff also shall appoint Members to those Hospital committees that require Medical Staff representation after written notification of such need is received by the Chief of Staff from the Administrator. These appointments are also subject to approval by the Executive Committee, the same as for Medical Staff committee appointments.

The Hospital shall provide such secretarial and statistical assistance as may be required by the Medical Staff committees, including scheduling, preparation of agendas and maintenance of accurate and complete minutes of all Medical Staff and Executive Committee meetings, as well as adequate meeting facilities, including meals at those committee meetings occurring during normal meal periods.

Committees Whose Function Is Improving Organization Performance

9.3.1 Medical Quality Improvement Committee

a. Composition:

The Medical Quality Improvement Committee shall consist of one (1) Active Staff member from the following Medical Staff Committee/Service: Surgery, OB/GYN, Pediatrics, Medicine, Radiology,
and Emergency Medicine). Members shall be appointed by the Chief of Staff subject to approval by the Executive Committee. Other members of the committee involved with the quality assurance and improvement program will include the following: an administrative representative, the Director of Nursing, and the Director of Quality/Risk Management. The Chair shall be elected by majority vote of the committee members, and in the event of a tie vote, shall be determined by the Chief of Staff.

b. The duties of the Medical Quality Improvement Committee shall include:

(1) establishing and participating in an organization-wide performance improvement plan which shall be designed to include:

(2) identification of important patient-focused and organization-focused functions;

(3) objective assessment of aspects of care, practice variations, and processes in order to identify the cause and scope of opportunities to improve, problems or concerns, including determination of priorities of both investigating and resolving problems; priorities shall be related to the degree of impact on patient care;

(4) implementation through appropriate officers of the Medical Staff and/or the Hospital of decisions or actions that are designed to resolve identified problems or reduce risk;

(5) monitoring activities designed to assure that the desired result has been achieved and sustained; and

(6) documentation in the form of a summary report that includes, but not limited to, issues recommendations, outcomes, and follow-up, that reasonably substantiates the effectiveness of the overall program to enhance patient care and to assure sound clinical performance.

c. It shall be the responsibility of the committee to propose policies and procedures for adoption by the Executive Committee and the Governing Board that are intended to achieve the foregoing goals.

(1) It is the intent of these Bylaws that all information given to the Medical Quality Improvement Committee, the Governing Board and others as necessary, as well as the record of actions and proceedings of the committee shall be confidential and shall be protected from disclosure as is stated in Article I.
(2) Meetings shall be held monthly, at a date and place determined by the chair upon notice to all committee members prior to scheduled meeting date.

9.3.2 Continuing Medical Education/Library Committee

a. Composition:

The Continuing Medical Education/Library Committee shall consist of a chair, four (4) Members, and a member of administration. The CME Coordinator shall serve as an ex-officio member without voting privileges.

b. The Continuing Medical Education/Library Committee shall be responsible for directing the education programs of the Medical Staff for Members with clinical privileges. When selecting said programs, the committee will remain cognizant of:

(1) the type and nature of the care offered at the Hospital;

(2) any findings of the Medical Quality Improvement Committee that may pertain to real or perceived need for continuing education; and

(3) the expressed educational needs of Members with clinical privileges.

Additionally, the participation in said educational programs of Members with clinical privileges shall be documented, and such documentation shall be forwarded no less than annually to Medical Staff Services for inclusion in each such Member's credentialing file.

The Continuing Medical Education/Library Committee also will be responsible for the access to knowledge-based information of the Medical Staff. Access to knowledge-based information may include library information and text informational services and technology. Recommendations for need and funding will be made annually to the Executive Committee.

b. Meetings shall be held not less than quarterly, at a date and place determined by the chair upon seven (7) day notice prior to the scheduled meeting to all committee members.

Committees Whose Functions Are the Care and Assessment of Patients:

9.3.3 Medicine/Radiology/Emergency Committee
a. **Composition:**

The Medicine/Radiology/Emergency Committee shall consist of Members whose scope of practice includes adult medical care, radiology and emergency medicine. Allied Health Professionals whose special expertise and training is in medicine, radiology or emergency medicine may serve on the Medicine/Radiology/Emergency Committee, but without voting privileges. The focus of the Medicine/Radiology/Emergency Committee shall be medication use, acute and critical care, and emergency care. Others Members may attend in a non-voting capacity. The chair shall be elected by majority vote of the committee members, and in the event of a tie vote, shall be determined by the Chief of Staff.

b. **The duties of the Medicine/Radiology/Emergency Committee are as follows:**

1. **To develop and implement a plan of action for use in the ongoing monitoring and evaluation of the appropriateness and quality of care and treatment provided to inpatients, radiology and emergency medicine patients.**

   When developing and using the above plan, it is anticipated that the medical record will be the primary item, though not necessarily the only item, used to evaluate objectively the appropriateness and quality of the care given. Such review of the medical record may well be designed to insure that the record contains sufficient information to identify the patient, the patient's diagnosis, support the Member's diagnosis, justify the treatment, and document the results accurately.

2. **To review quarterly, the findings from the monitoring and evaluation as delineated above. This review, at a minimum, shall specifically relate to both the overall care of patients as a group, as well as to the specific clinical performance of Members with clinical privileges. When such review(s) identifies an important issue(s), the Medicine/Radiology/Emergency Committee shall formulate a plan for improving care and monitoring the intervention outcome.**

3. **To make recommendations on Hospital matters (i.e., long range planning, equipment needs, staffing issues) to the Executive Committee for its use in making similar recommendations to the Governing Board through the Administrator.**

4. **To review policies and procedures related to medicine, radiology and emergency medicine.**
(5) The findings and conclusions of the above patient care monitoring, evaluating and issue-solving activities shall be documented in writing and reported quarterly to the Executive Committee.

(6) Meetings shall be held quarterly at minimum at a date and place determined by the chair upon notice to all committee members.

9.3.4 Pharmacy and Therapeutics Committee

a. Composition:

The Pharmacy and Therapeutics Committee shall consist of voting Members appointed by the Chief of Staff from the various practice specialties (i.e. surgery, medicine, pediatrics, obstetrics and gynecology, emergency medicine, family practice, and diagnostic imaging), the Pharmacy Director, and a representative from nursing. Representatives of other departments/services may be requested to attend meetings as non-voting members.

b. The duties of the Pharmacy and Therapeutics Committee are as follows:

(1) To serve in an evaluative, educational, and advisory capacity to the Medical Staff and administration in all matters pertaining to the use of drugs within the Hospital.

(2) To develop a formulary of drugs accepted for use at the Hospital and provide for its constant revision. The selection of items to be included in the formulary is to be based on objective evaluation of their therapeutic merits, safety, and cost. The Pharmacy and Therapeutics Committee will work to minimize duplication of the same basic drug type, drug entity, or drug product.

(3) To establish programs and procedures that will help to ensure safe and effective drug therapy.

(4) To establish programs and procedures that will help to ensure cost-effective drug therapy.

(5) To plan and establish suitable educational programs for the Medical Staff on matters related to drug use.

(6) To participate in quality-assurance activities related to distribution, administration, and use of drug therapy within the Hospital.
(7) To monitor and evaluate adverse drug reactions within the Hospital and make appropriate recommendations to prevent their occurrence.

(8) To initiate and/or direct drug use evaluation programs and studies, then review the results of such activities and recommend measures to optimize drug use at the Hospital.

(9) To develop policies and procedures relating to the selection, distribution, handling, use, and administration of drugs.

c. Meetings shall be held quarterly at minimum at a date and place determined by the chair upon notice to all committee members.

d. The decisions of the Pharmacy and Therapeutics Committee will be presented to the Executive Committee for approval prior to implementation.

9.3.5 OB/GYN/Pediatrics Committee

a. Composition:

The OB/GYN/Pediatrics Committee shall consist of Members whose scope of practice includes obstetrics, gynecology, and pediatric care. Others Members may attend in a non-voting capacity. The chair shall be elected by majority vote of the OB/GYN/Pediatrics Committee members, and in the event of a tie vote, shall be determined by the Chief of Staff. The focus of the OB/GYN/Pediatrics Committee shall be obstetric care to include labor, delivery, and nursery, gynecological care, and pediatric care.

b. The duties of the OB/GYN/Pediatrics Committee are as follows:

(1) To develop and implement a plan of action for use in the ongoing monitoring and evaluation of the appropriateness and quality of the care and treatment provided to patients.

When developing and using the above plan, it is anticipated that the medical record will be the primary item, though not necessarily the only item, use to evaluate objectively the appropriateness and quality of the care given. Such review of the medical record may well be designed to insure that the record contains sufficient information to identify the patient, the patient's primary diagnosis, support the Member's diagnosis, justify the treatment, and document the results accurately.
(2) To review quarterly, the findings from the monitoring and evaluation as delineated above. This review, at a minimum, shall specifically relate to both the overall care of patients as a group, as well as to the specific clinical performance of Members with clinical privileges. When such review(s) identifies an important issue(s), the OB/GYN/Pediatrics Committee shall formulate a plan for improving care and monitor the intervention outcome.

(3) To make recommendations on Hospital matters (i.e., long range planning, equipment needs staffing issues) to the Executive Committee for its use in making similar recommendations to the Governing Board through the Administrator.

(4) To review policies and procedures related to obstetrical, gynecological, and pediatric care.

(5) The findings and conclusions of the above patient care monitoring, evaluating and issue-solving activities shall be documented in writing and reported quarterly to the Executive Committee.

c. Meetings shall be held quarterly at a date and place determined by the Chair upon notice to all committee members.

9.3.6 Surgery/Anesthesia Committee

a. Composition:

The Surgery/Anesthesia/ Committee shall consist of Members whose scope of practice includes surgical and anesthesia. Allied Health Professionals whose special expertise and training is in surgery or anesthesia, may serve on the Surgery/Anesthesia Committee, but without voting privileges. Other Members with special interests primarily other than surgery, such as pathology, also may serve on the committee. The Chair shall be elected by majority vote of the Surgery/Anesthesia Committee members, and in the event of a tie vote, shall be determined by the Chief of Staff.

b. The duties of the Surgery/Anesthesia Committee include the following:

(1) The committee shall review all surgical procedures and an appropriate sampling of invasive diagnostic and therapeutic procedures performed at the Hospital in order to determine the acceptability and appropriateness of the procedure and, as to surgical procedures, the agreement or disagreement among the pre-operative, post-operative and pathological diagnosis; when such review consistently supports the justification and quality of
individual surgical procedures performed by Members, then the review of an adequate sample of cases in said category is acceptable; however, before altering the pattern of review from all cases to an adequate sample(s) (or vice-versa). The reasons for doing so as well as the intentions to change the pattern of review must be clearly documented in the committee minutes, and notwithstanding the acceptability to "sample" as specified above, all cases in which a major discrepancy exists between preoperative and postoperative (including pathologic) diagnoses shall continue to be evaluated.

(2) The development and implementation of a plan of action for use in the ongoing monitoring and evaluation of the appropriateness and quality of the care and treatment provided to patients surgical or anesthesia care.

When developing and using the above plan, it is anticipated that the medical record will be the primary source, though not necessarily the only one, used to evaluate objectively the appropriateness and quality of the care given. Such a review of the medical record may well be designed to insure that the record contains sufficient information to identify the patient, the patient's primary diagnosis, support the Member's diagnosis, justify the treatment, and document the results accurately.

(3) To review quarterly, the findings from the monitoring and evaluation as delineated above. This review, at a minimum, shall specifically relate to both the overall care of patients as a group, as well as to the specific clinical performance of Members with clinical privileges; the review shall encompass surgical and anesthesia care. When such review(s) identifies an important issue(s), the Surgery/Anesthesia Committee shall formulate a plan for improving care and monitoring the intervention outcome.

(4) To review policies and procedures related to surgery and anesthesia care.

(5) The Surgery /Anesthesia Committee shall review blood utilization report and perform the following:

   i. evaluate the appropriateness of all surgical and trauma cases in which patients were administered transfusions (including whole blood and blood components);

   ii. evaluate all significant transfusion reactions;
iii. develop policies and procedures relating to the distribution, handling, use, and administration of whole blood and blood components;

iv. review the adequacy of transfusion services to meet the needs of patients;

v. review the ordering practices for blood and blood products.

c. The Surgery /Anesthesia Committee shall make written reports of the above reviews and evaluations, and while fulfilling the above responsibilities, the committee does not set policy, but rather makes recommendations to the Executive Committee that are then acted upon by the Executive Committee.

d. Meetings shall be held quarterly at a date and place determined by the chair upon prior notice to all committee members.

Committees Whose Function Is Management of Information

9.3.7 Health Information / Utilization Review Committee

a. Composition:

The Health Information/Utilization Review Committee shall consist of a chair, appointed by the Chief of Staff, two (2) members appointed from the Active Staff, the Director of Health Information, a representative from Case Management, a representative from the Nursing Service and a representative from Administration.

b. The duties of the Health Information/Utilization Review Committee shall include:

(1) To review medical records to ensure that:

i. the record reflects the diagnosis, results of diagnostic tests, therapy rendered, condition and in-Hospital progress of the patient, and the condition of the patient at discharge;

ii. the record contains sufficient information to identify the patient, support the diagnosis, justify the treatment, and documents the results accurately;
iii. if the record contains abbreviations or symbols, only those abbreviations or symbols that have been approved by the Medical Staff are used; and

iv. the medical record fulfills the specific medical record requirements as specified in the Medical Staff Rules and Regulations and the Documentation for the Medical Record Policy including the timely completion of the medical records.

(2) To monitor the quality of applicable History and Physical Examinations

(3) To review the findings from the monitoring of medical records as delineated above, specifically relating this review, at a minimum, to both the adequacy and appropriateness of the medical records as a group, as well as the adequacy and appropriateness of the medical records of Members with clinical privileges.

(4) To review, not less than annually, the adequacy and appropriateness of the format of the medical record, the forms used in the medical record, and the use of electronic data processing and storage systems, as appropriate, for medical record purposes; if said review indicates that a change(s) should be made, then said recommendation(s) shall be forwarded to the Executive Committee for approval before any change is implemented.

(5) To prepare no less frequently than annually, and to submit to the Executive Committee for approval for the Medical Staff, a list or book of abbreviations and symbols that are permitted to be used in the medical record.

(6) To report and document in writing, not less than quarterly, the findings and conclusions of the above monitoring, and evaluating activities to the Executive Committee.

(7) Conduct utilization review studies designed to evaluate the appropriateness and medical necessity of admissions to the Hospital, continued stays, denials, discharge planning, trends, use of medical and Hospital services and all related factors which may contribute to the effective utilization of Hospital and Physician services.

(8) Perform review for medical utilization issues, including outlier cases or patterns of care involving major concern about appropriateness of designation of level of service, delay in service,
under or over utilization of Hospital services, or delay in appropriate Hospital discharge. Quality of care concerns shall be forwarded to the Medical Quality Improvement Committee for review and consideration.

(9) Communicate utilization information and issues to Medical Staff committees as appropriate.

c. Meetings shall be held no less than quarterly, at a date and place determined by the chair upon notice to all committee members.

**Committees Whose Functions Are Surveillance, Prevention and Control of Infection:**

9.3.8 Infection Control Committee

The Chief of Staff appoints the physician chair of the Infection Control Committee, generally a pathologist, due to his or her unique qualifications. This is a Hospital-wide committee. The functions and responsibilities of the Infection Control Committee are outlined in the Infection Control Manual. All Members are responsible for following infection control policies and procedures.

**Committees Whose Function Is Leadership:**

9.3.9 Joint Conference Committee

The composition, functions and responsibilities of the Joint Conference Committee are outlined in the Corporate Bylaws.
ARTICLE X: MEETINGS

10.1 ANNUAL MEETING

10.1.1 The annual meeting of the Medical Staff shall be held in December, at which time the retiring officers shall make such reports as may be indicated.

10.1.2 The election of officers and members to fill vacancies on the Executive Committee will be conducted as provided in Article XI of these Bylaws.

10.2 GENERAL MEDICAL STAFF MEETINGS

General Medical Staff meetings shall be held quarterly in March, June, September, and December. December is the annual meeting of the Medical Staff.

10.3 SPECIAL MEETINGS

Special meetings of the Medical Staff may be called at any time by the Executive Committee, the Chief of Staff, the Governing Board, or by twenty-five (25%) of the Active Staff, provided that written notice of the time, date and place together with an agenda of the special meeting is mailed or delivered to each Member at least seven (7) days in advance of the special meeting date.

10.4 QUORUM

10.4.1 Fifty percent (50%) of the voting members or three (3) voting members of the applicable committee, whichever is less, shall constitute a quorum for any Medical Staff Committee for the purpose of transacting such business of the Medical Staff as is permitted by these Bylaws, unless otherwise specified in any Medical Staff document applicable to such committee.

10.4.2 The quorum for any meeting of the General Medical Staff shall be fifty percent (50%) of the voting members of the Active Staff.

10.4.3 Once a quorum is established, the business of the meeting may continue and all actions taken shall be binding even if less than a quorum exists at a later time in the meeting.

10.5 EXECUTIVE SESSION

Executive session is a meeting of a Medical Staff committee that only voting members of the Medical Staff committee and the Chief Executive Officer, or his/her designee, may attend, unless others are expressly requested by such Medical Staff committee to attend. The committee chair may excuse the Chief Executive Officer when Hospital administration is under discussion, but an alternative representative of the Hospital shall be allowed to attend. Executive session may be called by the presiding officer at the
request of any Medical Staff committee member, and shall be called by the presiding officer pursuant to a duly adopted motion. Executive session may be called to discuss peer review issues, personnel issues, or any other issues requiring confidentiality.

10.6 ACTION WITHOUT MEETING

Action may be taken without a meeting by the Medical Staff or a Committee, upon the request of the Chief of Staff, the Chair of the Committee or by a majority of the current members of such Committee, by presentation of the question to each member eligible to vote, in person, mail or by e-mail, and by recording their votes. Such vote shall be binding so long as the question is voted on by at least the number of voting members of the group that could constitute a quorum.
ARTICLE XI: ELECTIONS

The Executive Committee shall conduct all elections, both regular and special, and shall be in
charge of all matters pertaining thereto.

Nominations for Medical Staff officers and the Member At-Large shall be submitted at the
annual Medical Staff meeting.

Election of officers so nominated shall be by simple majority vote by those Members who are
eligible to vote and who are present at the annual meeting. The mechanism of voting shall be by
secret written ballot, these ballots distributed, collected and tabulated by the Executive
Committee, which announces results when tabulation is complete.

If more than two (2) nominees for any one (1) office of the Medical Staff appear on the slate of
nominees, and no nominee receives a simple majority of the votes cast for such office, then all of
the nominees except for the two (2) receiving the highest vote totals shall be dropped, and a
second vote shall be taken at the meeting. In the event that such second vote is required, the
"voting rules" as specified above shall continue to apply. In the event the second vote process
results in a tie, the election shall be decided by a coin toss.

Except as otherwise provided in these Bylaws for the filling of vacancies, the term of offices of
the Medical Staff shall begin on the first day of the Medical Staff Year.
ARTICLE XII: CONFIDENTIALITY, IMMUNITY AND RELEASES

12.1 AUTHORIZATION AND CONDITIONS

By applying for, or exercising, clinical privileges within the Hospital, an Applicant or Member:

12.1.1 authorizes representatives of the Hospital and the Medical Staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the Applicant’s or Member's professional ability and qualifications;

12.1.2 authorizes persons and organizations to provide information concerning the Applicant or Member to the Medical Staff.

12.1.3 agrees to be bound by the provisions of this Article XII and to waive all legal claims against any representative of the Medical Staff or the Hospital who would be immune from liability under Article XII: Section 12.3; and

12.1.4 acknowledges that the provisions of this Article XII are express conditions to an application for Medical Staff membership, the continuation of such Medical Staff membership, and the exercise of clinical privileges at the Hospital.

12.2 CONFIDENTIALITY OF INFORMATION

12.2.1 GENERAL

Records and proceedings of all Medical Staff committees having the responsibility of evaluation and improvement of quality of care rendered in the Hospital, including, but not limited to, meetings of the Medical Staff, meeting as a committee of the whole, meetings of Medical Staff committees established under Article IX, and meetings of special or ad hoc committees created by the Executive Committee, including information regarding any Applicant or Member, shall, to the fullest extent permitted by law, be confidential.

12.2.2 BREACH OF CONFIDENTIALITY

As effective peer review and consideration of the qualifications of Applicants and Members to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of Medical Staff committees, except in conjunction with other Hospital, professional society, or licensing authorities, is outside appropriate standards of conduct for the Medical Staff, violates these Bylaws, and shall be deemed disruptive to the operations of the Hospital. If it is determined that such a breach has occurred, the Executive Committee may undertake such corrective action as it deems appropriate.
12.3 IMMUNITY FROM LIABILITY

12.3.1 FOR ACTION TAKEN

Each representative of the Medical Staff and the Hospital shall be immune, to the fullest extent provided by law, from liability to an Applicant or Member for damages or other relief for any action taken or statements or recommendations made within the scope of duties exercised as a representative of the Medical Staff or the Hospital.

12.3.2 FOR PROVIDING INFORMATION

Each representative of the Medical Staff and the Hospital and all third parties shall be immune, to the fullest extent provided by law, from liability to a Practitioner for damages or other relief by reason of providing information to a representative of another medical staff or hospital concerning such Practitioner who is, or has been, an Applicant or Member or who did, or does, exercise clinical privileges or provide services at the Hospital.

12.4 ACTIVITIES AND INFORMATION COVERED

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

12.4.1 application for appointment, reappointment, or clinical privileges;
12.4.2 corrective action;
12.4.3 hearings and appellate reviews;
12.4.4 utilization reviews;
12.4.5 other committee or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and
12.4.6 queries and reports concerning the National Practitioner Data Bank, peer review organization, the Medical Board of Nevada, and similar queries and reports.

12.5 RELEASES

Each Applicant or Member shall, upon request of the Medical Staff or the Hospital, execute general and specific releases in accordance with the express provisions and general intent of this Article XII. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article XII.
ARTICLE XIII: ALLIED HEALTH PROFESSIONALS

The term "Allied Health Professionals" means those paramedical professionals who are permitted to evaluate and/or treat patients at the Hospital, but who are not members of the Medical Staff. Allied Health Professionals may also be employees of the Hospital. Allied Health Professionals fall within two categories: Independent Allied Health Professionals (i.e. certified registered nurse anesthetists (CRNA) and such other professionals exercising independent judgment in their areas of competence, as approved by the Governing Board) and Dependent Allied Health Professionals (i.e. physician assistants (PA), registered nurse first assistants (RNFA), and registered advanced practitioners of nursing (RNP)). Only those classes of Allied Health Professionals that have been approved by the Governing Board will be permitted to practice or provide services in the Hospital. The identification of the classes of Allied Health Professionals that will be allowed to practice in the Hospital as well as the criteria for selection of Allied Health Professionals, the definition of their duties and responsibilities, the credentialing process, and any fair hearing and appeals processes which may apply to these individuals and the regulation of their patient care work in the Hospital shall be as established by the Hospital’s Allied Health Professionals Policy.
ARTICLE XIV: FAIR HEARING PLAN

14.1 DEFINITIONS

The following definitions, in addition to those stated in other provisions of the Medical Staff Bylaws, shall apply to the provisions of this Article XIV:

14.1.1 HEARING COMMITTEE: The committee appointed pursuant to Article XIV: Section 14.3.3 to hear a request for an evidentiary hearing properly filed and pursued by an Applicant or Member.

14.1.2 PARTIES: The Applicant or Member who requested the hearing or appellate review and the body upon whose adverse action a hearing or appellate review request is predicated.

14.1.3 SPECIAL NOTICE: Written notification sent by certified or registered mail, return receipt requested.

14.1.4 ADVERSE ACTION/RECOMMENDATION: A professional review action as defined in the “Health Care Quality Improvement Act of 1986.”

14.1.5 GOVERNING BOARD OR EXECUTIVE COMMITTEE: A professional review body as defined in the “Health Care Quality Improvement Act of 1986.”

14.2 INITIATION OF HEARING

14.2.1 Recommendation or Actions

The following recommendations or actions shall, if deemed adverse pursuant to Article XIV: Section 14.2.2, entitle the Applicant or Member affected thereby to a hearing, upon timely and proper request for same, unless such recommendation or action would be non-reviewable pursuant to Article VII: Section 7.3 above:

a. Denial of initial Medical Staff appointment;
b. Denial of reappointment;
c. Suspension of Medical Staff appointment;
d. Revocation of Medical Staff appointment;
e. Denial of requested modification of Medical Staff category;
f. Reduction of Medical Staff category;
g. Limitation of admitting privileges;
h. Denial of requested clinical privileges;
i. Reduction in or limitation of clinical privileges;
j. Suspension of clinical privileges; and
k. Revocation of clinical privileges.

14.2.2 When Deemed Adverse

A recommendation or action listed in Article XIV: Section 14.2.1 shall be deemed adverse action only when it has been:

a. Recommended by the Executive Committee;
b. A suspension continued in effect after review by the Executive Committee and/or the Governing Board;
c. Taken by the Governing Board contrary to a favorable recommendation by the Executive Committee under circumstances where no prior right to a hearing existed;
d. Taken by the Governing Board on its own initiative without benefit of a prior recommendation by the Executive Committee; or
e. Imposed automatically.

14.2.3 Notice of Adverse Recommendation or Action

An Applicant or Member against whom adverse action has been taken pursuant to Article XIV: Section 14.2.2 shall within thirty (30) days be given Special Notice of such action by the Administrator. The notice shall state:

a. That an adverse action has been taken or is proposed to be taken against the Applicant or Member;
b. The Applicant's or Member's alleged acts and omissions, a list of the specific or representative patient records in question, and/or the other reasons or subject matter forming the basis for the adverse action or recommendation that is the subject of the hearing;
c. That the Applicant or Member has no more than thirty (30) days from the date of receiving the notice to request a hearing, which request shall be in writing and delivered to the Administrator in person or by certified or registered mail;
d. That failure to request a hearing within the above stated time period and in the proper manner constitutes a waiver of rights to any hearing or appellate review on the matter that is the subject of the notice;

e. A summary of the hearing procedures and rights of the Applicant or Member, which can consist of furnishing the Applicant or Member a copy of this Article XIV with the notice; and

f. that after receipt of the request for a hearing, the Applicant or Member shall be notified of the date, time, and place of the hearing, and the witnesses expected to testify on behalf of the Executive Committee or the Governing Board, as the case may be.

14.2.4 The Executive Committee or the Governing Board, as the case may be, may modify its proposed adverse recommendation or action, or the grounds for such recommendation or action, and shall notify the Applicant or Member of all additions or deletions.

14.2.5 Request for Hearing

An Applicant or Member shall have no less than thirty (30) days following his or her receipt of a notice pursuant to Article XIV: Section 14.2.3 to file a written request for a hearing. Such request shall be deemed to have been made when delivered to the Administrator in person or when sent by registered mail to the Administrator, properly addressed and postage prepaid. Any time limits set forth in this Article XIV: Section 14.2.5 or any other provision of this Article XIV may be extended or shortened by mutual agreement of the Applicant or Member and the Administrator.

14.2.6 Waiver by Failure to Request a Hearing

An Applicant or Member who fails to request a hearing within the time and in the manner specified in Article XIV: Section 14.2.5, waives any right to such hearing and to any appellate review to which he or she might otherwise have been entitled. Such waiver shall apply only to the matters that were the basis for the adverse recommendation triggering the notice. A waiver shall constitute acceptance of the recommendation and action, which shall immediately be transmitted to the Governing Board for a final decision. The Administrator shall promptly send the Applicant or Member Special Notice of the decision of the Governing Board and also shall notify the Chief of Staff of such decision.

14.2.7 Waiver by Failure to Participate Constructively in the Hearing Process

An Applicant or Member who fails to participate constructively in the hearing process shall be deemed to have waived his/her right to any hearing or appellate review to which he/she might otherwise have been entitled. The Presiding Officer
must inform the Applicant or Member that a waiver is being considered and give the Applicant or Member reasonable opportunity to participate constructively prior to ruling that his/her hearing rights have been waived. Examples of failure to participate constructively include, but are not limited to, refusal of the Applicant or Member to be sworn in or to answer questions posed by the hearing committee, failure to proceed with the hearing; and failure to abide by a ruling of the Presiding Officer. The waiver has the same force and effect as provided in Article XIV: Section 14.2.6 above. An Applicant or Member who has been deemed to have waived his or her right to a hearing may request that the Executive Committee or the Governing Board, as the case may be, review the ruling and may submit information demonstrating why the ruling is unwarranted. Such request and information in support of the Applicant's or Member's position must be submitted, if at all, within ten (10) calendar days of the ruling. The Executive Committee or the Governing Board, as the case may be, shall decide whether to reinstate the Applicant’s or Member's hearing rights, and the Applicant or Member shall have no appeal or other rights in connection with the decision of the Executive Committee or the Governing Board, as the case may be.

14.3 HEARING PREREQUISITES

14.3.1 Notice of Time and Place of Hearing

Upon receipt of a timely request for hearing, the Administrator shall deliver such request to the Chief of Staff or to the Governing Board, depending on whose recommendation or action prompted the request for hearing. The Chief of Staff or the Chair or the Governing Board, as applicable, shall promptly schedule and arrange for a hearing. The Administrator shall send the Applicant or Member Special Notice of the time, place, and date of the hearing. The hearing date shall be not less than thirty (30) days not more than sixty (60) days from the date of the Applicant's or Member's receipt of the notice of the hearing, unless there are valid reasons for non-receipt of the Special Notice; in which case the date of the hearing can be extended. A hearing for an Applicant or Member who is under suspension must be held not later than twenty-one (21) days after the Applicant or Member has received Special Notice of the hearing, unless he or she requests, and offers valid reasons for, an extension.

14.3.2 Statement of Charges

The notice of hearing required by Article XIV: Section 14.3.1 shall contain a concise statement of the Applicant's or Member's alleged acts or omissions, a list by number of the specific or representative patient records in question, and/or the other reasons or subject matter forming the basis for the adverse recommendation or action which is the subject of the hearing, and a list of witnesses, if any, expected to testify on behalf of the Executive Committee or the Governing Board.

This statement of grounds and the list of supporting patient record numbers, and other information it contains, may be amended or added to at any time, even
during the hearings, so long as the additional material is relevant to the continued appointment or clinical privileges of the Applicant or Member, and that the Applicant or Member and his or her counsel have sufficient time to study this additional information and rebut it.

14.3.3 Appointment of Hearing Committee and Hearing Officer

a. By the Medical Staff: A hearing occasioned by an Executive Committee recommendation pursuant to Article XIV: Section 14.2.2 shall be conducted by a hearing committee appointed by the Chief of Staff and composed of at least three (3) Members, if possible, but, if not possible, other qualified persons may be appointed to serve on the hearing committee. One of the members so appointed shall be designated as the chair of the hearing committee.

b. By Governing Board: A hearing occasioned by an adverse action of the Governing Board pursuant to Article XIV: Section 14.2.2 above shall be conducted by a hearing committee appointed by the chair of the Governing Board and composed of at least three (3) persons. At least one (1) member of the committee shall be a member of the Governing Board, and other persons who are not members of the Governing Board may be requested to serve. One of the members so appointed shall be designated as the chair of the hearing committee.

c. Service on Hearing Committee: A Member or a Governing Board member shall not be disqualified from serving on a hearing committee solely because he or she has heard of the matter or has knowledge of the facts involved or what he or she supposes the facts to be. No member of a hearing committee shall be a Practitioner in direct economic competition with the Applicant or Member for whom the hearing is held, or a Practitioner who has either requested, or has served on a body that has recommended, the adverse action.

All members of a hearing committee shall be required to consider and decide the case with good faith objectivity.

d. Applicant's or Member's Right to Object: The Chief of Staff or the Administrator shall notify the Applicant or Member of the names of the hearing committee members and the date by which the Applicant or Member must object, if at all, to the appointment of any member(s). Such objection must be in writing and must include the basis for the objection. If the individual who appointed the hearing committee determines that the objection is reasonable, such individual may designate alternative member(s) and shall notify the Applicant or Member of such new member(s). The Applicant or Member may object to any new member(s) by giving written notice of the objection and the reasons therefore.
e. **Hearing Officer:** The Administrator, upon the request of the Chief of Staff or upon his or her own initiative, in the event of a hearing occasioned by an adverse action of the Executive Committee, or upon the request of the chair of the Governing Board, in the event of a hearing occasioned by an adverse action of the Governing Board, may appoint a hearing officer to conduct a hearing. The hearing officer shall serve as the Presiding Officer, maintain decorum, and rule on matters of law, procedure, and the admissibility of evidence, including the admissibility of testimony and exhibits. The hearing officer may participate in the deliberations and assist in the preparation of a written decision, but may not act as an advocate or advisor for either party and may not vote. The hearing officer need not be a Member or a Practitioner and may not be in direct economic competition or affiliation with the Applicant or Member. A hearing officer may, but need not, be an attorney, but shall be experienced in conducting hearings.

14.3.4 **List of Witnesses**

At least ten (10) calendar days prior to the scheduled date for commencement of the hearing, each party shall give to the other party a list of the names of the individuals who, as far as is then reasonably known, shall give testimony or evidence in support of the Applicant or Member at the hearing. The list shall contain only the names of individuals who can provide testimony relevant to the grounds for the adverse recommendation or action. Such list and the list of the Executive Committee's witnesses shall be amended as soon as possible when additional witnesses are identified. The Presiding Officer may permit a witness who has not been listed in accordance with this Article XIV: Section 14.3.4 to testify if he or she finds that the failure to list such witness was justified, that such failure did not prejudice the party entitled to receive the name of such witness, and that the testimony of such witness shall materially assist the hearing committee in making its report and recommendation under Article XIV: Section 14.5 below. The Applicant or Member and the representative of the Executive Committee or the Governing Board, as the case may be, shall be permitted to testify regardless of whether identified as a witness.

None of the affected Applicant or Member, his or her counsel, or any other person on his or her behalf shall contact any Hospital employees who appear on witness list of the Executive Committee or the Governing Board, as the case may be, or any Members who serve or served on any committees involved in the recommendation or action concerning the subject matter of the hearing, unless specifically agreed upon by counsel.

The affected Applicant or Member may not present evidence of competency or character by presenting testimony, endorsements or opinions of his or her patients.
14.3.5 Statements in Support

If a statement in support of a party's position is to be submitted to the hearing committee, such party shall supply five (5) copies of such statement to Medical Staff Services at least five (5) calendar days prior to the scheduled date for commencement of the hearing. The party also shall supply two (2) copies of the statement to the other party and his or her representative. Medical Staff Services shall distribute the statements (if any) to the members of the hearing committee at least three (3) calendar days prior to the scheduled date of the commencement of the hearing. Nothing in this Article XIV: Section 14.3.5 shall preclude the Executive Committee or the Governing Board, as the case may be, or its representative(s) from submitting procedural information to the hearing committee.

14.3.6 Exhibits

At least ten (10) calendar days prior to the scheduled date for commencement of the hearing, each party shall give the other party a copy of all exhibits, as far as then reasonably known, that shall be introduced during the hearing. Documents previously provided to a party need not be resupplied. The Presiding Officer may permit the introduction of an exhibit that has not been provided in accordance with this Article XIV: Section 14.3.6 if he or she finds that the failure to provide such exhibit was justified, that such failure did not prejudice the party entitled to receive such exhibit, and that such exhibit shall materially assist the hearing committee in making its report and recommendation under Article XIV: Section 14.5 below.

Except as set forth in this Article XIV, there is no right to any discovery in connection with the hearing.

14.3.7 Duty to Notify of Noncompliance

If the Applicant or Member believes that there has been a deviation from the procedures required by this Article XIV or applicable law, the Applicant or Member must promptly notify the Chief of Staff or the chair of the Governing Board, through the Administrator, of such deviation, including a citation to the applicable provision of this Article XIV, these Bylaws or to applicable law. If the Chief of Staff or the chair of the Governing Board, as the case may be, agrees that a deviation has occurred, is substantial and has created demonstrable prejudice, he or she shall correct such deviation.

14.3.8 Pre-Hearing Conference

The Presiding Officer may require counsel for both the Applicant or Member and the Executive Committee or the Governing Board, as the case may be, to
participate in a pre-hearing conference for purposes of resolving all procedural questions in advance of the hearing. The Presiding Officer may specifically require that:

a. All documentary evidence to be submitted by the parties be presented at this conference and that any objections to the documents shall be made at that time, and the Presiding Officer shall resolve such objections;

b. Evidence unrelated to the reasons for the unfavorable recommendation or unrelated to the Applicant's or Member’s qualifications for appointment or the relevant clinical privileges be excluded;

c. The names of all witnesses and a brief statement of their anticipated testimony be submitted;

d. The time granted to each witness’ testimony and cross-examination be agreed upon, or determined by the Presiding Officer, in advance; and

e. Witnesses and documentation not provided and agreed upon in advance of the hearing may be excluded from the hearing.

14.4 HEARING PROCEDURE

14.4.1 Personal Presence

The right to a hearing shall be waived if the Applicant or Member fails, without good cause, to appear. The personal presence of the Applicant or Member who requested the hearing is required. The presence of the Applicant's or Member's counsel or other representative does not constitute the personal presence of the Applicant or Member. An Applicant or Member who fails, without good cause, as determined by the hearing committee, to be present throughout such hearing shall be deemed to have waived his or her rights in the same manner and with the same consequence as provided in Article XIV: Section 14.2.5.

14.4.2 Presiding Officer

Either the hearing officer, if one is appointed pursuant to Article XIV: Section 14.3.3, or the chair of the hearing committee shall be the Presiding Officer. The Presiding Officer shall act to maintain decorum and to assure that all parties to the hearing have a reasonable opportunity to present relevant oral and documentary evidence. He or she shall be entitled to determine the order of procedure during the hearing and shall make all rulings on matters of law, procedure, and the admissibility of evidence. If acting as the Presiding Officer, the chair of the hearing committee shall not act as an advocate for any party to the hearing, but shall be entitled to vote.

14.4.3 Representation
The Applicant or Member who requested the hearing shall be entitled to be accompanied and represented at the hearing by a Member in good standing or by a member of his or her local professional society. The Executive Committee, when its recommendation has prompted the hearing, shall appoint at least one (1) of its members, some other Member, or another person of its choosing, to represent it at the hearing. The Governing Board, when its recommendation or action has prompted the hearing, shall appoint at least one (1) of its members, or another person of its choosing, to represent it at the hearing. Representation or assistance of either party by an attorney at law shall be governed by the provisions of Article XIV: Section 14.7.1

14.4.4 Conduct of Hearing

The party whose adverse recommendation or action prompted the hearing shall present evidence in support of its recommendations or action. The Applicant or Member who requested the hearing shall have the obligation of presenting evidence to challenge the adverse recommendation or action and showing that the adverse recommendation or action is not appropriate.

14.4.5 Rights of Parties

During a hearing, each party shall have the following rights, subject to the rulings of the Presiding Officer on the admissibility of evidence and provided that such rights shall be exercised in a manner so as to permit the hearing to proceed efficiently and expeditiously:

a. Call and examine witnesses;

b. Introduce exhibits and present relevant evidence;

c. Cross-examine any witness on any matter relevant to the issues;

d. Impeach any witness;

e. Rebut any evidence;

f. Submit a written statement in support of such party's position if such statement is tendered pursuant to Article XIV: Section 14.3.5; and

g. Have a record made of the hearing by use of a court reporter, copies of which may be obtained by the Applicant or Member upon payment of any reasonable charges associated with the preparation thereof.
If the Applicant or Member who requested the hearing does not testify in his or her own behalf, he or she may be called by the other party and examined as if under cross-examination.

After the reconsideration of the recommendation by the Executive Committee or the Governing Board, as the case may be, the Applicant or Member has the right to receive the written recommendations of the hearing committee and either the Executive Committee or the Governing Board, as the case may be, both of which shall include a statement of the basis for the decision.

14.4.6 Procedures and Evidence

a. The hearing shall not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant evidence shall be admitted if, in the judgment of the Presiding Officer, it is the sort of evidence upon which responsible persons customarily rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

b. During the hearing, each party shall be entitled to submit a statement of support concerning any issue of law or fact, if such statement was tendered pursuant to Article XIV: Section 14.3.5 and such statement shall become a part of the hearing record.

c. The hearing committee may ask questions of witnesses, call additional witnesses, or request documentary evidence if it deems it appropriate.

d. The Presiding Officer may, but shall not be required to, order that oral evidence be taken only on oath or affirmation administered by any person designated by him or her and entitled to notarize documents.

e. Evidence presented at the hearing may include, but need not be limited to, the following:

   (1) Oral or written testimony or deposition of witnesses, including experts;

   (2) Briefs, memoranda, or other documentation of points and reference to authorities presented in connection with the hearing, if such documentation is tendered pursuant to Article XIV: Section 14.3.5 above;

   (3) Any material contained in the Hospital's credentials files regarding the Applicant or Member who requested the hearing;
(4) Any application forms and informational material associated with the application and credentialing process;

(5) Quality assurance documentation;

(6) All evidentially noticed information; and

(7) Any other relevant materials.

14.4.7 Evidentiary Notice

In reaching a decision, the hearing committee may take note, for evidentiary purposes, either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration and of any facts that may be judicially noticed by the courts of the State of Nevada. Parties present at the hearing shall be informed of the matters to be noticed and those matters shall be recited in the hearing record. Each party shall be given opportunity, on timely request, to request that a matter be evidentially noticed and to refute the evidentially noticed matters by evidence or by written or oral presentation of authority, the manner of such refutation to be determined by the Presiding Officer.

14.4.8 Burden of Proof

The Executive Committee or the Governing Board, as the case may be, has the initial obligation to present evidence in support of the adverse action or recommendation. Thereafter, the Applicant or Member has the burden of demonstrating, by a preponderance of the evidence, that the adverse action or recommendation lacks any substantial factual basis or is otherwise arbitrary, unreasonable, or capricious.

14.4.9 Record of Hearing

A record of hearing shall be kept. A court reporter shall be used for making the record.

14.4.10 Postponement

Requests for postponement or continuance of a hearing shall be granted by the Presiding Officer only upon a timely showing of good cause. A hearing shall be postponed no more than two (2) times at the request of the Applicant or Member.

14.4.11 Recesses, Adjournment and Deliberations

The hearing committee may, exclusively at its discretion and without notice, recess the hearing and reconvene the same for the convenience of the participants.
or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be adjourned. The hearing committee shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties.

In reaching its conclusions of fact and making its recommendations, the hearing committee must act:

a. In the reasonable belief that the recommendation is in furtherance of quality health care;

b. After a reasonable effort to obtain the facts of the matter; and

c. In the reasonable belief that the action is warranted by the facts known after reasonable effort to obtain such facts.

14.5 HEARING COMMITTEE REPORT AND FURTHER ACTION

14.5.1 Hearing Committee Report

Within ten (10) days after final adjournment of the hearing, the hearing committee shall make a written report of its findings, conclusions and recommendations in the matter, including a statement of the basis for the recommendations, and shall forward the same, together with the hearing record and all other documentation considered by it, to the body whose adverse recommendation or action occasioned the hearing.

14.5.2 Action on Hearing Committee Report

Within thirty (30) days after receipt of the report of the hearing committee, the body to which the report is made shall consider the report and affirm, modify or reverse its previous recommendation or action in the matter. The body to which the report is made also shall have available to it the hearing record and all documentation submitted at the hearing. If the recommendation of the hearing committee differs from the initial recommendation of the Executive Committee or the Governing Board, as the case may be, the chair of the hearing committee may be invited to a meeting of the Executive Committee or the Governing Board, as the case may be, to discuss the findings, conclusions and recommendations of the hearing committee.

14.5.3 Notice of Determination and Effect of Result

a. As soon as practicable after action by the Executive Committee or the Governing Board, as the case may be, the Administrator shall send to the Applicant or Member, by Special Notice, a copy of the hearing committee's report and the reconsidered recommendation of the Executive
Committee or the Governing Board, as the case may be. A copy of the report and the recommendation also shall be sent to the Chief of Staff.

b. When the recommendation of the Executive Committee or the Governing Board is favorable to the Applicant or Member, the Administrator shall promptly forward it, together with all supporting documentation, to the Governing Board for final action.

c. If, after the Executive Committee or the Governing Board, as the case may be, has considered the hearing committee report and the hearing record, its reconsidered recommendation continues to be adverse, the Administrator shall promptly so notify the Applicant or Member by Special Notice. The Administrator also shall forward such recommendation and documentation to the Governing Board, but the Governing Board shall not take any action thereon until after the Applicant or Member has exercised or has been deemed to have waived the right to an appellate review.

14.6 APPELLATE REVIEW

Appeals shall be conducted in accordance with the Appellate Review Policies of the Governing Board, copies of which shall be provided to the Applicant or Member at the time of a request for appellate review or upon request by the Applicant or Member.

14.7 GENERAL PROVISIONS

14.7.1 Attorneys

If the affected Applicant or Member desires to be represented by an attorney at any hearing or at any appellate review, his or her request for such hearing or appellate review must so state. The Applicant or Member shall include the name, address and telephone number of the attorney in his or her request. The Executive Committee or the Governing Board, as the case may be, may also be allowed representation by an attorney upon providing notice to that effect to the Applicant or Member, even if the Applicant or Member is not so represented. If the Applicant or Member has not previously requested representation by legal counsel, the Applicant or Member shall be informed by the Administrator that the other party plans to be represented by counsel, and shall be given the opportunity to be represented by counsel upon notice to the Administrator as described above. When legal counsel attends and participates in proceedings, it is with the understanding that the proceedings are not a judicial forum, but a forum for evaluation of an Applicant or Member in the rendering of health care services. Accordingly, the hearing committee and/or appellate review committee retains the right to limit the role of legal counsel as participants in the proceedings, if necessary.
If an Applicant or Member elects to be represented by an attorney, he or she will be solely responsible for payment of all attorneys' fees, and this shall be true no matter which party prevails at the hearing.

14.7.2 Number of Reviews

Notwithstanding any other provision of these Bylaws, including this Article XIV, no Applicant or Member shall be entitled as a right to more than one (1) evidentiary hearing and one (1) appellate review with respect to the subject matter that is the basis of the adverse recommendation or action triggering the right.

14.7.3. Release

By requesting a hearing or appellate review under this Article XIV, the Applicant or Member agrees to be bound by the provisions of these Bylaws, including, without limitation, the provisions relating to confidentiality, releases and immunity from liability, in all matters relating thereto.
ARTICLE XV: ADOPTION AND AMENDMENT

15.1 MEDICAL STAFF RESPONSIBILITY

The Medical Staff shall have the responsibility to formulate, adopt and recommend to the Governing Board Medical Staff Bylaws and amendments thereto, which shall be effective when approved by the Governing Board. Such responsibility shall be exercised in good faith and in a reasonable, responsible and timely manner. This applies as well to the adoption and amendment of the related manuals and protocols developed to implement various sections of these Bylaws.

15.1.1 Direct Communication to the Governing Board.
Medical Staff members may communicate with the Governing Board regarding any Medical Staff rule, regulation or policy adopted by the Medical Staff or the Executive Committee by submitting comments or concerns with the Medical Staff's Report to the Governing Board.

15.1.2 Conflicting Recommendations.
The Medical Staff shall have the ability to adopt Bylaws, rules and regulations and propose the same directly to the Governing Board. Where the Medical Staff votes to recommend directly to the Governing Board an amendment to the Bylaws, Rules and Regulations or the Hospital’s Allied Health Professionals Policy that is different from what has been recommended by the Executive Committee:

a. Executive Committee Review
The Executive Committee will review the amendment at its next meeting and determine whether to recommend language that is acceptable to the Medical Staff and the Executive Committee. The Executive Committee may create a subcommittee to consider the proposed amendment and make recommendations to the Medical Executive Committee.

b. Medical Staff Reconsideration
Where the Executive Committee proposes language that is acceptable, the members of the Medical Staff who proposed the challenge can decide to recommend its language directly to the Governing Board.

c. Governing Board Action
The Governing Board will review all recommendations for amendments to the Bylaws, Rules and Regulations or Allied Health Professionals Policy and will take final action. The Governing Board has final authority to resolve differences between the Medical Staff and the Executive Committee.
15.2. METHOD OF ADOPTION AND AMENDMENT

Except as set forth in Section 15.1.1 above, Medical Staff Bylaws may be adopted, amended or repealed by the following actions:

15.2.1 General Procedure
The Medical Staff shall cause the Bylaws to be reviewed at least annually to determine whether any amendments should be considered for adoption. Unless any amendments are being proposed directly to the Governing Board under Section 15.1.1 above, any proposed amendment shall first be submitted to and/or considered by the Bylaws Committee as set forth under the procedures below. The Bylaws of the Medical Staff and amendments thereto must be approved by the Governing Board prior to becoming effective.

15.2.2 Submission of Amendments
A proposed amendment of these Bylaws may be submitted to the Bylaws Committee by a Member or the Chief Executive Officer. The Bylaws Committee shall review the proposed amendment in accordance with the provisions of these Bylaws. The Chair of the Bylaws Committee shall then present the proposed amendment to the Executive Committee. The Executive Committee shall review the proposed amendment at its next regular meeting or at a special meeting called for that purpose. The Executive Committee shall make recommendations for approval or denial of the proposed amendment and present its recommendations at the next annual meeting of the Medical Staff or at a special meeting called for that purpose.

15.2.3 Notice to Medical Staff
A written copy of the proposed amendments to these Bylaws shall be distributed to the Medical Staff at least seven (7) days before the meeting at which such proposed amendments shall be discussed.

15.2.4 Adoption of Amendments
To be adopted, an amendment shall require a two-thirds (2/3rds) vote for approval by the Active Staff present. All amendments presented to a meeting of the Medical Staff shall be recorded in the minutes of the Medical Staff meeting and forwarded to the Governing Board for consideration at its next meeting or at a special meeting called for that purpose. Amendments approved by the Medical Staff by the required two-thirds (2/3rds) majority do not become effective until they are approved by the Governing Board.

15.2.5 Adoption by Ballot
In lieu of a Medical Staff meeting, changes to these Bylaws may be approved by the Medical Staff by a signed ballot with approval indicated by at least two-thirds (2/3rds) of the Active Staff. An affirmative vote may be cast either by
marking the ballot “yes” and returning it to the Medical Staff Services Department or by discarding the ballot. A negative vote may be cast by marking the ballot "no" and returning it to the Medical Staff Services Department. Proposed changes are to be specifically identified as deletions from, or additions or modifications to, the current version of these Bylaws. An explanation, if indicated, should also be distributed with the proposed changes.

15.2.6 Minor Changes to Bylaws:
The Executive Committee may make minor corrections and Bylaw changes when such correction or change is necessary due to spelling, punctuation, grammar, context or if required by the law. No prior notice of such change is required. All changes thus made will be reported at the next regular Medical Staff meeting. Any such amendment approved by the Executive Committee shall become effective only after approval by the Governing Board.
ARTICLE XVI: MEDICAL STAFF RULES AND REGULATIONS

16.1 GENERAL CONSIDERATIONS

The Medical Staff shall adopt rules and regulations as may be necessary for the proper conduct of the Medical Staff's work. The Medical Staff Rules and Regulations are a part of, and have the same force and effect as, these Bylaws. The Medical Staff Rules and Regulations become effective only upon approval by the Governing Board.

16.2 REVISIONS

The Medical Staff Rules and Regulations may be revised pursuant to Article XV above.

16.3 EMERGENCY SCREENING

In compliance with the Emergency Medical Treatment and Active Labor Act (EMTALA), every patient presenting to the Hospital requesting emergency care is provided a medical screening examination to determine whether an emergency medical condition exists, utilizing those facilities and tests routinely available to the Emergency Department. At the Hospital, this screening may be performed by a physician, physician assistant, or nurse practitioner who is appropriately credentialed to provide emergency care.

16.4 ADMISSIONS

16.4.1 General

a. Patients may be admitted to the Hospital only by those Members who have specifically delineated admitting privileges.

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3 An emergency medical condition is now defined in the regulations as:
(i) A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in-
(A) Placing the health of the individual (or, with respect to pregnant woman, the health of the woman and her unborn child) in serious jeopardy; or
(B) Serious impairment to bodily functions; or
(C) Serious dysfunction of any bodily organ or part; or
(ii) With respect to a pregnant woman who is having contractions-
(A) That there is inadequate time to effect a safe transfer to another hospital before delivery; or
(B) That transfer may pose a threat to the health or safety of the woman or the unborn child.
Exception: A Member on Emergency Department back-up call may admit a patient for another Member, if the second Member (1) has delineated admitting privileges, and (2) agrees to assume care of the patient being admitted by the first Member.

The intent of this exception is, for example, to allow an Emergency Department physician to admit for the patient's primary physician, to allow a Member on Emergency Department back-up call to admit for the patient's primary physician, or to allow a member of a group practice to admit for another member of such group.

b. At the time of admission, the name of the admitting Member must be delineated in writing. This "admitting" Member then becomes the patient's "attending" Member, except where the admission falls into a category under the exception to Article XVI: Section 16.4.1(a) above, in which case, the "second" Member is the patient's "attending" Member.

c. At the time of admission, the patient's provisional diagnosis must be delineated in writing.

d. The attending Member must physically assume care of the patient within twenty-four (24) hours of the time of admission, and the date and time of this initial visit must be documented in the medical record in the minimum form of an admitting progress note, documented within 24 hours of admission.

Exception 1: In the event that a Member on Emergency Department back-up call (who might be the "admitting" Member, but not the "attending" Member in accordance with Article XVI: Section 16.4.1(b) above), with appropriate privileges, is actively caring for the patient, this twenty-four (24) hour time limit for the attending Member to assume care may be extended to forty-eight (48) hours. However, if the attending Member has not assumed care by forty-eight (48) hours, then a "new" attending Member, with appropriate privileges and with the patient's permission, must be delineated in writing. This "new" attending Member must then assume active care within the twenty-four (24) hour limit.

The intent of this exception is to assure that, at the end of forty-eight (48) hours of care being rendered by an "on call" Member, a specific decision is made regarding which Member is primarily responsible for the care of the patient, and that if the "attending" Member's responsibility continues to rest with the "on call" Member, then the "attending" Member responsibility shall be assumed by the "on call" Member (or transferred to another Member).
Exception 2: At such time that a patient is admitted (or transferred) to the Intensive Care Unit, the attending Member must physically assume care of the patient within twelve (12) hours of the time of admission (or transfer), and the date and time of this initial visit must be documented in the medical record in the minimum form of a progress note (see Exception 1 above regarding the time limits for the assumption of care by the attending Member from an "on call" Member).

e. An appropriate history and physical examination must be completed and dictated (or written into the medical record) by the physician or Allied Health Professional who is approved by the medical staff to perform admission history and physical examinations, within twenty-four (24) hours of admission (see Article XVI: Section 16.4.1 for additional explanations and any exceptions). The completed history and physical must be on the medical record prior to surgery or invasive procedure or any procedure in which anesthesia or procedural/moderate sedation will be administered or the case will be cancelled unless the responsible practitioner documents in writing that such delay would constitute a hazard to the patient. A legible history and physical performed within 7 days prior to admission is acceptable with an updated medical record entry documenting an examination for any changes in the patient’s condition. (see the Documentation Requirements for the Medical Record Policy for required contents of the history and physical)

f. A medical record shall be initiated, and shall include, at a minimum, those requirements specified in Article XVI: Section 16.5 and in the Documentation Requirements for the Medical Record Policy.

g. In the event that a patient presents to the Emergency Department for treatment, and, in the judgment of the Emergency Department physician, needs admission to the Hospital, and if said patient has a primary physician who is a Member, then such Member shall assume the care of the patient, or care shall be assumed by such Member's "on call" Member until the primary physician assumes direct care, again adhering to the provisions of Article XVI: Section 16.4.1(d) above.

Exception: If said patient does not have a primary physician who is a Member, then the Emergency Department "on call" Member shall assume the care of said patient, with the patient's permission, in accordance with the above rules.

h. The above general admitting requirements shall also apply to Obstetrics and Surgery procedures, subject to and together with the additional requirements and/or enumerated exceptions set forth in Article XVI: Sections 16.4.2 and 16.4.3 below.
16.4.2 Obstetrics

a. The attending Member must physically assume care of the patient within sixteen (16) hours of the time of admission and the date and time of this initial visit must be documented in the medical record in the minimum form of a progress note.

Exception: Same as Exception 1 to Article XVI: Section 16.4.1(d) above, substituting sixteen (16) hours for twenty-four (24) hours.

b. In cases of normal vaginal deliveries and obstetrical related procedures, a legible copy of a prenatal record reflecting a gestation of no less than 36 weeks and current update will suffice as the History and Physical Examination. This prenatal record shall be provided to the Hospital no later than the time limit specified in Article XVI: Section 16.4.1(e) above. This prenatal record shall contain, at a minimum, the following:

(1) Name and address of the attending Member.

(2) Patient's full name and date of birth.

(3) The progress of the patient over the prenatal course (for which records are available) to include:

i. appropriate weights and measurements.

ii. appropriate blood pressure readings.

iii. educational instructions.

iv. copies of appropriate laboratory records to include the following:

- ABO and Rh;
- Antibody screen (and antibody identification if positive);
- Rubella;
- Syphilis serology;
- Hepatitis B (HbsAg); and
- HIV

These laboratory records must include the name and address of the laboratory performing the work as well as the date of the testing and the patient's name. In the event
that these records do not include this information, or the work was not done at a CLIA certified laboratory, the above testing will be performed by the Hospital laboratory when requested by the nursing service under the authority of this standing order.

Surgery

a. In addition to the requirements specified in Article XVI: Section 16.5, the following additional requirements apply to "surgical" patients undergoing operative procedures (also see Article XVI: Section 16.8 for anesthesia requirements):

(1) The Member who is responsible for the patient shall record and authenticate in the medical record a preoperative diagnosis prior to the initiation of the operative procedure.

(2) The above Member shall record (or dictate in accordance with the exception below) and authenticate in the medical record a complete history and physical examination prior to the initiation of the operative procedure.

Exception 1: In the event that the history and physical examination has been completed and dictated but it has not been transcribed into the medical record by the time of the initiation of the operative procedure, then the above Member shall make a written entry in the medical record indicating that the history and physical examination has been completed and dictated.

Exception 2: In the event that the history and physical examination has not been dictated or recorded in the medical record by the time of initiation of a non-elective operative procedure, and in the opinion of the above Member delaying the initiation of the procedure to complete the above requirement would be detrimental to the patient's welfare, then the above Member shall record this opinion in the medical record before the initiation of the procedure.

(3) Immediately following an operative procedure, an operative report (i.e., "op note") shall be dictated or written in the medical record, and shall include the name of the primary surgeon and any assistant(s), a description of the findings, the technical procedures used, the specimen(s) removed, estimated blood loss, and the postoperative diagnosis. The full report must be documented immediately, as well as the recording of a post-operative progress note to be made available in the record after the procedure providing sufficient and pertinent information for use by any
practitioner who is required to attend the patient. Procedures requiring documented operative reports are identified in the Documentation Requirements for the Medical Record Policy.

b. In all operative procedures where the surgeon may require assistance, a first assistant will be utilized.

16.5 MEDICAL RECORDS

16.5.1 General: A Medical Record is established and maintained for each patient who has been treated or evaluated at the Hospital. The Medical Record, including electronic data, medical imaging, pathological specimens and slides, are the property of the Hospital. An initial assessment, and documentation of such, shall be completed as specified below, such documentation to be made a part of the medical record at the time of this initial assessment. The Medical Record must identify the patient, support the diagnosis, justify the treatment, and document the course and results of treatment and facilitate continuity of care (See the Documentation Requirements for the Medical Record Policy).

a. The attending physician is responsible for each patient’s medical record. The medical record must identify who is primarily responsible for the care of the patient. Transfers of primary responsibility of the patient are not effective until documented in the clinical information system by the transferring physician and accepted in the clinical information system by the accepting physician.

b. All clinical entries in the patient’s record must be accurately dated, timed and individually authenticated by the responsible physician; group signing of documentation is not permissible.

c. Authentication means to establish authorship by written or electronic signature and shall consist of the practitioner’s name and professional title indicating the professional credential. Electronic signature authentication of medical records is the standard practice.

d. Legibility: All practitioner entries in the medical record must be legible, pertinent, complete and current.

16.5.2 Medical Records Completion: Medical Records will be classified as delinquent if not completed in their entirety within seven (7) days after the patient’s discharge. The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient.

16.5.3 History and Physical Examination (H&P): A complete/appropriate history and physical examination shall be completed as delineated in Article XVI: Section 16.4.1(e), above on all admissions, as well as all patients undergoing ambulatory surgeries by a physician, or Allied Health Professional who is approved by the
medical staff to perform admission history and physical examinations, and placed in the patient’s medical record within twenty-four (24) hours after admission. The completed H&P must be on the medical record prior to surgery or invasive procedures, or any procedure in which anesthesia or procedural/moderate sedation will be administered or the case will be cancelled unless the responsible physician documents in writing that such delay would constitute a hazard to the patient. A legible history and physical performed within 7 days prior to admission is acceptable with an updated medical record entry documenting an examination for any changes in the patient’s condition. The contents of a complete H&P shall include, but not limited to, documentation of date, of admission, identification, data, chief complaint, allergies, details of present illness, pertinent past/social/family history, pertinent psychosocial needs, medications and a review of body systems. A physical exam must reflect a comprehensive physical assessment and be authenticated by the physician or Allied Health Professional. A statement of the conclusion or impression (provisional diagnosis) drawn from the admission H&P and a course of action planned for the patient must be documented. (See the Documentation Requirements for the Medical Record Policy for further guidelines and contents of the H&P).

Exception: If a complete history and/or physical examination has been obtained within seven (7) days prior to admission, such as in the office of a Member, a legible copy of this report may be used in the patient’s Hospital medical record, provided that there have been no subsequent changes or that the changes have been recorded at the time of admission (Nevada Administrative Code, NAC 449.379 Medical Records. 8).

A statement of the conclusion(s) or impression(s) drawn from the above history and physical examination shall be included in the medical record.

A statement of the course of action planned for the patient while in the Hospital shall be included in the medical record.

16.5.4 Orders: All orders shall be in writing, and signed, dated and timed by the ordering practitioner.

Verbal/Telephone Orders: Orders may be verbally transmitted to those Hospital personnel who have been authorized by the Hospital to receive and transcribe orders. Verbal orders shall be discouraged and shall be accepted only when it is not practical for them to be given in writing. Orders for medications must be timed, dated and countersigned by the ordering practitioner within forty-eight (48) hours.

Exception: When a prescribing Member gives a verbal order, it is acceptable for a covering Member to co-sign the verbal order of the prescribing Member. The signature indicates that the covering Member assumes responsibility for the prescribing Member's order as being complete, accurate and final.
The following professionals may take verbal orders within their specific areas of expertise and scope of practice: registered nurses, licensed practical nurses, physical therapists, occupational therapists, respiratory therapists, pharmacists, certified registered nurse anesthetists, certified physician assistants, advanced practice nurses (nurse practitioners), imaging/radiology technicians, registered dietitians, speech and language pathologists, and laboratory personnel. All other verbal orders must be countersigned within the time provision of Article XVI: Section 16.6.3.

Note: Standing orders, when needed and appropriate, shall be formulated and approved by the appropriate clinical committee, and before institution, must be reviewed and approved by the Medical Executive Committee. When standing orders are instituted, this should not be construed to mean that the attending Member has a mandatory requirement to use them, but rather is free to use any or all of said standing orders as that Member deems appropriate for the clinical situation. However, when said standing orders are used, they must be signed and dated by the Member, just as for any other orders, and if one or more, including all, of the standing orders are not appropriate for that particular situation, such order(s) must be "lined out" and initialed by the Member.

The concept, or purpose, behind said standing orders is to reflect an awareness by the Medical Staff that types of patients, or patients with a particular diagnosis, generally require the same type(s) of treatment, medications, monitoring, etc., and because of this, the Medical Staff feels that these patients should generally be treated in this standard (i.e., "standing orders") manner.

The above is not intended to preclude, or discourage, an individual Member from establishing, and using, "routine" orders for his or her individual patients, and each Member would be free to have these individual "routine" orders preprinted on a form(s) currently prescribed and in use by the Hospital for the transcription of orders, without needing to meet the above requirements of approving "standing orders." This is so because these "routine" orders apply only to that particular Member. However, as with all orders, these individual "routine" orders (which would generally be used to improve a Member's administrative efficiency) would continue to require signature, date and time, as delineated in the Article XVI: Section 16.5.2.

16.5.5 Informed Consent: Prior to any operative procedures, the medical record must contain an informed consent. The practitioner doing such procedure(s) shall document in the medical record prior to the initiation of said procedure that informed consent was obtained from the patient. Such documentation of informed consent shall include an indication that the patient has been informed of the potential risks and benefits, potential problems related to recuperation, the likelihood of success, the possible results of non-treatment, and alternative courses of treatment.
The intent of this rule is to place the requirement of documenting the obtainment of informed consent upon the practitioner, such that the Hospital has the documentation of said consent in the medical record BEFORE any procedure(s) is initiated.

Exception 1: When caring for minor children, informed consent must be obtained from the child's parent(s) or legal guardian.

Exception 2: In the event the patient's medical situation is of such urgency that the patient's life is in immediate jeopardy and there is insufficient time to obtain properly informed consent (or because of the patient's condition, truly informed consent CANNOT be obtained), then the details regarding the lack of informed consent must be fully documented in the medical record.

16.5.6 Progress Notes: All inpatients shall be visited by their attending Member (or "on call" Member in the attending Member's absence) at least once every twenty-four (24) hours, and a record of this visit, in the minimum form of a progress note, shall be entered into the patient's medical record and signed and dated and timed by the Member making such entry (See the Documentation Requirements for the Medical Record Policy).

a. Admitting Note: The responsible provider must see the patient and document an admitting note (that justifies admission and determines the plan of treatment) within twenty-four (24) hours of admission.

16.5.7 Consultations: If a consultation was requested by the physician, a consultation includes examination of the patient which must be documented/dictated within twenty-four (24) hours. When operative procedures are involved, the consultation shall be recorded prior to the procedure (except in an emergency).

16.5.8 Emergency Department Reports: A report is required for all Emergency Department visits and shall be documented within twenty-four (24) hours of discharge/disposition from the Emergency Department (See the Documentation Requirements for the Medical Record Policy).

16.5.9 Transfers: Documentation for inpatient transfers to another facility – The transferring physician must dictate or electronically create a transfer summary at the time of transfer, no later than twenty-four (24) hours thereafter regardless of length of stay to include documentation that patient was advised of risks/benefits of transfer (See the Documentation Requirements for the Medical Record Policy).

16.5.10 Abbreviations: Abbreviations and symbols that have not been approved by the Executive Committee (this list to include the abbreviation or symbol and its respective meaning) shall not to be entered into the medical record.
16.5.11 Miscellaneous: The medical record, as a matter of policy and legality, is the property of the Hospital, and as such, no Member is permitted to remove any medical record from the Hospital without the written approval of the Administrator.

Note: The above rule should not be construed to mean that an attending Member is not allowed to receive a copy of the medical record (or a part of it) for inclusion, for instance, in that patient's medical record in the attending Member's office.

16.5.12 Authentication: All authenticating signatures entered into a patient’s medical record shall be by signature, initials or electronic signature. Authentication of transcribed or scanned reports and progress notes shall be completed within seven (7) days from the date of discharge.

16.6 DISCHARGES

16.6.1 Authority: All inpatients shall be discharged from the Hospital only on the order of the attending Member, or in the event the patient's care was temporarily assumed by an "on call" Member, by order of the "on call" Member.

16.6.2 Discharge Summary: A complete dictated and transcribed discharge summary, to include pertinent data and final diagnosis(es) in standard terminology, shall be completed within 24 hours following the patient's discharge from the Hospital in accordance with the provisions of the Documentation Requirements for the Medical Record Policy.

Exception: A final Discharge Progress note, including discharge instructions, patient’s condition at discharge, final diagnosis(es) and follow-up care may be substituted for the above discharge summary in the case of patients with problems of a minor nature who required less than a forty-eight (48) hour period of hospitalization, no surgical procedures except endoscopic procedures or postpartum tubal ligations, and in the case of a normal newborn infant, an uncomplicated obstetrical delivery should be documented immediately upon discharge but no later than 24 hours post discharge. For the purposes of this Exception, patients with problems of a minor nature are defined as those patients admitted for medical intervention only (i.e., pain control or observation), who are not critically ill and do not have life threatening conditions.

16.6.3 The completed medical record must have all required signatures completed within seven (7) days following discharge.

16.6.4 AMA (Against Medical Advice): In the event that a patient leaves the Hospital without having been formally discharged by the patient's attending Member (i.e., the patient left AMA), then the attending Member (or the Member on Emergency Department back-up call, as appropriate) shall make an entry in the medical
16.7 DEATHS

16.7.1 In the event of a Hospital death, the deceased shall be pronounced dead by the attending Member, by the Member on back-up call for the Emergency Department, or by another Member when designated by the attending Member and the nursing service is notified of such designation.

16.7.2 The pronouncement of death shall not be considered complete until an entry into the medical record, in minimum form of a progress note, has been completed, dated and timed, and signed by the Member specified in Article XVI: Section 16.7.1 above.

16.7.3 Article XVI: Section 16.7.1 and Article XVI: Section 16.7.2 above shall be documented at the time of death but no later than 24 hours thereafter by the responsible practitioner.

16.8 ANESTHESIA

The following specific requirements, at a minimum, apply to all inpatients and outpatients at the Hospital who receive anesthesia. The anesthesia provider is responsible for assuring compliance with these requirements (See the Documentation Requirements for the Medical Record Policy):

16.8.1 A pre-anesthesia evaluation is performed for each patient who receives general, regional or monitored anesthesia by a provider who is qualified to administer such anesthesia services. This assessment is performed within forty-eight (48) hours prior to surgery or a procedure requiring these anesthesia services.

16.8.2 Prior to anesthesia, there is a determination, based upon the pre-anesthesia evaluation, that the patient is an appropriate candidate to undergo the planned anesthesia.

16.8.3 Immediately prior to the induction of general anesthesia, the patient is reevaluated (pre-induction reevaluation), and equipment, drugs and gas supply are checked.

16.8.4 The patient is appropriately monitored during anesthesia. There is an intra-operative anesthesia record documented for each patient who receives general, regional or monitored anesthesia.

16.8.5 A post-anesthesia evaluation is completed and documented by a provider qualified to administer anesthesia services, no later than forty-eight (48) hours after surgery or a procedure requiring general, regional or monitored anesthesia services.
16.8.6 A Member who has appropriate clinical privileges and who is familiar with the patient is responsible for the decision to discharge the patient from the post-anesthesia recovery area or, when the surgical or anesthesia services are provided on an ambulatory basis, from the Hospital.

16.8.7 The above pre-anesthesia evaluation, determination, pre-induction reevaluation, monitoring, post-anesthesia evaluation and discharge shall be documented in the medical record and authenticated by the Member(s) completing the specific requirements.

16.9 DENTAL AND PODIATRIC ADMISSIONS

A patient admitted to the Hospital for dental or podiatric care is a dual responsibility of the dental or podiatric Member who has admitted the patient and the physician Member who was designated at the time of admission as the responsible physician Member. The dentist or podiatrist Member is, by definition, the "admitting" and "attending" Member, and as such, is the Member responsible for adherence to the applicable rules and regulations. In addition, the following requirements shall apply to dental and podiatric admissions.

16.9.1 Dentist or Podiatrist Member Responsibilities

a. Recording (or dictating) a complete dental or podiatric history and dental or podiatric physical examination in the medical record (see Article XVI: Section 16.4.1(e) for time requirements and Article XVI: Section 16.4.3 for specific requirements prior to any operative procedure).

b. Delineating in the medical record that "informed consent" has been obtained from the patient prior to the initiation of any operative procedure (see Article XVI: Section 16.5.5).

c. Recording (or dictating) a complete operative report that adheres to those provisions specified in Article XVI: Section 16.4.3. In addition, in the case of dental extraction of teeth, the operative report shall clearly state the number(s) of the teeth removed.

d. Visiting and recording progress notes pertaining to the dental or podiatric condition as delineated in Article XVI: Section 16.5.6.

e. Discharging the patient from the Hospital only after review of the patient's medical condition with the responsible physician Member, and documenting this review in the medical record in the minimum form of a progress note.

f. Completion of the discharge summary as delineated in Article XVI: Section 16.6.2.
16.9.2 Physician Member Responsibilities

a. The completion and recording (or dictating) of the patient's medical history and physical examination as delineated in Article XVI: Section 16.5.1(a) and Article XVI: Section 16.5.1(b).

b. Supervision of the patient's general "medical" health while the patient is hospitalized, as well as being available to the dentist or podiatrist Member for consultation regarding any general "medical" health concerns that the dentist or podiatrist Member may have for said patient.

c. Reviewing with the dentist or podiatrist Member the progress and general condition of the patient prior to discharge of the patient from the Hospital.

16.10 ELECTRONIC MEDICAL RECORD (EMR): Banner Health is a “paper light” organization. As such, physicians need to adhere to record keeping practices that support the electronic environment. As much data as possible will be created electronically and paper-based documentation will be scanned.

16.10.1 Use of EMR: All medical record documents created after the patient is admitted will be created utilizing Banner Health approved forms of Banner Health electronic systems to allow for patient information to be exchanged and shared electronically among healthcare providers (See the Documentation Requirements for the Medical Record Policy).

16.10.2 Access to the EMR: Access to patient information on the EMR will be made available to Medical Staff and Allied Health Staff members and their staff though Clinical Connectivity. All access to electronic records is tracked and unauthorized access to a patient’s record is not tolerated.

16.10.3 EMR Training: All Medical Staff, Allied Health Staff and Practitioners who are appointed to the Medical Staff or Allied Health Staff after August 9, 2011 pending Banner electronic medical record training (EMR) and who have not completed this training within six (6) months of appointment may be considered to have voluntarily resigned from staff. Practitioners will be advised of the training requirements at or prior to appointment and reminded of the requirement five (5) months from the date of appointment. Exceptions will be made on a case my case basis to be determined by the Medical Executive Committee and/or Hospital CEO.

16.11 TIMELY COMPLETION OF MEDICAL RECORDS: The Medical Record is not considered complete until all its essential elements are documented and authenticated, and all final diagnoses and any complications are recorded, consistent with these Rules and Regulations. No Medical Record shall be considered complete without fulfilling the
documentation requirements except on order of the Medical Executive Committee (See the Documentation Requirements for the Medical Record Policy).

16.12 ALLIED HEALTH PROFESSIONALS

The following requirements shall apply to any care rendered by Allied Health Professionals to hospitalized patients, or patients undergoing outpatient invasive diagnostic or therapeutic procedures. These requirements are in addition to any specific requirements that have been delineated in Hospital’s Allied Health Professionals Policy.

16.12.1 An Allied Health Professional shall clearly identify himself or herself to hospitalized patients and Hospital personnel as to such Allied Health Professional’s title (e.g. clinical psychologist, nurse anesthetist, etc.).

16.12.2 Allied Health Professionals may not admit patients to the Hospital, although Allied Health Professionals may write admission orders to admit to a physician Member who has agreed to accept the patient.

16.12.3 All entries into the medical record by an independent Allied Health Professional shall be authenticated by such Allied Health Professional at the time the entry is made. The requirement for signature and date shall be the same as for Members.

16.12.4 In accordance with NAC 630.370 and NAC 632.256, a supervising Member shall review and initial selected medical records of the patients of a physician assistant and an advanced practitioner of nursing.
ARTICLE XVII: ADOPTION

These Bylaws were adopted by the Medical Staff on ____________, 201_.

____________________________
Chief of Staff

Upon recommendation of the Medical Staff, these Bylaws were approved by the Banner Health Board of Directors on January 8, 2015.

____________________________________
Secretary, Governing Board