BANNER LASSEN MEDICAL CENTER

MEDICAL STAFF BYLAWS

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BANNER LASSEN MEDICAL CENTER
MEDICAL STAFF BYLAWS

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ARTICLE I: PURPOSES AND TERMS

1.1 PURPOSES OF THESE BYLAWS

These Bylaws are adopted in order to provide for the organization of the Medical Staff, to provide a framework for self-government in order to permit the Medical Staff to discharge its responsibilities in matters involving the quality of medical care, and to govern the orderly resolution of those purposes. These Bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Board of Directors, and relations with Applicants and Members.

1.2 DEFINITIONS

1.2-1 APPLICANT means 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.

1.2-2 AUTHORIZED REPRESENTATIVE means the individual designated by the Hospital and approved by the Medical Executive Committee to provide information to and request information from the National Practitioner Data Bank or the Medical Board of California according to the terms of these Bylaws.

1.2-3 BOARD OF DIRECTORS means the governing body of Banner Health, an Arizona nonprofit corporation, the owner and operator of the Hospital, or any subcommittee thereof, as may be designated by the Board of Directors, unless otherwise specified.

1.2-4 CHIEF EXECUTIVE OFFICER means the person appointed by the Board of Directors, or its designated representative, to serve as the chief administrative officer of the Hospital.

1.2-5 CHIEF OF STAFF means the chief administrative officer of the Medical Staff elected by the Members.

1.2-6 CLINICAL PRIVILEGES means the permission granted to Members to provide patient care and includes unrestricted access to those Hospital resources (including equipment, facilities and Hospital personnel) that are necessary to effectively exercise those Clinical Privileges.

1.2-7 HOSPITAL means Banner Lassen Medical Center.

1.2-8 MEDICAL EXECUTIVE COMMITTEE means the executive committee of the Medical Staff, which shall constitute the governing authority of the Medical Staff as described in these Bylaws.

1.2-9 MEDICAL STAFF means the group of Practitioners who hold a current license to practice within the scope of such license and who have been appointed to

membership on the organized medical staff of the Hospital pursuant to the terms of these Bylaws.

1.2-10 MEDICAL STAFF YEAR means the period from July 1 to June 30.

1.2-11 MEDICINE SERVICE means the group of Members who have been granted Clinical Privileges in one of the general areas of medicine.

1.2-12 MEMBER means, unless otherwise expressly limited, any Practitioner who has been appointed to membership on the Medical Staff by the Board of Directors.

1.2-13 OBSTETRIC SERVICE means the group of Members who have been granted Clinical Privileges in obstetrics.

1.2-14 PHYSICIAN means an individual with an MD or DO degree, or the equivalent degree (i.e., foreign) as recognized by the Medical Board of California or the California Board of Osteopathic Examiners, who is licensed by either the Medical Board of California or the California Board of Osteopathic Examiners.

1.2-15 PRACTITIONER means a Physician, a dentist, or a podiatrist.

1.2-16 SERVICE means the Medicine Service, the Obstetric Service or the Surgery Service as the case may be.

1.2-17 SURGERY SERVICE means the group of Members who have been granted Clinical Privileges in one of the general areas of surgery.

1.3 NAME

The name of this organization is the Medical Staff of Banner Lassen Medical Center.

ARTICLE II: MEMBERSHIP

2.1 NATURE OF MEMBERSHIP

No Practitioner, including those Practitioners in a medical administrative position by virtue of a contract with the Hospital, shall admit or provide medical or health-related services to patients in the Hospital unless the Practitioner is a Member or has been granted temporary Clinical Privileges in accordance with the procedures set forth in these Bylaws. Appointment to the Medical Staff shall confer only such Clinical Privileges and prerogatives as have been granted by the Board of Directors in accordance with these Bylaws.

2.2 QUALIFICATIONS FOR MEMBERSHIP

2.2-1 GENERAL QUALIFICATIONS

Only Practitioners who meet the following criteria shall be deemed to possess basic qualifications for membership on the Medical Staff, except for the Honorary Staff and the Retired Staff in which case these criteria shall only apply as deemed individually applicable by the Medical Staff:

(a) Each Practitioner must be able to document his/her (1) current licensure in California, (2) adequate experience, education, and training, (3) current professional competence, (4) good judgment, and (5) current adequate physical and mental health status, so as to demonstrate to the satisfaction of the Medical Staff that such Practitioner is professionally and ethically competent and that patients treated by such Practitioner can reasonably expect to receive quality medical care;

(b) Each Practitioner must be determined (1) to adhere to the ethics of his/her professions, (2) to be able to work cooperatively with others so as not to adversely affect patient care, (3) to keep as confidential, as required by law, all information or records received in the Practitioner-patient relationship, and (4) to be willing to participate in and properly discharge those responsibilities determined by the Medical Staff; and

(c) Each Practitioner must maintain continuous professional medical malpractice liability coverage, in an amount not less than $1,000,000 per occurrence and $3,000,000 in the annual aggregate, of a kind acceptable to the Medical Executive Committee and the Board of Directors.

2.2-2 PARTICULAR QUALIFICATIONS

(a) Physician Membership.

An Applicant for Physician membership on the Medical Staff must hold an MD or DO degree or their equivalent and a valid and NON-SUSPENDED certificate to practice medicine issued by the Medical Board of California or the California Board of Osteopathic Examiners. For the purpose of this Section 2.2-2(a), the phrase "or their equivalent" shall mean any degree (i.e., foreign) recognized by the Medical Board of California or the California Board of Osteopathic Examiners.

(b) Limited License Practitioner Membership.

(1) Dentists:

An Applicant for dental membership on the Medical Staff must hold a DDS or equivalent degree and a valid and NON-SUSPENDED certificate to practice dentistry issued by the Board of Dental Examiners of California.

(2) Podiatrists:

An Applicant for podiatric membership on the Medical Staff must hold a DPM degree and a valid and NON-SUSPENDED certificate to practice podiatry issued by the Medical Board of California.

(c) Allied Health Practitioners.

The term "Allied Health Practitioners" means those persons who are permitted to practice or provide services in the Hospital, but who are not Practitioners. Only those classes of non-physician practitioners that have been approved by the Board of Directors shall be permitted to practice or provide services in the Hospital. The identification of the classes of Allied Health Practitioners that shall be allowed to practice in the Hospital as well as the criteria for selection of Allied Health Practitioners, the definition of their duties and responsibilities, and the regulation of their patient care work in the Hospital shall be as established by the Hospital Policy for Allied Health Practitioners. Allied Health Practitioners are not Members of the Medical Staff, however, Allied Health Practitioners may serve as voting members of certain Medical Staff service committees, as specified in these Bylaws and may serve as the co-chair of such specified Medical Staff service committees along with a Medical Staff Member.

2.3 EFFECT OF OTHER AFFILIATIONS

No Practitioner shall be entitled to membership on the Medical Staff merely because such Practitioner holds a certain degree, is licensed to practice in the State of California or in any other state, is a member of any professional organization, is certified by any clinical board, or because such Practitioner had, or presently has, medical staff membership or privileges at another health care facility. Medical Staff membership or Clinical Privileges shall not be conditioned or determined on the basis of a Practitioner's participation or non-participation in (a) a particular medical group, IPA, PPO, PHO, Hospital-sponsored foundation or other organization, or (b) in contracts with a third party that contracts with the Hospital.

2.4 NONDISCRIMINATION

No aspect of Medical Staff membership or particular Clinical Privileges shall be denied on the basis of sex, race, age, creed, color, national origin, or physical or mental impairment that does not pose a threat to the quality of patient care.

2.5 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Except for the honorary and retired staff, the ongoing responsibilities of each member of the medical staff include:

(a) providing patients with the quality of care meeting the professional standards of the Medical Staff;

(b) abiding by these Bylaws, the Medical Staff Rules and Regulations, and applicable policies and procedures of the Medical Staff;

(c) discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the Member by virtue of Medical Staff membership, including committee assignments;

(d) preparing and completing in timely fashion medical records for all the patients to whom the Member provides care in the Hospital;

(e) abiding by the lawful ethical principles of the California Medical Association or the Member's professional association;

(f) aiding in any Medical Staff approved educational programs for Members, medical students, interns, resident Practitioners, nurses and other personnel;

(g) working cooperatively with other Members, nurses, Hospital administration and others so as not to adversely affect patient care;

(h) making appropriate arrangements for coverage of the Member's patients as determined by the Medical Staff;

(i) refusing to engage in improper inducements for patient referral;

(j) participating in continuing education programs as determined by the Medical Staff;

(k) participating in such emergency service coverage or consultation panels as may be determined by the Medical Staff;

(l) responding within such Member's scope of practice, when requested and available to do so, to any type of urgent or emergent situation at the Hospital, such as community emergencies or resuscitation situations, regardless of whether there is an existing physician/patient relationship;

(m) treating as confidential, any information discussed in executive session and using 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, to conduct authorized research activities, or to perform Medical Staff responsibilities;

(n) refraining from disclosing confidential information to anyone unless authorized to do so;

(o) protecting access codes and computer passwords to ensure confidential information is not disclosed;

(p) notifying the Chief Executive Officer of any change in the status of liability coverage, licensure, DEA registration, or any other information on the application form for Medical Staff membership;

(q) immediately notifying the Chief Executive Officer of his/her denial or loss of medical 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 California, 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;

(r) providing information to and/or testifying on behalf of the Medical Staff or an accused Practitioner regarding any matter under an investigation pursuant to Section 6.1-3, or any matter that is the subject of a hearing pursuant to Article VII; and

(s) discharging such other Medical Staff obligations as may be lawfully established from time to time by the Medical Staff and/or the Medical Executive Committee.

(t) A history and physical examination (H&P) in all cases shall be completed 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 24 hours after admission. The completed H&P must be on the medical record prior to surgery or invasive procedure (see section 4.16.1 of the Medical Staff Rules and Regulations), or any procedure in which conscious 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 office history and physical performed within 30 days prior to admission is acceptable with an updated medical record entry documenting an examination for any changes in the patient's condition. If approved by the Medical Staff, the Emergency Room Report, or Consultation report may be used as the H&P as long as all the elements in section 4.18 of the Medical Staff Rules and Regulations are included and the document is filed as a History and Physical on the EMR. The updated examination must be completed and documented in the patient's

medical record within 24 hours after registration or admission but prior to surgery or a procedure requiring anesthesia services. The Obstetrical H&P will consist of the prenatal record, where applicable, updated in the EMR by the responsible physician or Allied Health professional.

Failure to continuously meet these responsibilities may result in non-reappointment or the imposition of corrective action as provided in the Article VI of these Bylaws.

2.6 HARASSMENT PROHIBITED

Harassment by a Member against any individual (e.g., against another Member, a Hospital employee or a patient) on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex, gender or sexual orientation shall not be tolerated.

Sexual harassment is unwelcome verbal or physical conduct of a sexual nature that may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as the display of derogatory cartoons, drawings, or posters).

Sexual harassment includes unwelcome advances, requests for sexual favors, and any other verbal, visual, or physical conduct of a sexual nature when (a) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, or other aspects of employment; or (b) this conduct substantially interferes with the individual's employment or creates an intimidating, hostile, or offensive work environment. Sexual harassment also includes conduct that indicates that employment and/or employment benefits are conditioned upon acquiescence in sexual activities.

All allegations of sexual harassment shall be immediately investigated by the Medical Executive Committee and, if confirmed, shall result in appropriate corrective action, from reprimands up to and including termination of Medical Staff membership and/or Clinical Privileges, if warranted by the facts.

2.7 MEDICAL DIRECTOR ROLE

(a) 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.

(b) 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.

2.8 BOARD CERTIFICATION

2.8-1 Board certified or qualified for Board certification. Where membership and privileges are granted on the basis of Board qualification, certification must be obtained within five years of completion of training or sooner as required by the applicable Medical Staff section or the American Board of Medical Specialties (ABMS), the American Osteopathic Board (AOA), or the Royal College of Physicians and Surgeons of Canada. Failure to become certified within the time allowed under these Bylaws or failure to pass the Board certification exam on the third attempt shall result in the voluntary, automatic relinquishment of Medical Staff membership and privileges.

2.8-2 For purposes of this section, "Board certification" or "Board certified" means certified by a board approved by the ABMS or the AOA or by a board determined by the applicable Medical Staff section to be equivalent. For purposes of this section, "Board qualification" or "Board qualified" means the Applicant has completed the training necessary to be accepted to become, has applied for and has been accepted to become an active candidate for certification as determined by the appropriate board. Where the board requires a period of practice prior to submitting an application for certification, the Applicant will be deemed qualified during this time period if the director of his/her training program certifies that the Applicant has met all training requirements for qualification by the appropriate board.

2.8-3 Exceptions to achieving board certification may be considered in the following circumstances as determined by the Medical Executive Committee:

(a) where a practitioner had membership and privileges as of the date of approval of these bylaws and based upon bylaws then in effect, the practitioner was not required to be certified;

(b) where a particular field or specialty of the applicable Medical Staff section does not have a Board certification;

(c) where privileges are limited to surgical assisting or referring only;

(d) to Applicants/Members where there is a shortage of qualified Medical Staff Members in the practitioner's specialty necessary to meet the Medical Center's demand for services where the Medical Executive Committee has determined that the practitioner's training and experience approximates as nearly as possible those assured by Board certification;

(e) where a practitioner has obtained a level of training, experience and expertise commensurate with board certification through an alternative

pathway that does not offer board certification. (Examples would include training through a foreign training program.);

(f) 75% of the Medical Executive Committee must recommend approval of any exception set forth in this Section 2.8-2(a).

ARTICLE III: CATEGORIES OF MEMBERSHIP

3.1 CATEGORIES

The categories of the Medical Staff shall include the following: Active Staff, Courtesy Staff, Consulting Staff, Provisional Staff, Honorary Staff, and Retired Staff. At initial appointment and at the time of each reappointment, the Member's Medical Staff category shall be determined.

3.2 ACTIVE STAFF

3.2-1 QUALIFICATIONS

The Active Staff shall consist of Members who:

(a) meet the general qualifications for membership set forth in Section 2.2;

(b) have offices or residences that, in the opinion of the Medical Executive Committee, are located closely enough to the Hospital to provide appropriate continuity of quality care;

(c) regularly care for patients in the Hospital or are regularly involved in Medical Staff functions, as determined by the Medical Executive Committee; and

(d) except for good cause shown, as determined by the Medical Staff, have satisfactorily completed their designated term as a member of the Provisional Staff.

3.2-2 PREROGATIVES

Except as otherwise provided, the prerogatives of a member of the Active Staff shall be to:

(a) admit patients and exercise such Clinical Privileges as are granted pursuant to Article V;

(b) attend and vote on matters presented at general and special meetings of the Medical Staff and of the committees to which the Member is duly appointed; and

(c) hold Medical Staff office and serve as a voting member of committees to which the Member is duly appointed or elected by the Medical Staff or duly authorized representative thereof.

3.2-3 TRANSFER OF ACTIVE STAFF MEMBER

After two (2) consecutive years in which a member of the Active Staff fails to regularly care for patients in the Hospital or be regularly involved in Medical Staff functions as determined by the Medical Executive Committee, such Member shall be automatically transferred to the appropriate category, if any, for which the Member is qualified.

3.3 COURTESY STAFF

3.3-1 QUALIFICATIONS

The Courtesy Staff shall consist of Members who:

(a) meet the general qualifications set forth in Section 3.2-1(a)-(b);

(b) do not admit, or regularly care for (or reasonably anticipate admitting or regularly caring for), more than twenty-four (24) inpatients per year in the Hospital; and

(c) are members in good standing of the active or associate medical staff of another California licensed hospital; provided, however, that exceptions to this requirement may be made by the Medical Executive Committee for good cause; and

(d) have satisfactorily completed their designated term as a member of the Provisional Staff.

3.3-2 PREROGATIVES

Except as otherwise provided, a member of the Courtesy Staff shall be entitled to:

(a) admit patients to the Hospital with the limitations of Section 3.3-1(b);

(b) exercise such Clinical Privileges as are granted pursuant to Article V; and

(c) attend Medical Staff meetings, including open committee meetings and educational programs, but shall have no right to vote at such meetings.

Courtesy Staff members shall not be eligible to hold office in the Medical Staff, but may serve upon committees.

3.3-3 LIMITATION

Courtesy Staff members who admit inpatients or regularly care for patients at the Hospital shall, upon review of the Medical Executive Committee, be obligated to seek appointment to the appropriate Medical Staff category.

3.4 CONSULTING STAFF

3.4-1 QUALIFICATIONS

Although any Member in good standing may consult in such Member's area of expertise, the Consulting Staff shall consist of Members who:

(a) are not otherwise qualified for appointment to another Medical Staff category but who meet the general qualifications set forth in Section 2.2, except that this requirement shall not preclude an out-of-state Practitioner from appointment to the Consulting Staff as may be permitted by law if such Practitioner is otherwise deemed qualified by the Medical Executive Committee;

(b) posses adequate clinical and professional expertise;

(c) are willing and able to come to the Hospital on schedule or promptly respond when called to render clinical services within their area of competence; and

(d) are members of the active or associate medical staff of another hospital licensed by the State of California or another state; provided, however, that exceptions to this requirement may be made by the Medical Executive Committee for good cause; and

(e) have satisfactorily completed their designated term as a member of the Provisional Staff.

3.4-2 PREROGATIVES

A member of the Consulting Staff shall be entitled to:

(a) exercise such Clinical Privileges as are granted pursuant to Article V; and

(b) attend Medical Staff meetings, including open committee meetings and educational programs, but shall have no right to vote at such meetings.

Consulting Staff members shall not be eligible to hold office in the Medical Staff, but may serve upon committees.

3.5 PROVISIONAL STAFF

3.5-1 QUALIFICATIONS

The Provisional Staff shall consist of Members who:

(a) meet the general qualifications set forth in Section 3.2-1(a)-(b) or Section 3.4-1(a)–(d); and

(b) immediately prior to their application and appointment were not Members (or were no longer Members).

3.5-2 PREROGATIVES

A member of the Provisional Staff shall be entitled to:

(a) admit patients to the Hospital and exercise such Clinical Privileges as are granted pursuant to Article V; and

(b) attend Medical Staff meetings, including open committee meetings and educational programs, but shall have no right to vote at such meetings.

Provisional Staff members shall not be eligible to hold office in the Medical Staff, but may serve upon committees.

3.5-3 OBSERVATION OF PROVISIONAL STAFF MEMBER

Each Provisional Staff member shall undergo a period of observation by designated proctors, as described in Section 5.3 below. The purpose of the observation shall be to evaluate the Provisional Staff member's (a) proficiency in the exercise of Clinical Privileges initially granted, and (b) overall eligibility for continued Medical Staff membership and advancement within Medical Staff categories. Appropriate committees designated by the Medical Executive Committee shall establish in the Medical Staff Rules and Regulations the frequency and format of observation such committees deems appropriate in order to adequately evaluate Provisional Staff members, including, but not limited to, concurrent or retrospective chart review, mandatory consultation, and/or direct observation. Appropriate records shall be maintained. The results of each observation shall be communicated by the proctors to the appropriate Service Committee.

3.5-4 TERM OF PROVISIONAL STAFF MEMBERSHIP

A Member shall remain on the Provisional Staff for a period of six (6) months, unless such membership is extended by the Medical Executive Committee for an additional period of up to six (6) months, upon a determination of good cause, which determination shall not be subject to review pursuant to Articles VI or VII.

3.5-5 ACTION AT CONCLUSION OF PROVISIONAL STAFF MEMBERSHIP

(a) If the Provisional Staff member has satisfactorily demonstrated the ability to exercise the Clinical Privileges initially granted and otherwise appears qualified for continued Medical Staff membership, such Provisional Staff member shall be eligible for placement in the Active Staff, the Courtesy Staff or the Consulting Staff, as appropriate, upon the recommendation of the Medical Executive Committee.

(b) In all other cases, the appropriate Service Committee shall advise the Medical Executive Committee which, in turn shall make its recommendation to the Board of Directors regarding a modification or termination of Clinical Privileges or a termination of Medical Staff membership.

3.6 HONORARY STAFF AND RETIRED STAFF

3.6-1 QUALIFICATIONS

(a) Honorary Staff.

The Honorary Staff shall consist of Members who do not actively practice at the Hospital but who are deemed deserving of membership by virtue of their outstanding reputation, noteworthy contributions to the health and medical sciences, or their previous long-standing service to the Hospital, and who continue to exemplify high standards of professional and ethical conduct.

(b) Retired Staff.

The Retired Staff shall consist of Members who have retired from active practice and, at the time of their retirement, were members in good standing of the Active Staff, and who continue to adhere to appropriate professional and ethical standards.

3.6-2 PREROGATIVES

Honorary Staff members and Retired Staff members are not eligible to admit patients to the Hospital, to exercise Clinical Privileges in the Hospital, or to vote or hold office in the Medical Staff, but they may serve upon committees without vote at the discretion of the Medical Executive Committee. They may attend Medical Staff meetings, including open committee meetings and educational programs.

3.6-3 RESPONSIBILITIES

The ongoing responsibilities of each member of the Honorary Staff and each member of the Retired Staff include:

(a) abiding by applicable provisions of these Bylaws, the Medical Staff Rules and Regulations, and applicable policies and procedures of the Medical Staff;

(b) abiding by the lawful ethical principles of the California Medical Association or the Member's professional association;

(c) treating as confidential, any information discussed in executive session and using 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, to conduct authorized research activities, or to perform Medical Staff responsibilities;

(d) refraining from disclosing confidential information to anyone unless authorized to do so;

(e) protecting access codes and computer passwords to ensure confidential information is not disclosed;

(f) notifying the Chief Executive Officer of any change in any information on the application form for Medical Staff membership;

(g) providing information to and/or testifying on behalf of the Medical Staff or an accused Practitioner regarding any matter under an investigation pursuant to Section 6.1-3, or any matter that is the subject of a hearing pursuant to Article VII; and

(h) discharging such other Medical Staff obligations as may be lawfully established from time to time by the Medical Staff and/or the Medical Executive Committee.

Failure to continuously meet these responsibilities may result in non-reappointment or the imposition of corrective action as provided in the Article VI of these Bylaws.

3.7 LIMITATION OF PREROGATIVES

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

3.8 GENERAL EXCEPTIONS TO PREROGATIVES

Regardless of the category of membership in the Medical Staff, Limited License Practitioner Members:

(a) shall be non-voting members of the Medical Staff; and

(b) shall exercise Clinical Privileges only within the scope of their licensure and as set forth in Section 5.4.

3.9 MODIFICATION OF MEMBERSHIP

On its own, upon recommendation of the appropriate Service Committees, pursuant to a request by a Member under Section 4.6-1(b), or upon direction of the Board of Directors as set forth in Section 7.1-6, the Medical Executive Committee may recommend a change in the Medical Staff category of a Member consistent with the requirements of these Bylaws. If the recommended change is adverse to the Member, the Member shall be entitled to request a hearing pursuant to Article VII.

ARTICLE IV: APPOINTMENT AND REAPPOINTMENT

4.1 GENERAL

Except as otherwise specified herein, no Practitioner shall exercise Clinical Privileges in the Hospital unless and until such Practitioner applies for and receives appointment to the Medical Staff or is granted temporary Clinical Privileges as set forth in these Bylaws, or, with respect to Allied Health Professionals, has been granted a service authorization or Clinical Privileges under applicable Medical Staff policies. By applying to the Medical Staff for appointment or reappointment (or, in the case of members of the Honorary Staff or the Retired Staff, by accepting an appointment to such category), the Applicant acknowledges responsibility to first review these Bylaws, the Medical Staff Rules and Regulations and applicable policies and procedures of the Medical Staff, and agrees, throughout any period of membership, to comply with the responsibilities of Medical Staff membership and with these Bylaws, the Medical Staff Rules and Regulations and applicable policies and procedures of the Medical Staff as they exist and as they may be modified from time to time. Appointment to the Medical Staff shall confer on the Member only such Clinical Privileges as have been granted in accordance with these Bylaws.

4.2 BURDEN OF PRODUCING INFORMATION

In connection with all applications for appointment, reappointment, advancement, or transfer, the Applicant shall have the burden of producing information for an adequate

evaluation of the Applicant's qualifications and suitability for the Clinical Privileges and the Medical Staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. The Applicant's failure to sustain this burden shall be grounds for denial of the application. To the extent consistent with applicable law, this burden may include submission to a medical or psychological examination, at the Applicant's expense, if deemed appropriate by the Medical Executive Committee, which may select the examining physician.

4.3 APPOINTMENT AUTHORITY

Appointments, denials and revocations of appointments to the Medical Staff shall be made as set forth in these Bylaws, but only after there has been a recommendation from the Medical Executive Committee, or as set forth in Section 6.1-6.

4.4 DURATION OF APPOINTMENT AND REAPPOINTMENT

Except as otherwise provided in these Bylaws, initial appointments to the Medical Staff shall be for a period of not more than two (2) years. Each reappointment shall be for a period of not more than two (2) years. Applicants retained by the Hospital shall be subject to the same requirements and procedures for appointment and reappointment as all other Applicants.

4.5 APPLICATION FOR INITIAL APPOINTMENT AND REAPPOINMENT

4.5-1 APPLICATION FORM

An application form shall be completed by the Applicant. The form shall require detailed information, which shall include, but not be limited to, information concerning:

(a) the Applicant's qualifications, including, but not limited to, professional training and experience, current clinical competence, current licensure, current DEA registration, and continuing medical education information related to the Clinical Privileges to be exercised by the Applicant;

(b) peer references familiar with the Applicant's professional competence and ethical character;

(c) requests for membership categories and Clinical Privileges;

(d) past or pending professional disciplinary action, voluntary or involuntary denial, revocation, suspension, reduction or relinquishment of medical staff membership or privileges or any licensure or registration, and related matters;

(e) any current felony charges pending against the Applicant and any past charges, including their resolution;

(f) any pending or current actions against the Applicant that may exclude the Applicant from participation in Medicare and/or any other federally-supported healthcare program;

(g) current physical and mental health status;

(h) final judgments or settlements made against the Applicant in professional liability cases, and any filed and served cases pending; and

(i) 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 identified in Section 2.2-1(c).

Each application for initial appointment to the Medical Staff shall be in writing, submitted on the form prescribed by the Medical Executive Committee with all provisions completed (or accompanied by an explanation of why answers are unavailable), and signed by the Applicant. When an Applicant requests an application form, the Applicant shall be given a copy of these Bylaws, the Medical Staff Rules and Regulations, and, as deemed appropriate by the Medical Executive Committee, copies or summaries of any other applicable Medical Staff policies relating to clinical practice in the Hospital.

4.5-2 EFFECT OF APPLICATION

In addition to the matters set forth in Section 4.1, by applying for appointment to the Medical Staff, each Applicant:

(a) signifies willingness to appear for interviews in regard to the application;

(b) authorizes consultation with others who have been associated with the Applicant and who may have information bearing on the Applicant's current clinical competence, qualifications and performance, and authorizes such individuals and organizations to candidly provide all such information;

(c) consents to inspection of records and documents that may be material to an evaluation of the Applicant's qualifications and ability to carry out Clinical Privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;

(d) releases from any liability, to the fullest extent provided by law, all persons for their acts performed in connection with investigating and evaluating the Applicant;

(e) releases from any liability, to the fullest extent provided by law, all individuals and organizations who provide information regarding the Applicant, including otherwise confidential information;

(f) consents to the disclosure to other hospitals, medical associations, licensing boards, and to other similar organizations as required by law, any information regarding the Applicant's professional or ethical standing that the Hospital or the Medical Staff may have, and releases the Hospital and the Medical Staff from liability for so doing to the fullest extent permitted by law;

(g) pledges to provide for continuous quality care for patients;

(h) pledges to maintain an ethical practice, including refraining from illegal inducements for patient referral, providing for the continuous care of the Applicant's patients, seeking consultation whenever necessary, refraining from providing "ghost" surgical or medical services, and refraining from delegating patient care responsibility to non-qualified or inadequately supervised individuals; and

(i) agrees to be bound by these Bylaws, the Medical Staff Rules and Regulations, and applicable policies and procedures of the Medical Staff and the Hospital.

4.5-3 VERIFICATION OF INFORMATION

The Applicant shall deliver a completely filled-in, signed, and dated application and supporting documents to the Medical Staff Office or other designated location. The Chief Executive Officer shall be notified of the application. The Medical Staff Office, or other designated individuals, shall expeditiously seek to collect or verify the references, licensure status, and other evidence submitted in support of the application. The Authorized Representative shall query the National Practitioner Data Bank and the Medical Board of California regarding the Applicant and submit any resulting information to the appropriate Service Committee for inclusion in the Applicant's credentials file. The Applicant shall be notified of any problems in obtaining the information required, and it shall be the Applicant's obligation to obtain any reasonably requested information. If any requested information is not obtained from the Applicant within sixty (60) days after written request for same, the subject application shall be deemed withdrawn from consideration and no further action shall be taken on such application. When collection and verification of information is accomplished, the application shall be considered complete, and all such information shall be transmitted to the appropriate Service Committee. No

final action on an application may be taken until receipt of the National Practitioner Data Bank report and the Medical Board of California report.

4.5-4 SERVICE COMMITTEE ACTION

After receipt of the application, the appropriate Service Committee shall review the application and supporting documentation, and may conduct a personal interview with the Applicant at the discretion of the appropriate Service Committee. The appropriate Service Committee shall evaluate all matters deemed relevant to a recommendation, including information concerning the Applicant's provision of services within the scope of Clinical Privileges granted, and the Applicant's participation in relevant continuing education and shall transmit to the Medical Executive Committee a written report and recommendation as to appointment and, if appointment is recommended, as to Medical Staff category, Clinical Privileges to be granted, and any special conditions to be attached. The appropriate Service Committee may also request that the Medical Executive Committee defer action on the application.

4.5-5 MEDICAL EXECUTIVE COMMITTEE ACTION

At its next regular meeting after receipt of the appropriate Service Committee's report and recommendation, or as soon thereafter as is practicable, the Medical Executive Committee shall consider the report and any other relevant information. The Medical Executive Committee may request additional information, return the matter to the appropriate Service Committee for further investigation, and/or elect to interview the Applicant. The Medical Executive Committee shall forward to the Chief Executive Officer, for prompt transmittal to the Board of Directors, a written report and recommendation as to Medical Staff appointment and, if appointment is recommended, as to Medical Staff category, Clinical Privileges to be granted, and any special conditions to be attached to the appointment. The Medical Executive Committee may also defer action on the application. The reasons for each recommendation shall be stated.

4.5-6 EFFECT OF MEDICAL EXECUTIVE COMMITTEE ACTION

(a) Favorable Recommendation.

When the recommendation of the Medical Executive Committee is favorable to the Applicant, it shall be promptly forwarded, together with supporting documentation, to the Board of Directors.

(b) Adverse Recommendation.

When the recommendation of the Medical Executive Committee is adverse to the Applicant, the Board of Directors and the Applicant shall be promptly

informed by written notice. The Applicant shall then be entitled to procedural rights as provided in Article VII.

4.5-7 ACTION ON THE APPLICATION

The Board of Directors may accept or reject, in whole or in part, the recommendation of the medical executive committee or may refer the matter back to the medical executive committee for further consideration, stating the purpose for such referral and setting a reasonable time limit for making a subsequent recommendation. The following procedures shall apply with respect to action on the application:

(a) If the Medical Executive Committee issues a favorable recommendation, the Board of Directors shall affirm the recommendation of the Medical Executive Committee if the Medical Executive Committee's decision is supported by substantial evidence.

(1) If the Board of Directors concurs with the recommendation of the Medical Executive Committee, the decision of the Board of Directors shall be deemed final action.

(2) If the determination of the Board of Directors is adverse to the Applicant, the Chief Executive Officer shall give the Applicant written notice of the adverse determination and the Applicant shall be entitled to the procedural rights set forth in Article VII. If procedural rights are waived by the Applicant, the determination of the Board of Directors shall be deemed final action.

(b) In the event the recommendation of the Medical Executive Committee, or any significant part of it, is adverse to the Applicant, the procedural rights set forth in Article VII shall apply.

(1) If procedural rights are waived by the Applicant, the recommendations of the Medical Executive Committee shall be forwarded to the Board of Directors for final action, which shall affirm the recommendation of the Medical Executive Committee if the Medical Executive Committee's decision is supported by substantial evidence.

(2) If the Applicant requests a hearing following an adverse recommendation by the Medical Executive Committee pursuant to Section 4.5-6(b) or an adverse determination by the Board of Directors pursuant to Section 4.5-7(a)(2), the Board of Directors shall take final action only after the Applicant has exhausted all procedural rights as established by Article VII. After exhaustion by the Applicant of the procedures set forth in Article VII, the Board of

Directors shall make a final decision and shall affirm the decision of the Judicial Review Committee if the Judicial Review Committee's decision is supported by substantial evidence, following a fair procedure. The decision of the Board of Directors shall be in writing and shall specify the reasons for the action taken.

(c) **Process for "Distant Site" Credentialing of Telemedicine Providers** Where the Medical Center ("Originating Site") has a contract with a Joint Commission accredited facility ("Distant Site") approved by the Medical Executive Committee, the Medical Center will accept the credentialing and privileging decision of the Distant Site for applicants who provide telemedicine services and are credentialed at the Distant Site. Privileges at the Originating Site shall be identical to those granted at the Distant Site, except for services which the Medical Center does not perform. Privileges shall be granted and renewed for the same period as have been granted by the Distant Site. Board approval of privileges at the Distant Site qualifies as Board approval at the Medical Center.

4.5-8 NOTICE OF FINAL DECISION

(a) Notice of the final decision of the Board of Directors shall be given to the Chief of Staff, the Medical Executive Committees, the chair of the appropriate Service, the Applicant, and the Chief Executive Officer.

(b) A decision and notice to appoint or reappoint shall include, if applicable: (1) the Medical Staff category to which the Applicant is appointed; (2) the Clinical Privileges granted; and (3) any special conditions attached to the appointment.

4.5-9 REAPPLICATION AFTER ADVERSE APPOINTMENT DECISION

An Applicant who has received a final adverse decision regarding appointment shall not be eligible to reapply to the Medical Staff for a period of one (1) year. Any such reapplication shall be processed as an initial application, and the Applicant shall submit such additional information as may be required to demonstrate that the basis for the earlier adverse action no longer exists.

4.6 REAPPOINTMENTS AND REQUESTS FOR MODIFICATIONS OF MEDICAL STAFF CATEGORY OR CLINICAL PRIVILEGES

4.6-1 APPLICATION

(a) At least three (3) months prior to the expiration of a Member's current Medical Staff appointment, a reapplication form, which has developed by

the Medical Executive Committee, shall be mailed or delivered to such Member. If an application for reappointment is not received at least sixty (60) days prior to the expiration date, written notice shall be promptly sent to the Applicant advising that the application has not been received. At least forty-five (45) days prior to the expiration of the Member's current Medical Staff appointment, such Member shall submit to the Medical Staff Office or other designated location the completed application form for renewal of appointment to the Medical Staff and for renewal or modification of Clinical Privileges. The reapplication form shall include all information necessary to update and evaluate the qualifications of the Applicant, including, but not limited to, the matters set forth in Section 4.5-1, as well as other relevant matters. Upon receipt of the application, the information shall be processed as set forth commencing at Section 4.5-3.

(b) A Member who seeks a change in Medical Staff category or modification of Clinical Privileges may submit such a request at any time upon a form developed by the Medical Executive Committee, except that such application may not be filed within one (1) year of the time a similar request has been denied.

4.6-2 EFFECT OF APPLICATION

The effect of an application for reappointment or modification of Medical Staff category or Clinical Privileges is the same as that set forth in Section 4.5-2.

4.6-3 STANDARDS AND PROCEDURE FOR REVIEW

When a Member submits the Member's first application for reappointment, and every two (2) years thereafter, or when a Member submits an application for modification of Medical Staff category or Clinical Privileges, the Member shall be subject to an in-depth review generally following the procedures set forth in Sections 4.5-3 through 4.5-11.

To be eligible to apply for renewal of Clinical Privileges, a Member must have performed sufficient procedures, treatments or therapies in the previous appointment period to enable the appropriate Service Committee and the Medical Executive Committee to assess the Member's current clinical competence.

4.6-4 FAILURE TO SUBMIT A COMPLETE REAPPOINTMENT APPLICATION

Failure, without good cause, to submit a complete reappointment application or to provide all requested information within forty-five (45) days prior to the expiration of the Member's current Medical Staff appointment shall be deemed a voluntary resignation from the Medical Staff at the end of such Member’s current appointment period, and the procedures set forth in Article VII shall not apply. In

such event, the subject Member shall be required to reapply for Medical Staff membership and Clinical Privileges.

4.7 LEAVE OF ABSENCE

4.7-1 LEAVE STATUS

At the discretion of the Medical Executive Committee, a Member may obtain a voluntary leave of absence from the Medical Staff upon submission a written request to the Medical Executive Committee stating the approximate period of leave desired, which may not exceed one (1) year. During the period of the leave, the Member shall not exercise Clinical Privileges at the Hospital, and membership rights and responsibilities shall be inactive.

4.7-2 TERMINATION OF LEAVE

At least sixty (60) days prior to the termination of a Member's leave of absence, or at any earlier time, the Member may request reinstatement of Medical Staff membership and Clinical Privileges by submitting a written notice to that effect to the Medical Executive Committee. The Member shall submit a summary of relevant activities during the leave, 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 period, then the Member also shall be required to complete an application for reappointment to the Medical Staff. The Medical Executive Committee shall make a recommendation concerning the reinstatement of the Member’s Medical Staff membership and Clinical Privileges, and the procedures provided in Sections 4.5-5 through 4.5-9 shall be followed.

4.7-3 FAILURE TO REQUEST REINSTATEMENT

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the Medical Staff and shall be deemed an automatic relinquishment of the Member's Medical Staff membership and Clinical Privileges. A Member whose Medical Staff membership is automatically relinquished pursuant to this Section 4.7-3 shall be entitled to the procedural rights provided in Article VII for the sole purpose of determining whether the failure to request reinstatement was unintentional or otherwise excusable. A request for Membership subsequently received from the subject Member shall be submitted and processed in the manner specified for applications for initial appointments.

4.7-4 MEDICAL LEAVE OF ABSENCE

The Medical Executive Committee shall determine the circumstances under which a particular Member shall be granted a leave of absence for the purpose of obtaining treatment for a medical condition or disability. Unless accompanied by a reportable restriction of Clinical Privileges, the leave shall be deemed, at the discretion of the

Medical Executive Committee, a "medical leave" that is not granted for medical disciplinary cause or reason. Upon request for reinstatement, the Member shall submit a report from the Member's Physician 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.

4.7-5 MILITARY LEAVE OF ABSENCE

Requests for leave of absence to fulfill military service obligations shall be granted upon notice and review by the Medical Executive Committee and approval of the Board of Directors. Reactivation of Medical Staff membership and Clinical Privileges previously held shall be granted upon recommendation by the Medical Executive Committee, subject to monitoring and/or proctoring as determined by the Medical Executive Committee and the Board of Directors.

4.8 CONTRACTED PRACTITIONERS

Applicants retained by the Hospital shall be subject to the same requirements and procedures for appointment and reappointment as all other Applicants. Any Member providing services through a contract with the Hospital shall not have his or her Medical Staff membership or Clinical Privileges modified in any manner without the same due process provided to any other Member, unless such Member's contract with the Hospital specifically provides otherwise.

ARTICLE V: CLINICAL PRIVILEGES

5.1 EXERCISE OF CLINICAL PRIVILEGES

Except as otherwise provided in these Bylaws, a Member providing clinical services at the Hospital shall be entitled to exercise only those Clinical Privileges specifically granted. Said Clinical Privileges must be Hospital-specific, within the scope of any license, certificate or other legal credential authorizing practice in the State of California and consistent with any restrictions thereon, and shall be subject to the rules, regulations and authority of the appropriate Service Committee and the Medical Staff. Clinical Privileges may be granted, continued, modified or terminated by the Board of Directors only upon recommendation of the Medical Executive Committee, only for reasons directly related to quality of patient care and other provisions of these Bylaws, and only following the procedures outlined in these Bylaws.

5.1-1 IN GENERAL

(a) The following must be successfully completed by new practitioners prior to exercising privileges at the Hospital:

- Banner's electronic medical record/computerized physician order entry (CPOE) training to the extent provided for the Medical Staff Rules and Regulations; and
- Banner's electronic New Provider Orientation.
- Exceptions may be made for practitioners granted temporary or disaster privileges.

(b) Except in an emergency, a practitioner providing clinical services at the Hospital may exercise only those clinical privileges specifically granted.

5.2 DELINEATION OF CLINICAL PRIVILEGES IN GENERAL

5.2-1 REQUESTS

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific Clinical Privileges desired by the Applicant. A request by a Member for a modification of Clinical Privileges may be made at any time, but such requests must be supported by documentation of training and/or experience supportive of the request.

5.2-2 BASES FOR CLINICAL PRIVILEGES DETERMINATION

Requests for Clinical Privileges shall be evaluated on the basis of the Member's education, training, experience, current demonstrated professional competence and judgment, clinical performance, current health status, and the documented results of patient care and other quality review and monitoring that the Medical Staff deems appropriate. Clinical Privilege determinations may also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where the Member exercises clinical privileges.

5.2-3 ESTABLISHMENT OF CRITERIA

In the event a request for Clinical Privileges is submitted for a procedure for which no criteria have been created, the request shall be tabled for a reasonable period of time during which the Board of Directors shall, after consultation with the Medical Executive Committee, formulate the necessary criteria unless it is determined that such a procedure shall not be performed at the Hospital. Once objective criteria have been established, the original request shall be processed as described herein. The Board of Directors will review recommendations forwarded by the Medical Executive Committee pertaining to the establishment of new privilege criteria at its next regularly-scheduled meeting and will approve or reject such criteria or will refer the matter back to the Medical Executive Committee for further consideration.

5.3 PROCTORING

5.3-1 GENERAL PROVISIONS

Except as otherwise determined by the Medical Executive Committee, all new Members and all Members granted new Clinical Privileges shall be subject to a period of proctoring. Each new Member or each Member granted new Clinical Privileges shall be assigned to the appropriate Service Committee, where performance of an appropriate number of cases, as established by the Medical Executive Committee or by the appropriate Service Committee as the designee of the Medical Executive Committee, shall be observed or reviewed by the chair of the appropriate Service Committee, or the chair's designee, during the period of proctoring specified in the Medical Staff Rules and Regulations, to determine the Member's suitability to continue to exercise the Clinical Privileges granted. The exercise of Clinical Privileges subject to monitoring by the appropriate Service Committee may also be subject to direct observation by the chair of the appropriate Service or the chair's designee. The Member shall remain subject to such proctoring until the Medical Executive Committee has been furnished with:

(a) a report signed by the chair of the Service to which the Member is assigned describing the types and numbers of cases observed and the evaluation of the Member's performance, a statement that the Member appears to meet all of the qualifications for unsupervised practice in the Hospital, has discharged all of the responsibilities of Medical Staff membership, and has not exceeded or abused the prerogatives of the Medical Staff category to which the appointment was made; and

(b) a report signed by the chair of any other committee(s) under whose authority the Member may exercise Clinical Privileges, describing the types and number of cases observed and the evaluation of the Member's performance and a statement that the Member has satisfactorily demonstrated the ability to exercise the Clinical Privileges initially granted.

On occasion, a Member may request Clinical Privileges that no Member currently holds. Subject to Section 5.2-3 regarding establishment of criteria for new procedures, proctoring information from an outside facility at which the Member already has privileges shall be reviewed by the Medical Executive Committee in addition to following the usual proctoring routine as described above. The Medical Executive Committee shall reserve the right to obtain external information by requesting retrospective chart review by an outside reviewer, by hiring consulting specialists, or by such other means as may be necessary.

5.3-2 FAILURE TO COMPLETE PROCTORING

If a new Member fails to complete proctoring or a Member exercising new Clinical Privileges fails to furnish such proctoring, those specific Clinical Privileges shall automatically terminate.

5.3-3 MEDICAL STAFF CATEGORY ADVANCEMENT

The failure to obtain certification for any specific Clinical Privileges shall not, of itself, preclude advancement in Medical Staff category of any Member. If such advancement is granted absent such certification, continued proctorship on the uncertified Clinical Privileges shall continue for the specified time period.

5.4 CONDITIONS FOR CLINICAL PRIVILEGES OF LIMITED LICENSE PRACTITIONER MEMBERS

5.4-1 ADMISSIONS

(a) Except as provided by Section 5.4-1(b) below, when a Limited License Practitioner Member admits patients, a Physician Member must conduct the admitting history and physical examination (except for the portion related to dentistry or podiatry) and assume responsibility for the care of the patient's medical problems present at the time of admission or that may arise during hospitalization and that are outside of the Limited License Practitioner Member's lawful scope of practice.

(b) An oral and maxillofacial surgeon who has successfully completed a postgraduate program in oral and maxillofacial surgery accredited by a nationally recognized accrediting body approved by the United States Office of Education and who has been determined by the Medical Staff to be competent to do so, may perform a history and physical examination and may determine the ability of his/her patient to undergo the surgical procedures the oral and maxillofacial surgeon proposes to perform. Completion of a history and physical by a qualified oral and maxillofacial surgeon under this Section 5.4-1(b) shall satisfy the appraisal portion of the requirements of Section 5.4-2 below. For patients with existing medical conditions or abnormal findings beyond the surgical indications, a Physician Member must conduct or directly supervise the admitting history and physical examination, except for the portion related to the oral and maxillofacial surgery, and must assume responsibility for the care of the patient's medical problems present at the time of admission or that may arise during hospitalization and that are outside of the oral and maxillofacial surgeon's lawful scope of practice.

5.4-2 MEDICAL APPRAISAL

All patients admitted for care in the Hospital by a Limited License Practitioner Member shall receive the same basic medical appraisal as patients admitted to a

Physician Member, and the Limited License Practitioner Member shall seek consultation with a Physician Member to determine the patient's medical status and need for medical evaluation whenever the patient's clinical status indicates the presence of a medical problem. Where a dispute exists regarding proposed treatment between a Physician Member and a Limited License Practitioner Member based upon medical or surgical factors outside of the scope of licensure of the Limited License Practitioner Member, the treatment shall be suspended insofar as possible while the dispute is resolved by the appropriate Service Committee(s).

5.5 TEMPORARY CLINICAL PRIVILEGES

5.5-1 CIRCUMSTANCES

(a) Temporary Clinical Privileges may be granted where good cause exists to a Practitioner for the care of specific patients (but not more than four (4) times during a calendar year) provided that the procedure described in Section 5.5-2 has been followed.

(b) Following the procedures in Section 5.5-2, temporary Clinical Privileges may be granted to a Practitioner serving as a locum tenens for a Member. Such Practitioner may attend only patients of the Member(s) for whom the Practitioner is providing coverage, for a period not to exceed sixty (60) days, unless the Medical Executive Committee recommends a longer period for good cause.

(c) Following the procedures in Section 5.5-2, temporary Clinical Privileges may be granted to an Applicant whose application qualifies as an expedited application under the Board of Directors' Medical Staff Expedited Review Policy. Temporary Clinical Privileges may be granted upon a recommendation for approval by the Medical Executive Committee pending review by the Board of Directors.

5.5-2 APPLICATION AND REVIEW

Upon receipt of a completed application appropriate to the circumstances and supporting documentation from an Applicant or Practitioner authorized to practice in California, the Chief of Staff and the Chief Executive Officer may grant temporary Clinical Privileges to the Applicant or Practitioner if the Applicant or Practitioner appears to have qualifications, ability and judgment, consistent with Section 2.2-1, but only after the Authorized Representative has queried and received a response from the National Practitioner Data Bank and the Medical Board of California regarding the Applicant for temporary Clinical Privileges.

5.5-3 GENERAL CONDITIONS

(a) If granted temporary Clinical Privileges, the Applicant or Practitioner shall act under the supervision of the chair of the Service to which the Applicant or Practitioner has been assigned, and shall ensure that the chair of the Service, or the chair's designee, is kept closely informed as to the activities of the Applicant or Practitioner within the Hospital.

(b) Temporary Clinical Privileges shall automatically terminate at the end of the designated period, unless earlier terminated or suspended under these Bylaws or unless affirmatively renewed following the procedure set forth in Section 5.5-2.

(c) Requirements for proctoring and monitoring, including, but not limited to, those in Section 5.3, shall be imposed, on such terms as may be appropriate under the circumstances, upon any Applicant or Practitioner granted temporary Clinical Privileges by the Chief of Staff after consultation with the chair of the appropriate Service or the chair's designee.

(d) Temporary Clinical Privileges may at any time be suspended or terminated under these Bylaws. In such cases, the chair of the appropriate Service or, in the chair's absence, the Chief of Staff, shall assign a Member to assume responsibility for the care of such Applicant's or Practitioner's patient(s). The wishes of the patient shall be considered in the choice of a replacement for the Applicant or Member.

(e) All Practitioners and Applicants requesting or receiving temporary Clinical Privileges shall be bound by these Bylaws and the Medical Staff Rules and Regulations.

5.6 EMERGENCY CLINICAL PRIVILEGES

(a) In the case of an emergency, any Member, to the degree permitted by the scope of the Member's license and regardless of the Member's Service assignment, Medical Staff category, or Clinical Privileges, shall be permitted to do everything reasonably possible to save the life of a patient or to save a patient from serious harm. The Member shall make every reasonable effort to communicate promptly with the chair of the appropriate Service concerning the need for emergency care and assistance by Members with appropriate Clinical Privileges, and once the emergency has passed or assistance has been made available, shall defer to the chair of the appropriate Service with respect to further care of the patient at the Hospital.

(b) In the event of an emergency, any person shall be permitted to do whatever is reasonably possible to save the life of a patient or to save a patient from serious harm. Such persons shall promptly yield such care to qualified Members when they become reasonably available.

5.7 DISASTER MANAGEMENT

Upon the recommendation of the Chief of Staff or another member of the Medical Executive Committee, the Chief Executive Officer or his/her designee may grant temporary Clinical Privileges to a Practitioner or eligible Allied Health Professional who is volunteering in the event of a mass disaster, but only after the identity of the Practitioner or eligible Allied Health Professional has been verified. The minimum acceptable sources of identification for the Practitioner or eligible Allied Health Practitioner providing emergency care include a current license to practice in the State of California, together with (a) a government issued photo identification or (b) verification of the Practitioner's or eligible Allied Health Practitioner's identity by a Member or Hospital employee. Primary source verification of licensure or identification indicating that the Practitioner or eligible Allied Health Practitioner is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group will be obtained. If primary source verification of licensure of the volunteer Practitioner or eligible Allied Health Practitioner cannot be obtained within 72 hours, it will be performed as soon as possible. This verification after 72 hours will have supporting documentation as to the reason it could not be performed, evidence of the Practitioner's or eligible Allied Health Practitioner's demonstrated ability to continue to provide adequate care, treatment and services, and that the verification was performed as soon as the Hospital is able to do so. Such temporary Clinical Privileges shall last for the duration of the disaster or for ninety (90) days, whichever occurs first. Furthermore, notwithstanding any existing delineation of Clinical Privileges or scope of authority, Members, Allied Health Professionals, 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.

Disaster privileges will be granted to volunteer Practitioners or eligible Allied Health Practitioners only when the Emergency Operations Plan has been activated in response to a disaster and the Hospital is unable to meet immediate patient needs. Upon the recommendation of the Chief of Staff or another member of the Medical Executive Committee, the Chief Executive Officer or his/her designee may grant temporary privileges for volunteer Practitioners or eligible Allied Health Practitioners.

During a disaster, the Medical Staff will oversee the performance of each volunteer Practitioner or eligible Allied Health Practitioner. Each volunteer Practitioner or eligible Allied Health Practitioner will be advised in writing regarding his or her role(s) in emergency response and to whom he or she reports to during an emergency. Within 72 hours of granting disaster privileges the Medical Staff Member responsible for the oversight of the volunteer Practitioner or eligible Allied Health Practitioner assigned to him or her, will determine if temporary privileges should continue.

Identification badges of volunteer Practitioners or Allied Health Practitioners will be differentiated as provided under the Emergency Operations Plan.

5.8 TELEMEDICINE PRIVILEGES

5.8-1 DEFINITION OF TELEMEDICINE PRIVILEGES AND RELATED TERMS

(a) "Telemedicine Privileges" means the authorization granted to a Practitioner by the Board of Directors 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.
(b) "Originating Site" means the site where the patient is located at the time the service is provided.
(c) "Distant Site" means the site where the Practitioner providing the professional service is located.

5.8-2 REQUIRED DOCUMENTATION

Any Practitioner who wishes to be considered for Telemedicine Privileges, except for those Practitioners who meet the qualifications under Section 5.8-4 for Distant Site Credentialing below, will provide the following documentation to the Medical Staff Office or its designee:

(a) Signed consent and release/authorization form;
(b) Current California 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 hospital/organization accredited by the Joint Commission on Healthcare Organizations ("JCAHO") or at an equivalent hospital/organization; and
(h) Such additional information as may be requested by the Hospital

5.8-3 REQUIRED VERIFICATIONS

The following verifications will be completed by the Medical Staff Office 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 JCAHO 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);
(e) Verification of the Practitioner's current DEA status (when applicable); and
(f) Verification of the Practitioner's current board status (when applicable).

5.8-4 DISTANT SITE CREDENTIALING

The Board of Directors may approve telemedicine privileges relying upon credentialing information from a Distant Site if all of the following requirements are met:

(a) the Distant Site is a Medicare-participating hospital; and
(b) the Practitioner's privileges at the Distant Site are for the same services to be provided at the Originating Site; and
(c) The Originating Site has evidence of internal review of the Practitioner's performance of his or her privileges at the Distant Site, including but not limited to any adverse outcomes, patient complaints and staff complaints related to the Practitioner's provision of telemedicine services at the Originating Site to the Distant Site for use in the Originating Site hospital's appraisal of the Practitioner; and
(d) Prior to the provision of any telemedicine services, the Medical Executive Committee will ensure that there is a written agreement in place between the Originating Site and the Distant Site and that such agreement shall specify that the governing body of the Distant Site is responsible for ensuring that the telemedicine services provided by the Practitioner providing telemedicine services meets the requirements set forth in 42 CFR Sections 485.616(c) (1)(i) through (c)(1) (vii).

5.8-5 ACTIONS TO BE TAKEN

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

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

5.8-6 REVIEW

All Practitioners who have been granted Telemedicine Privileges will be reviewed, and all information regarding such Practitioners will be re-verified.

5.8-7 OBLIGATION TO REPORT

A Practitioner who has been granted Telemedicine Privileges will immediately report to the Chief Executive Officer the loss or suspension of any license, certificate or authorization described in Section 5.8-2 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 the Medical Staff Office or its designee of any Practitioner who requires Telemedicine Privileges and of any Practitioner who no longer needs to maintain Telemedicine Privileges.

5.8-8 PROVISION OF DIRECT PATIENT CARE

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.

5.9 MODIFICATION OF CLINICAL PRIVILEGES

On its own motion, upon recommendation of the appropriate Service Committee, or pursuant to a request under Section 4.6-1(b), the Medical Executive Committee may recommend a change in the Clinical Privileges of a Member. The Medical Executive Committee may also recommend that the granting of additional Clinical Privileges to a Member be made subject to monitoring in accordance with procedures similar to those outlined in Section 5.3-1. Any such recommended change in Clinical Privileges shall be subject to approval of the Board of Directors. In addition, if the recommended change is adverse to the Member, the Member shall be entitled to request a hearing pursuant to Article VII.

5.10 LAPSE OF APPLICATION

If a Member requesting a modification of Clinical Privileges fails to timely furnish the information reasonably necessary to evaluate the request within thirty (30) days after written notice of the request for same, the subject request shall be deemed withdrawn from consideration, no further action shall be taken on such request, and the Member shall not be entitled to a hearing as set forth in Article VII.

ARTICLE VI: CORRECTIVE ACTION

6.1 CORRECTIVE ACTION

6.1-1 CRITERIA FOR INITIATION

Any person may provide information to the Medical Staff about the conduct, performance, or competence of a Member. When reliable information indicates a Member may have exhibited acts, demeanor, or conduct reasonably likely to be (a) detrimental to patient safety or to the delivery of quality patient care within the Hospital; (b) unethical; (c) contrary to these Bylaws and/or the Medical Staff Rules or Regulations; or (d) below applicable professional standards, a request for an investigation or corrective action against such Member may be initiated by the Chief of Staff, the Medical Executive Committee.

6.1-2 INITIATION

A request for an investigation must be in writing, submitted to the Medical Executive Committee, and supported by reference to specific activities or conduct alleged. If the Medical Executive Committee initiates the request, it shall make an appropriate recordation of the reasons.

6.1-3 INVESTIGATION

If the Medical Executive Committee concludes an investigation is warranted, it shall direct an investigation to be undertaken. The Medical Executive Committee may conduct the investigation itself, or may assign the task to an appropriate Medical Staff officer, Service Committee, or standing or ad hoc committee of the Medical Staff. The Medical Executive Committee in its discretion may appoint Practitioners who are not Members to serve on a standing or ad hoc committee, should circumstances warrant. If the investigation is delegated to an officer or a committee other than the Medical Executive Committee, such officer or committee shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the Medical Executive Committee as soon as practicable. The report may include recommendations for appropriate corrective action. The Member shall be notified that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The individual or body investigating the matter may, but is not obligated to, conduct interviews with persons involved; provided, however, that such investigation shall not constitute a "hearing" as the term is used in Article VII, nor shall the procedural rules with respect to hearings or appeals apply. Despite the status of any investigation, at all times the Medical Executive Committee shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process, or other action.

6.1-4 MEDICAL EXECUTIVE COMMITTEE ACTION

As soon as practicable after the conclusion of the investigation, the Medical Executive Committee shall take action, which action may include, without limitation, the following:

(a) determining that no corrective action be taken and, if the Medical Executive Committee determines there was no credible evidence for the complaint in the first instance, removing any adverse information from the Member's file;

(b) deferring action for a reasonable time where circumstances warrant;

(c) issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude the chair of the appropriate Service from issuing informal written or oral warnings outside of the mechanism for corrective action;

(d) recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of Clinical Privileges, including, without limitation, requirements for co-admission, mandatory consultation, or monitoring;

(e) recommending reduction, modification, suspension or revocation of Clinical Privileges;

(f) recommending reductions of Medical Staff category or limitation of any prerogatives directly related to the Member’s delivery of patient care;

(g) recommending suspension, revocation or probation of Medical Staff membership; or

(h) taking other actions deemed appropriate under the circumstances.

In the event any letters are issued by the Medical Executive Committee or the chair of the appropriate Service, the affected Member may make a written response, which shall be placed in the Member's file.

6.1-5 SUBSEQUENT ACTION

(a) If corrective action, as set forth in Section 7.2-1(a)-(k), is recommended by the Medical Executive Committee, that recommendation shall be transmitted to the Board of Directors.

(b) So long as the recommendation of the Medical Executive Committee is supported by the evidence, the Board of Director's action will be final unless the Member requests a hearing, in which case the final decision shall be determined as set forth in Article VII.

(c) Board action, after completion of the procedural rights provided in these Bylaws or after waiver of these rights, is effective as of the final decision of the Board of Directors.

6.1-6 INITIATION BY BOARD OF DIRECTORS

If the Medical Executive Committee fails to investigate or take disciplinary action, contrary to the weight of the evidence, the Board of Directors may direct the Medical Executive Committee to initiate investigation or disciplinary action, but only after consultation with the Medical Executive Committee. The request by the Board of Directors for Medical Executive Committee action shall be in writing and shall set forth the basis for the request. If the Medical Executive Committee fails to take action in response to the direction from the Board of Directors, the Board of Directors may initiate corrective action after written notice to the Medical Executive Committee, but such corrective action must comply with Articles VI and VII of these Bylaws.

6.2 SUMMARY RESTRICTION OR SUSPENSION

6.2-1 CRITERIA FOR INITIATION

Whenever a Member's conduct appears to require that immediate action be taken to protect the life or well-being of patient(s) or to reduce a substantial and imminent likelihood of significant impairment of the life, health, or safety of any patient, prospective patient, or other person, the Chief of Staff, the Chief Executive Officer in consultation with a member of the Medical Executive Committee, or the Medical Executive Committee, may summarily restrict or suspend the Medical Staff membership or Clinical Privileges of such Member. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the person or body responsible shall promptly give written notice to the Medical Executive Committee and the Chief Executive Officer. In addition, the affected Member shall be provided written notice of the action, which notice shall fully comply with the requirements of Section 6.2-2 below. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. The Member also may be given an opportunity to refrain voluntarily from exercising Clinical Privileges pending an investigation. Unless otherwise indicated by the terms of the summary restriction or suspension, the Member's patients shall be promptly assigned to another Member by the chair of the appropriate Service or by the Chief of Staff, considering, where feasible, the wishes of the patient in the choice of a substitute Member.

6.2-2 WRITTEN NOTICE OF SUMMARY SUSPENSION

Within one (1) working day of imposition of a summary suspension, the affected Member shall be provided with written notice of such summary suspension. This initial written notice shall include a statement of facts demonstrating that the summary suspension was necessary because failure to suspend or restrict the Member's Clinical Privileges summarily could reasonably result in an imminent danger to the health of any individual. The statement of facts provided in this initial notice shall also include a summary of one or more particular incidents giving rise to the assessment of imminent danger. This initial notice shall not substitute for, but is in addition to, the notice required under Section 7.3-1 (which applies in all cases where the Medical Executive Committee does not immediately terminate the summary suspension). The notice under Section 7.3-1 may supplement the initial notice provided under this Section 6.2-2, by including any additional relevant facts supporting the need for summary suspension or other corrective action.

6.2-3 MEDICAL EXECUTIVE COMMITTEE ACTION

Within one (1) week after such summary restriction or suspension has been imposed, a meeting of the Medical Executive Committee, or a subcommittee thereof appointed by the Chief of Staff, shall be convened to review and consider the action. Upon request, the Member may attend and make a statement concerning the issues under investigation, on such terms and conditions as the Medical Executive Committee may impose, although in no event shall any meeting of the Medical Executive Committee, with or without the Member, constitute a "hearing" within the meaning of Article VII, and no such procedural rules shall apply. The Medical Executive Committee may modify, continue, or terminate the summary restriction or suspension, but in any event it shall furnish the Member with notice of its decision within two (2) working days of the meeting.

6.2-4 PROCEDURAL RIGHTS

Unless the Medical Executive Committee or the Board of Directors promptly terminates the summary restriction or suspension within fourteen (14) calendar days of its imposition, the Member shall be entitled to the procedural rights afforded by Article VII.

6.2-5 INITIATION BY BOARD OF DIRECTORS

If the Chief of Staff and the members of the Medical Executive Committee are not available to summarily restrict or suspend the Medical Staff membership or Clinical Privileges of such Member, the chair of the Board of Directors, the Chief Executive Officer of Banner Health, or the Senior Vice President of Quality and Care Management of Banner Health may immediately suspend a Member's Clinical Privileges if a failure to summarily suspend such Clinical Privileges is likely to result in an imminent danger to the health of any person, provided that the person initiating the action made reasonable attempts to contact the Chief of Staff and the

members of the Medical Executive Committee before imposing the summary suspension.

Such a summary suspension is subject to ratification by the Medical Executive Committee. If the Medical Executive Committee does not ratify such a summary suspension within two (2) working days, excluding weekends and holidays, the summary suspension shall terminate automatically. If the Medical Executive Committee does ratify the summary suspension, all other provisions under Section 6.2 of these Bylaws shall apply. In such event, the date of imposition of the summary suspension shall be considered to be the date of ratification by the Medical Executive Committee for purposes of compliance with the notice and hearing requirements, but not for compliance with Section 6.2.4.

6.3 AUTOMATIC SUSPENSION OR LIMITATION

In the following instances, a Member's Clinical Privileges and/or Medical Staff membership may be suspended or limited as described, and a hearing, if requested, shall be limited to the question of whether the grounds for automatic suspension or limitation, as set forth below, have occurred. Unless otherwise indicated by the terms of the automatic suspension, the Member's patients shall be promptly assigned to another Member by the chair of the appropriate Service or by the Chief of Staff, considering, where feasible, the wishes of the patient in the choice of a substitute Member.

6.3-1 LICENSURE

(a) Revocation, Suspension and Expiration.

Whenever a Member's license or other legal credential authorizing practice in the State of California is revoked or suspended by the applicable licensing or certifying authority or expires without renewal, the Member's Medical Staff membership and Clinical Privileges shall be automatically revoked as of the date such action becomes effective.

(b) Restriction.

Whenever a Member's license or other legal credential authorizing practice in the State of California is limited or restricted by the applicable licensing or certifying authority, any Clinical Privileges that the Member has been granted at the Hospital that are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner as of the date such action becomes effective and throughout its term.

(c) Probation.

Whenever a Member is placed on probation by the applicable licensing or certifying authority, the Member's Medical Staff membership and Clinical

Privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

6.3-2 CONTROLLED SUBSTANCES

(a) Revocation, Suspension, Restriction or Expiration.

Whenever a Member's DEA certificate or other authorization to prescribe controlled substances is revoked, limited, or suspended or expires without renewal, the Member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate or other authorization, as of the date such action becomes effective and throughout its term.

(b) Probation.

Whenever a Member's DEA certificate or other authorization to prescribe controlled substances is subject to probation, the Member's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

6.3-3 MEDICAL RECORDS

History and Physical Examination ("H&P") - A history and physical examination in all cases shall be completed 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 24 hours after admission. The completed H&P must be on the medical record prior to surgery or invasive procedure (see 4.16.1), or any procedure in which conscious 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 office history and physical performed within 30 days prior to admission is acceptable with an updated medical record entry documenting an examination for any changes in the patient's condition. If approved by the Medical Staff, the Emergency Room Report, or Consultation report may be used as the H&P as long as all the elements in section 4.18 are included and the document is filed as a History and Physical on the EMR. The updated examination must be completed and documented in the patient's medical record within 24 hours after registration or admission but prior to surgery or a procedure requiring anesthesia services. The Obstetrical H&P will consist of the prenatal record, where applicable, updated in the EMR by the responsible physician or Allied Health professional.

6.3-4 PROFESSIONAL LIABILITY INSURANCE

Failure to maintain professional liability insurance as required by these Bylaws shall be grounds for automatic suspension of the Member's Clinical Privileges, and if, within ninety (90) calendar days after written warning of the delinquency, the Member does not provide evidence of the required professional liability insurance coverage, the Member shall be deemed to have resigned voluntarily from the Medical Staff and must reapply for Medical Staff membership and Clinical Privileges.

6.3-5 EXCLUSION FROM FEDERAL PROGRAMS

Whenever a Member is excluded from Medicare, Medicaid or other federally-funded healthcare programs, the Member's Medical Staff membership and Clinical Privileges shall be automatically suspended. An affected Member may request reinstatement during a period of ninety (90) calendar days following such suspension, upon presentation of proof of ability to participate in such federally-funded healthcare programs. Thereafter, such Member shall be deemed to have voluntarily resigned from the Medical Staff and must reapply for Medical Staff membership and Clinical Privileges.

6.3-6 FAILURE TO EXECUTE RELEASES OR PROVIDE REQUESTED INFORMATION

A Member who fails to execute a release, as more particularly described in Section 11.5, or who fails to provide documentation or other information during a term of appointment when requested by the chair of the appropriate Service or the Chief of Staff shall be automatically suspended. If the release is executed and/or documents provided within thirty (30) calendar days from the receipt of notice regarding the suspension, the Member shall be reinstated. Thereafter, the Member shall be deemed to have resigned voluntarily from the Medical Staff and must reapply for Medical Staff membership and Clinical Privileges.

6.3-7 MEDICAL EXECUTIVE COMMITTEE DELIBERATION

As soon as practicable after action is taken or warranted as described in Section 6.3-1(b) or (c), Section 6.3-2, Section 6.3-4 or Section 6.3-5, the Medical Executive Committee shall convene to review and consider the facts, and may recommend any further corrective action as it may deem appropriate in accordance with these Bylaws.

ARTICLE VII: HEARINGS AND APPELLATE REVIEWS

7.1 GENERAL PROVISIONS

7.1-1 EXHAUSTION OF REMEDIES

If adverse action, as described in Section 7.2 below, is taken or recommended, the Applicant or Member must exhaust the remedies afforded by these Bylaws before resorting to legal action.

7.1-2 APPLICATION OF ARTICLE

In addition to Applicants and Members, clinical psychologists who are providing or applying to provide professional services in the Hospital, but who are not Members, are entitled to the hearing rights specified in this Article VII.

7.1-3 TIMELY COMPLETION OF PROCESS

The hearing and appeal process shall be completed within a reasonable time.

7.1-4 FINAL ACTION

Recommended adverse actions, as described in Section 7.2 below, shall become final only after the hearing and appellate rights set forth in these Bylaws have either been exhausted or waived, and only upon being adopted as final actions by the Board of Directors.

7.1.5 AS THE CASE MAY BE

As used in this Article VII, the phrase "as the case may be" is intended to direct attention to the body that took the adverse action in a particular situation, which would be either the Medical Executive Committee or the Board of Directors.

7.2 GROUNDS FOR HEARING

7.2-1 RECOMMENDATIONS OR ACTIONS

Except as otherwise specified in these Bylaws, any one or more of the following actions or recommended actions shall be deemed actual or potential adverse action and constitute grounds for a hearing:

(a) denial of Medical Staff membership;

(b) denial of requested advancement in Medical Staff category;

(c) denial of reappointment to the Medical Staff;

(d) demotion to a lower Medical Staff category;

(e) suspension of Medical Staff membership for more than fourteen (14) calendar days;

(f) revocation of Medical Staff membership;

(g) denial of requested Clinical Privileges;

(h) involuntary reduction of Clinical Privileges;

(i) suspension of Clinical Privileges for more than fourteen (14) calendar days, except for suspension of Clinical Privileges due to delinquent medical records;

(j) termination of Clinical Privileges; or

(k) involuntary imposition of significant consultation or monitoring requirements (excluding monitoring incidental to provisional Medical Staff status in accordance with Section 5.3).

7.2-2 WHEN DEEMED ADVERSE

A recommendation or action listed in Section 7.2-1 above shall be deemed adverse only when it has been:

(a) recommended by the Medical Executive Committee;

(b) taken by the Board of Directors, if contrary to a favorable recommendation from the Medical Executive Committee and under circumstances where no specific right to a hearing existed;

(c) a summary suspension continued in effect after review by the Medical Executive Committee; or

(d) taken by the Board of Directors on its own initiative without benefit of a prior recommendation by the Medical Executive Committee.

7.3 REQUESTS FOR HEARING

7.3-1 NOTICE OF ACTION OR PROPOSED ACTION

In all cases in which action has been taken or a recommendation made as set forth in Section 7.2, the Chief of Staff or designee on behalf of the Medical Executive Committee shall give the Applicant or Member prompt written notice of (a) the recommendation or final proposed action and that such action, if adopted, shall be taken and reported to the Medical Board of California and/or to the National Practitioner Data Bank if required; (b) the reasons for the proposed action, including the acts or omissions with which the Applicant or Member is charged; (c) the right to request a hearing pursuant to Section 7.3-2, and that such hearing must

be requested within thirty (30) calendar days from the date the notice is received; (d) the effect of failure to request a hearing within the above stated time period and in the proper manner, namely that it constitutes a waiver of rights to any hearing or appellate review on the matter that is the subject of the notice; and (e) a summary of the rights granted in the hearing pursuant to these Bylaws. If the recommendation or final proposed action is reportable to the Medical Board of California and/or to the National Practitioner Data Bank, the written notice shall state the text of the proposed report(s).

7.3-2 REQUEST FOR HEARING

The Applicant or Member shall have thirty (30) calendar days following receipt of notice of such action to request a hearing. The request shall be in writing addressed to the Medical Executive Committee or to the Board of Directors, as the case may be. In the event the Applicant or Member does not request a hearing within the time and in the manner described in these Bylaws, the Applicant or Member shall be deemed to have waived any right to a hearing or appellate review and to accepted the recommendation or action involved.

7.3-3 TIME AND PLACE FOR HEARING

Upon receipt of a request for hearing, the Medical Executive Committee or the Board of Directors, as the case may be, shall schedule a hearing and, within fifteen (15) calendar days from the date of receipt of such request, shall give notice to the Applicant or Member of the time, place and date of the hearing. Unless extended by the judicial review committee, the date of the commencement of the hearing shall be not less than thirty (30) calendar days from the date the notice of the hearing is received by the Member, and not more than sixty (60) calendars days from the date of receipt of such request for a hearing by the Medical Executive Committee or the Board of Directors, as the case may be; provided, however, that when the request is received from a Member who is under summary suspension, the hearing shall be held as soon as the arrangements may reasonably be made, but not to exceed forty-five (45) calendar days from the date of receipt of the request for the hearing.

7.3-4 NOTICE OF HEARING

Together with the notice stating the place, time and date of the hearing, which date shall not be less than thirty (30) calendar days after the date the notice of the hearing is received by the Member, unless waived by a Member under summary suspension, the Medical Executive Committee or the Board of Directors, as the case may be, shall provide the reasons for the recommended action, including the acts or omissions with which the Applicant or Member is charged, a list of the charts in question, where applicable, a list of the witnesses (if any) expected to testify at the hearing on behalf of the Medical Executive Committee or the Board of Directors,

as the case may be. The content of this list is subject to update pursuant to Section 7.4-1.

7.3-5 JUDICIAL REVIEW COMMITTEE

(a) When a hearing is requested as a result of an adverse action of the Medical Executive Committee, the Medical Executive Committee shall appoint a judicial review committee composed of not less than three (3) Members. The judicial review committee members shall gain no direct financial benefit from the outcome of the hearing, and shall not have acted as accusers, investigators, fact finders, or initial decision makers or have otherwise actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude a Member from serving as a member of the judicial review committee. In the event that it is not feasible to appoint a judicial review committee from the members of the Active Staff, the Medical Executive Committee may appoint Members from other Medical Staff categories or Practitioners who are not Members, such as members of the regional medical society. Such appointment shall include designation of the chair of the judicial review committee. Membership on a judicial review committee shall consist of one member who shall have same healing arts licensure as the accused, and where feasible, shall include an individual practicing the same specialty as the Applicant or Member. All other members of the judicial review committee shall be Physicians.

(b) When a hearing is requested as a result of an adverse action of the Board of Directors, the hearing shall be conducted by a judicial review committee appointed by the chair of the Board of Directors and composed of at least three (3) persons, at least one of who shall be a member of the Board of Directors. The judicial review committee members shall gain no direct financial benefit from the outcome of the hearing, and shall not have acted as accusers, investigators, fact finders, or initial decision makers or have otherwise actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude a person from serving as a member of the judicial review committee. One of the members so appointed shall be designated as chair of the judicial review committee. The judicial review committee, where feasible, shall include an individual practicing the same specialty as the Applicant or Member.

7.3-6 FAILURE TO APPEAR OR PROCEED

Failure of the Applicant or Member without good cause to personally attend and proceed at such a hearing in an efficient and orderly manner shall be deemed to constitute voluntary acceptance of the recommendations or actions involved.

7.3-7 POSTPONEMENTS AND EXTENSIONS

Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these Bylaws may be permitted by the hearing officer, on a showing of good cause, or upon agreement of the parties.

7.4 HEARING PROCEDURE

7.4-1 PRE-HEARING PROCEDURE

(a) If either party to the hearing requests, in writing, a list of witnesses from the other party, within fifteen (15) calendar days of such request, and in no event less than ten (10) calendar days before commencement of the hearing, the other party shall furnish to the party making the request a written list of the names and addresses of the individuals, so far as is reasonably known or anticipated, who are anticipated to give testimony or evidence in support of such party at the hearing. The Applicant or Member shall have the right to inspect and copy documents or other evidence upon which the charges are based, as well as all other evidence relevant to the charges. The Applicant or Member shall also have the right to receive, at least thirty (30) calendar days prior to the hearing, a copy of the evidence forming the basis of the charges that is reasonably necessary to enable the Applicant or Member to prepare a defense, including all evidence that was considered by the Medical Executive Committee or the Board of Directors, as the case may be, in determining whether to proceed with the adverse action, and any exculpatory evidence in the possession of the Hospital, the Medical Executive Committee and/or the Board of Directors. Failure to provide such evidence at least thirty (30) calendar days before the commencement of the hearing shall constitute good cause for a continuance. In addition, the Applicant or Member and the Medical Executive Committee or the Board of Directors, as the case may be, shall have the right to receive all evidence that shall be made available to the judicial review committee. Failure to disclose the identity of a witness or produce copies of all documents expected to be produced at least ten (10) calendar days before the commencement of the hearing shall constitute good cause for a continuance.

(b) The Medical Executive Committee or the Board of Directors, as the case may be, shall have the right to inspect and copy at its expense any documents or other evidence relevant to the charges that the Applicant or

Member possesses or controls as soon as practicable after receiving the request for a hearing from the Applicant or Member.

(c) The failure by either party to provide access to any requested documents or other evidence relevant to the charges at least thirty (30) calendar days before the hearing shall constitute good cause for a continuance. The right to inspect a copy by either party does not extend to confidential information referring solely to individually identifiable Members, other than the Applicant or Member under review.

(d) The hearing officer shall consider and rule upon any request for access to information and may impose any safeguards that the protection of the peer review process and justice requires. In so doing, the hearing officer shall consider:

(1) whether the information sought may be introduced to support or defend the charges;

(2) the exculpatory or inculpatory nature of the information sought, if any;

(3) the burden imposed on the party in possession of the information sought, if access is granted; and

(4) any previous requests for access to information submitted or resisted by the parties to the same proceeding.

(e) The Applicant or Member shall be entitled to a reasonable opportunity to question and challenge the impartiality of any members of the judicial review committee and the hearing officer. Challenges to the impartiality of any member of the judicial review committee or the hearing officer shall be ruled on by the hearing officer.

(f) It shall be the duty of the Applicant or Member and the Medical Executive Committee or the Board of Directors, as the case may be, to exercise reasonable diligence in notifying the hearing officer or the chair of the judicial review committee of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be succinctly made at the hearing.

7.4-2 REPRESENTATION

The hearings provided for in these Bylaws are for the purpose of intraprofessional resolution of matters bearing on professional conduct, professional competency, or character.

The Applicant or Member shall be entitled to representation by legal counsel in any phase of the hearing, if the Applicant or Member so chooses, and shall receive notice of the right to obtain representation by an attorney at law. In the absence of legal counsel, the Applicant or Member shall be entitled to be accompanied by and represented at the hearing only by a Practitioner licensed to practice in the State of California who is not also an attorney at law, and the Medical Executive Committee or the Board of Directors, as the case may be, shall appoint a representative who is not an attorney at law to present its action or recommendation, the materials in support thereof, examine witnesses, and respond to appropriate questions. The Medical Executive Committee or the Board of Directors, as the case may be, shall not be represented by an attorney at law if the Applicant or Member is not so represented.

7.4-3 THE HEARING OFFICER

The Medical Executive Committee or the Board of Directors, as the case may be, shall recommend a hearing officer to preside at the hearing. The hearing officer may be an attorney at law qualified to preside over a quasi-judicial hearing, but attorneys from a firm regularly utilized by the Hospital, the Medical Staff or the affected Applicant or Member for legal advice regarding their affairs and activities shall not be eligible to serve as the hearing officer. The hearing officer shall gain no direct financial benefit from the outcome of the hearing and must not act as a prosecuting officer or as an advocate. The hearing officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The hearing officer shall be entitled to determine the order of, or procedure, for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions that pertain to matters of law, procedure or the admissibility of evidence. If the hearing officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the hearing officer may take such discretionary action as seems warranted by the circumstances. If requested by the judicial review committee, the hearing officer may participate in the deliberations of the judicial review committee and be a legal advisor to it, but the hearing officer shall not be entitled to vote.

7.4-4 RECORD OF THE HEARING

A shorthand reporter shall be present to make a record of the hearing proceedings, and the pre-hearing proceedings if deemed appropriate by the hearing officer. The cost of attendance of the shorthand reporter shall be borne by the Hospital, but the

cost of the transcript, if any, shall be borne by the party requesting it. The judicial review committee may, but shall not be required to, order that oral evidence shall be taken only on oath administered by any person lawfully authorized to administer such oath.

7.4-5 RIGHTS OF THE PARTIES

Within reasonable limitations, both sides at the hearing may call and examine witnesses for relevant testimony, introduce relevant exhibits or other documents, cross-examine or impeach witnesses who shall have testified orally on any matter relevant to the issues, and otherwise rebut evidence, as long as these rights are exercised in an efficient and expeditious manner. The Applicant or Member may be called by the Medical Executive Committee or the Board of Directors, as the case may be, and examined as if under cross-examination.

7.4-6 MISCELLANEOUS RULES

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under this Article VII. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The judicial review committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate. At its discretion, the judicial review committee may request or permit both sides to file written arguments. The hearing process shall be completed within a reasonable time after the notice of the action is received, unless the hearing officer issues a written decision that the Applicant or Member or the Medical Executive Committee or the Board of Directors, as the case may be, failed to provide information in a reasonable time or consented to the delay.

7.4-7 BURDENS OF PRESENTING EVIDENCE AND PROOF

(a) At the hearing, the Medical Executive Committee or the Board of Directors, as the case may be, shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. The Applicant or Member shall be obligated to present evidence in response.

(b) An Applicant shall bear the burden of persuading the judicial review committee, by a preponderance of the evidence, of the Applicant's qualifications by producing information that allows for adequate evaluation and resolution of reasonable doubts concerning the Applicant's current qualifications for Medical Staff membership and Clinical Privileges. An Applicant shall not be permitted to introduce information requested by the

Medical Staff but not produced during the application process unless the Applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

(c) Except as provided in Section 7.4-7(b) above, throughout the hearing, the Medical Executive Committee or the Board of Directors, as the case may be, shall bear the burden of persuading the judicial review committee, by a preponderance of the evidence, that its action or recommendation is reasonable and warranted.

7.4-8 ADJOURNMENT AND CONCLUSION

After consultation with the chair of the judicial review committee, the hearing officer may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted, with due consideration for reaching an expeditious conclusion to the hearing. Both the Applicant or Member and the Medical Executive Committee or the Board of Directors, as the case may be, may submit a written statement at the close of the hearing. Upon conclusion of the presentation of oral and written evidence, or the receipt of closing written arguments, if submitted, the hearing shall be adjourned.

7.4-9 BASIS FOR DECISION

The decision of the judicial review committee shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony. The decision of the judicial review committee shall be subject to such rights of appeal as described in these Bylaws.

7.4-10 DECISION OF THE JUDICIAL REVIEW COMMITTEE

Within thirty (30) calendar days after final adjournment of the hearing, the judicial review committee shall render a decision that shall be accompanied by a report in writing and shall be delivered to the Medical Executive Committee or the Board of Directors, as the case may be. If the Member is currently under suspension, however, the time for the decision and report shall be fifteen (15) calendar days. The report shall contain a concise statement of the reasons in support of the decision including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the conclusion reached.

7.4-11 ACTION ON JUDICIAL REVIEW COMMITTEE REPORT

At its next regularly scheduled meeting after receipt of the report of the judicial review committee, the Medical Executive Committee or the Board of Directors, as the case may be, shall consider the report and affirm, modify or reverse its previous recommendation or action in the matter. The Medical Executive Committee or the Board of Directors, as the case may be, also shall have available to it the hearing

record and all documentation submitted at the hearing. If the recommendation of the judicial review committee differs from the initial recommendation of the Medical Executive Committee or the Board of Directors, as the case may be, the chair of the judicial review committee may be invited to a meeting of the Medical Executive Committee or the Board of Directors, as the case may be, to discuss the findings, conclusions and recommendation of the judicial review committee.

7.4-12 NOTICE OF DETERMINATION AND EFFECT OF RESULT

(a) As soon as practicable after action by the Medical Executive Committee or the Board of Directors, as the case may be, the Chief Executive Officer shall send to the Applicant or Member a copy of the judicial review committee's report and the reconsidered recommendation of the Medical Executive Committee or the Board of Directors, 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 Medical Executive Committee or the Board of Directors, as the case may be, is favorable to the Applicant or Member, the Chief Executive Officer shall promptly forward it, together with all supporting documentation, to the Applicant or Member, to the Medical Executive Committee, and to the Board of Directors for final action.

(c) If, after the Medical Executive Committee or the Board of Directors, as the case may be, has considered the judicial review committee report and the hearing record, its reconsidered recommendation continues to be adverse, the Chief Executive Officer shall promptly so notify the Applicant or Member in writing, together with a written explanation of the procedure for appealing the decision. The Chief Executive Officer also shall forward such recommendation and documentation to the Board of Directors, but the Board of Directors 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.

(d) If the final proposed action adversely affects the Clinical Privileges of a physician or dentist Applicant or Member for a period longer than thirty (30) days and is based on competence or professional conduct, the decision shall state that the action, if adopted, shall be reported to the National Practitioner Data Bank. The decision also shall state whether the action, if adopted, shall be reported to the Medical Board of California.

7.5 APPEAL

Appeals shall be conducted in accordance with the Appellate Review Policies of the Board of Directors. A copy of the current version of the Appellate Review Policies of the Board of Directors shall be attached to these Bylaws. A copy of the current version of the Appellate

Review Policies of the Board of Directors also 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.

7.6 RIGHT TO ONE (1) HEARING AND ONE (1) APPELLATE REVIEW

No Applicant or Member shall be entitled to more than one (1) evidentiary hearing and one (1) appellate review on any matter that shall have been the subject of adverse action or recommendation.

7.7 NATIONAL PRACTITIONER DATA BANK REPORTING

The Authorized Representative shall report an adverse action to the National Practitioner Data Bank only upon its adoption as final action or as otherwise required by applicable law.

ARTICLE VIII: OFFICERS

8.1 OFFICERS OF THE MEDICAL STAFF

8.1-1 IDENTIFICATION

The officers of the Medical Staff shall be the Chief of Staff, the Vice Chief of Staff, and the Secretary-Treasurer.

8.1-2 QUALIFICATIONS

Officers must be members of the Active Staff at the time of their nominations and election, and must remain members of the Active Staff in good standing during their term of office. Failure to maintain such Active Staff status shall create a vacancy in the office involved.

8.1-3 NOMINATIONS

(a) Officers shall be elected every two years at the annual meeting of the Medical Staff in April. A nominating committee shall be appointed. The nominating committee shall consist of three (3) Members appointed by the Chief of Staff. The nominating committee shall nominate one (1) or more nominees for each office. The names of the nominees shall be reported to the Medical Executive Committee at least thirty (30) calendar days prior to the annual meeting of the Medical Staff.

(b) Further nominations may be made for any office by any voting Member. Nominations from the floor shall be recognized if the nominee is present and consents.

8.1-4 ELECTIONS

The Chief of Staff, the Vice Chief of Staff and the Secretary-Treasurer shall be elected at the annual meeting of the Medical Staff. Voting shall be by secret written ballot. A nominee shall be elected upon receiving a majority of the valid votes cast. If no nominee for an office receives a majority vote on the first (1st) ballot, a run-off election shall be held promptly between the two (2) nominees receiving the highest number of votes. In the case of a tie on the second (2nd) ballot, the majority vote of the Medical Executive Committee shall decide the election by secret written ballot.

8.1-5 TERM OF ELECTED OFFICE

Each officer shall serve a two (2) year term, commencing on the first (1st) day of the Medical Staff Year following such officer's election. Each officer shall serve in such officer's office until the end of such officer's term, or until a successor is elected, unless such officer sooner resigns or is removed from office.

8.1-6 RECALL OF OFFICERS

Any Medical Staff officer may be removed from office for valid cause, including, but not limited to, gross neglect or misfeasance in office, or serious acts of moral turpitude. Recall of a Medical Staff officer may be initiated by the Medical Executive Committee or shall be initiated by a petition signed by at least one-third (1/3) of the Members eligible to vote for officers. Recall shall be considered at a special meeting called for that purpose. Recall shall require a two-thirds (2/3) vote of the Members eligible to vote for Medical Staff officers who actually cast votes at the special meeting in person or by mail ballot.

8.1-7 VACANCIES IN ELECTED OFFICE

Vacancies in office occur upon the death, disability, resignation, or removal of the officer, or upon such officer's loss of membership in the Medical Staff. Vacancies, other than the office of the Chief of Staff, shall be filled by appointment by the Medical Executive Committee until the next regular or special election. If there is a vacancy in the office of the Chief of Staff, then the Vice Chief of Staff shall serve out the remaining term and shall immediately appoint an ad hoc nominating committee to decide promptly upon nominees for the office of the Vice Chief of Staff. Such nominees shall be reported to the Medical Executive Committee and to the Medical Staff. A special election to fill the office of the Vice Chief of Staff shall occur at the next regular Medical Staff meeting. If there is a vacancy in the office of Vice Chief of Staff, such office need not be filled by election, but the Medical Executive Committee shall appoint an interim officer to fill the office of Vice Chief

of Staff until the next regular election, at which time the election shall also include the office of Chief of Staff.

8.2 DUTIES OF OFFICERS

8.2-1 CHIEF OF STAFF

The Chief of Staff shall serve as the chief administrative officer of the Medical Staff. The duties of the Chief of Staff shall include, but shall not be limited to:

(a) enforcing these Bylaws and the Medical Staff Rules and Regulations, implementing sanctions where indicated, and promoting compliance with procedural safeguards where corrective action has been requested or initiated;

(b) calling, presiding at, and being responsible for the agenda of all meetings of the Medical Staff;

(c) serving as chair of the Medical Executive Committee and calling, presiding at, and being responsible for the agenda of all meetings thereof;

(d) serving as an ex-officio member of all other Medical Staff committees, without vote, unless the Chief of Staff's membership on a particular committee is required by these Bylaws;

(e) interacting with the Chief Executive Officer and the Board of Directors in all matters of mutual concern within the Hospital;

(f) appointing, in consultation with the Medical Executive Committee, committee members for all standing committees other than the Medical Executive Committee, and all special Medical Staff, liaison, or multi-disciplinary committees, except where otherwise provided by these Bylaws, and, except where otherwise indicated, designating the chairs of these committees;

(g) representing the views and policies of the Medical Staff to the Board of Directors and to the Chief Executive Officer;

(h) being a spokesperson for the Medical Staff in external professional and public relations;

(i) performing such other functions as may be assigned to the Chief of Staff by these Bylaws, the Medical Staff, or by the Medical Executive Committee;

(j) serving on liaison committees with members of the Board of Directors and Hospital administration, as well as outside licensing or accreditation agencies; and

(k) Serving as a voting member of the local Hospital advisory board.

8.2-2 VICE CHIEF OF STAFF

The Vice Chief of Staff shall assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff. The Vice Chief of Staff shall be a member of the Medical Executive Committee and shall perform such other duties as the Chief of Staff may assign or as may be delegated by these Bylaws, or by the Medical Executive Committee.

8.2-3 SECRETARY-TREASURER

The Secretary-Treasurer shall be a member of the Medical Executive Committee. The duties of the Secretary-Treasurer shall include, but shall not be limited to:

(a) maintaining a roster of Members;

(b) keeping accurate and complete minutes of all Medical Executive Committee meetings and all general Medical Staff meetings;

(c) calling meetings on the order of the Chief of Staff or the Medical Executive Committee;

(d) attending to all appropriate correspondence and notices on behalf of the Medical Staff;

(e) receiving and safeguarding all funds of the Medical Staff;

(f) excusing absences from meetings on behalf of the Medical Executive Committee; and

(g) performing such other duties as ordinarily pertain to the office or as may be assigned from time to time by the Chief of Staff or the Medical Executive Committee.

8.3 SERVICE CHAIRS

Each Service shall have a chair appointed by the Chief of Staff with the concurrence of the Medical Executive Committee. The chair of each Service shall be a member of the Active Staff and shall be qualified by training, experience, and demonstrated ability in at least one (1) of the clinical areas covered by the Service. The chair of each Service must be certified by an appropriate specialty board or must demonstrate comparable competence. The chair

of each Service shall serve a one (1) year term or until a successor is chosen, unless the chair of a Service shall sooner resign or be removed from office or lose Medical Staff membership or Clinical Privileges in the applicable Service. The chair of a Service may be removed by the Medical Executive Committee, and vacancies due to any reason shall be filled for the unexpired term by the Medical Executive Committee.

The chair of each Service shall:

(a) be the chair of the Service Committee performing quality management activities relevant to the applicable Service;

(b) generally monitor the quality of patient care and professional performance rendered by Members with Clinical Privileges in the applicable Service;

(c) conduct investigations and submit reports and recommendations to the appropriate committees regarding the Clinical Privileges to be exercised within the applicable Service by Applicants and Members;

(d) give guidance on the overall medical policies of the Medical Staff and make specific recommendations and suggestions regarding the applicable Service; and

(e) perform such other duties commensurate with the office as may from time to time be reasonably requested by the Chief of Staff or the Medical Executive Committee.

ARTICLE IX: COMMITTEES

9.1 DESIGNATION

Medical Staff committees shall include, but shall not be limited to, the Medical Staff, meeting as a committee of the whole, meetings of committees established under this Article IX, and meetings of special or ad hoc committees created by the Medical Executive Committee pursuant to this Article IX. The committees described in this Article IX shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the Medical Executive Committee to perform specified tasks. Unless otherwise specified, the chair and the members of all committees shall be appointed by, and may be removed by, the Chief of Staff, subject to consultation with, and approval by, the Medical Executive Committee. Medical Staff committees shall be responsible to the Medical Executive Committee.

9.2 GENERAL PROVISIONS

9.2-1 TERMS OF COMMITTEE MEMBERS

Unless otherwise specified, committee members shall be appointed for a term of one (1) year, and shall serve until the end of this period or until the committee

member's successor is appointed, unless the committee member shall sooner resign or be removed from the committee.

9.2-2 REMOVAL

If a committee member ceases to be a Member in good standing, loses a contract relationship with the Hospital, or suffers a loss or significant limitation of Clinical Privileges, or if any other good cause exists, such committee member may be removed from committee membership by the Medical Executive Committee.

9.2-3 VACANCIES

Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made; provided, however, that if a committee member who obtains membership by virtue of these Bylaws is removed for cause, a successor may be selected by the Medical Executive Committee.

9.2-4 DELEGATION OF TASKS

Documentation and other similar tasks as outlined in these Bylaws for medical staff leaders may be delegated to an employee of the Hospital such as the Medical Staff Coordinator. It is the responsibility of this individual to assist and coordinate these duties and follow through on all committee actions as applicable.

9.3 MEDICAL EXECUTIVE COMMITTEE

9.3-1 COMPOSITION

The Medical Executive Committee shall consist of the following members:

(a) the officers of the Medical Staff; and

(b) the Chief Executive Officer.

9.3-2 DUTIES

The duties of the Medical Executive Committee shall include, but shall not be limited to:

(a) representing and acting on behalf of the Medical Staff in the intervals between Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws;

(b) coordinating and implementing the professional and organizational activities and policies of the Medical Staff;

(c) receiving and acting upon reports and recommendations from Medical Staff committees and assigned activity groups;

(d) recommending actions to the Board of Directors on matters of a medical administrative nature;

(e) establishing the structure of the Medical Staff, the mechanism to review credentials and to delineate individual Clinical Privileges, the organization of quality assessment and improvement activities and mechanisms of the Medical Staff, and the termination of Medical Staff membership and fair hearing procedures, as well as other matters relevant to the operation of the Medical Staff;

(f) evaluating the medical care rendered to patients in the Hospital;

(g) participating in the development of all Medical Staff policies and applicable Hospital policies, practices, and planning;

(h) establishing criteria and reviewing the qualifications, credentials, performance, professional competence, and character of Applicants and Members, and making recommendations to the Board of Directors at least quarterly regarding Medical Staff appointments and reappointments, Service assignments, Clinical Privileges, and corrective action;

(i) taking reasonable steps to promote ethical conduct and competent clinical performance on the part of all Members, including the initiation of, and participation in, Medical Staff corrective or review measures when warranted;

(j) taking reasonable steps to develop continuing education activities and programs for the Medical Staff;

(k) planning, implementing, coordinating and promoting ongoing special clinical and scientific programs for the Medical Staff, which includes the following:

(1) identifying the educational needs of the Medical Staff;

(2) formulating clear statements of objectives for each program;

(3) assessing the effectiveness of each program as well as an annual assessment of the overall continuing medical education program;

(4) choosing appropriate teaching methods and knowledgeable faculty for each program; and

(5) documenting Medical Staff attendance at each program;

(l) assisting in developing processes to promote optimal patient care and to contribute to the continuing education of each Member;

(m) establishing liaison with the quality management program of the Hospital in order to be apprised of special areas in patient care that may be addressed by a specific continuing medical education activity;

(n) advising Hospital administration of the financial needs of the continuing medical education program.

(o) the secretary of the Medical Executive Committee in conjunction with the medical staff manager will coordinate the CME program.

(p) designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Medical Staff and approving or rejecting appointments to such committees as made by the Chief of Staff;

(q) reporting to the Medical Staff at each regular Medical Staff meeting;

(r) assisting in obtaining and maintaining accreditation of the Hospital;

(s) developing and maintaining methods for the protection and care of patients and others in the event of internal or external disaster;

(t) appointing such special or ad hoc committees as may seem necessary or appropriate to assist the Medical Executive Committee in carrying out its functions and those of the Medical Staff;

(u) reviewing the quality and appropriateness of services provided by contract physicians;

(v) reviewing and approving the designation of the Authorized Representative for purposes of the National Practitioner Data Bank and the Medical Board of California;

(w) establishing a mechanism for dispute resolution between Members (including Limited License Practitioner Members) involving the care of a patient;

(x) reviewing and evaluating the qualifications of each Applicant and each Allied Health Professional applying for initial appointment, reappointment, or modification of Clinical Privileges, and, in connection therewith,

obtaining and considering the assessment of the appropriate Service Committees;

(y) submitting required reports and information on the qualifications of each Applicant applying for Medical Staff membership or particular Clinical Privileges, including recommendation with respect to appointment, Medical Staff category, Clinical Privileges, and special conditions;

(z) investigating, reviewing and reporting on matters referred by the Chief of Staff or the Medical Executive Committee regarding the qualifications, conduct, professional character, or competence of any Applicant or Member; and

(aa) developing a Hospital-wide infection prevention and control program and maintaining surveillance over the program.

9.3-3 MEETINGS

The Medical Executive Committee shall meet as often as necessary, but at least ten (10) times per year, and shall maintain a record of its proceedings and actions.

9.4 MEDICINE COMMITTEE

9.4-1 COMPOSITION

The Medicine Committee shall consist of at least four (4) members of the Active Staff and up to two (2) members of the Allied Health Practitioner Staff, including the chair of the Medicine Service, who have a primary practice or interest in medicine, family practice, or pediatrics and newborns, and a radiologist, all as assigned by the Medical Executive Committee. Other Hospital management staff shall be members of the Medicine Committee as assigned by the Chief Executive Officer.

9.4-2 DUTIES

The duties of the Medicine Committee shall include:

(a) Reviewing, evaluating and monitoring the quality of care and appropriateness of treatment provided to patients within the Medicine Service;

(b) Developing and recommending to the Medical Executive Committee written policies and procedures for the Medicine Service;

(c) Submitting recommendations to the Medical Executive Committee for maintaining and improving the quality of care provided in the Medicine Service and the Hospital;

(d) Submitting recommendations to the Medical Executive Committee concerning Applicant appointment, reappointment, criteria and delineation of Clinical Privileges, monitoring and corrective action within the Medicine Service and serving as the credential committee for the Medicine Service;

(e) Overseeing the effective conduct of the patient care, evaluation and monitoring function delegated by the Medical Executive Committee, including cooperating with nursing, ancillary services and Hospital administration in matters such as personnel, supplies and equipment, special regulations, standing orders, and techniques;

(f) Reviewing and monitoring pharmacy and therapeutics; coordinating action on findings from the Medical Staff's review of the clinical use of antibiotics;

(g) Reviewing and monitoring documentation in the medical records and utilization management;

(h) Performing medical morbidity and mortality reviews;

(i) Performing annual evaluations of the Medicine Service;

(j) Overseeing the CPR training program;

(k) Monitoring the results of quality assessment and improvement activities throughout the Hospital;

(l) Coordinate quality management activities; and

(m) Submitting regular confidential reports to the Medical Executive Committee on the quality of medical care provided within the Hospital and on quality assessment and improvement activities conducted.

9.4-3 MEETINGS

The Medicine Committee shall meet at the call of its chair, but at least ten (10) times per year, and shall maintain a permanent record of its findings, proceedings, and actions, and shall report to the Medical Executive Committee.

9.5-1 COMPOSITION

The Surgery Committee shall consist of at least four (4) members of the Active Staff and up to two (2) members of the Allied Health Practitioner Staff, including the chair of the Surgery Service, who have a primary practice or interest in surgery, obstetrics, anesthesia, emergency medicine or pathology, as assigned by the Medical Executive Committee. Other Hospital management staff shall be members of the Surgery Committee, as assigned by the Chief Executive Officer.

9.5-2 DUTIES

(a) Reviewing, evaluating and monitoring the quality of care and appropriateness of treatment provided to patients within the Surgery Service;

(b) Developing and recommending to the Medical Executive Committee written policies and procedures for the Surgery Service;

(c) Submitting recommendations to the Medical Executive Committee for maintaining and improving the quality of care provided in the Surgery Service and the Hospital;

(d) Submitting recommendations to the Medical Executive Committee concerning Applicant appointment, reappointment, criteria and delineation of Clinical Privileges, monitoring and corrective action within the Surgery Service and serving as the credentials committee for the Surgery Service;

(e) Overseeing the effective conduct of the patient care, evaluation and monitoring functions delegated by the Medical Executive Committee, including cooperating with nursing, ancillary services, and Hospital administration in matters such as personnel, supplies and equipment, special regulations, standing orders and techniques;

(f) Reviewing and monitoring transfusions and blood types;

(g) Reviewing and monitoring surgical tissue and invasive procedures;

(h) Performing surgical and emergency service morbidity and mortality reviews;

(i) Performing annual evaluations of the Surgery Service;

(j) Developing a system for reporting, identifying and analyzing the incidence and cause of nosocomial infections, including assignment of responsibility for the ongoing collection and analytic review of such data, and follow-up activities;

(k) Developing and implementing a preventative and corrective program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques;

(l) Developing written policies defining special indications for isolation requirements;

(m) Acting upon recommendations related to infection prevention received from the Chief of Staff, the Medical Executive Committee, and other committees;

(n) Reviewing sensitivities or organisms specific to the Hospital;

(o) Monitoring the results of quality assessment and improvement activities throughout the Hospital;

(p) Coordinate quality management activities; and

(q) Submitting regular confidential reports to the Medical Executive Committee on the quality of medical care provided within the Hospital an don quality assessment and improvement activities conducted.

9.5-3 MEETINGS

The Surgery Committee shall meet at the call of its chair, but at least four (4) times per year, and shall maintain a permanent record of its findings, proceedings, and actions, and shall report to the Medical Executive Committee.

9.6 OBSTETRIC COMMITTEE

9.6-1 COMPOSITION

The Obstetric Committee shall consist of at least three (3) members of the Active Staff and up to two (2) members of the Allied Health Practitioner Staff, each of whom shall have a practice or interest in obstetrics and one (1) of whom shall be a diagnostic radiologist. Other Hospital management staff shall be members of the Obstetric Committee, as assigned by the Chief Executive Officer.

9.6-2 DUTIES

The duties of the Obstetric Committee shall include:

(a) Developing and recommending to the Medical Executive reviewing, evaluating and monitoring the quality of care and appropriateness of treatment provided to patients within the Obstetric Service;

(b) Developing and recommending to the Medical Executive Committee written policies and procedures for the Obstetric Service;

(c) Submitting recommendations to the Medical Executive Committee for maintaining and improving the quality of care provided in the Obstetric Service and the Hospital;

(d) Submitting recommendations to the Medical Executive Committee concerning Applicant appointment, reappointment, criteria and delineation of Clinical Privileges, monitoring and corrective action within the Obstetric Service and serving as the credentials committee for the Obstetric Service;

(e) Overseeing the effective conduct of the patient care, evaluation and monitoring functions delegated by the Medical Executive Committee, including cooperating with nursing, ancillary services, and Hospital administration in matters such as personnel, supplies and equipment, special regulations, standing orders and techniques;

(f) Reviewing and monitoring transfusions and blood types;

(g) Reviewing C-Sections, invasive procedures and complicated deliveries;

(h) Performing surgical and emergency service morbidity and mortality reviews;

(i) Performing annual evaluations of the Obstetric Service;

(j) Acting upon recommendations related to infection prevention received from the Chief of Staff, the Medical Executive Committee, and other committees;

(k) Reviewing sensitivities of organisms specific to the Hospital;

(l) Monitoring the results of quality assessment and improvement activities throughout the Hospital;

(m) Coordinating quality management activities; and

(n) Submitting regular confidential reports to the Medical Executive Committee on the quality of medical care provided within the Hospital and on quality assessment and improvement activities conducted.

9.6-3 MEETINGS

The Obstetric Committee shall meet at the call of its chair, but at least five (5) times per year, and shall maintain a permanent record of its findings, proceedings, and actions, and shall report to the Medical Executive Committee.

9.7 COMMITTEE ON INTERDISIPLINARY PRACTICE (CIDP)

9.7-1 COMPOSITION

The Committee on Interdisciplinary Practice (CIDP) shall consist of, at a minimum, the Hospital director of nursing, the Chief Executive Officer or designee, and an equal number of Physicians and up to two (2) members of the Allied Health Practitioner Staff appointed by the Medical Executive Committee and registered nurses appointed by the Hospital director of nursing. Licensed or certified health professionals other than registered nurses who perform functions requiring standardized procedures shall be included in the CIDP. The chair of the CIDP shall be a Physician of the Active Staff and a member of the Allied Health Practitioner Staff may serve as co-chair, as appointed by the Medical Executive Committee.

9.7-2 DUTIES

The duties of the CIDP shall include:

(a) evaluating and making recommendations regarding the need for, and appropriateness of, the performance of Hospital inpatient services by Allied Health Practitioners and other licensed or certified professionals;

(b) evaluating and making recommendations regarding the following:

(1) the mechanism for evaluating the qualifications and credentials of Allied Health Practitioners and other professionals who are eligible to apply for and provide Hospital inpatient services;

(2) the minimum standards of training, education, character, competence, and overall fitness of Allied Health Practitioners and other professionals who are eligible to apply for and provide Hospital inpatient services;

(3) the identification of Hospital inpatient services that may be performed by Allied Health Practitioners or other professionals, as well as any applicable terms and conditions thereon; and

(4) the professional responsibilities of those Allied Health Practitioners and other professionals who have been determined eligible to perform Hospital inpatient services;

(c) making recommendations regarding appropriate monitoring, supervision, and evaluation of those Allied Health Practitioners and other professionals who may be eligible to perform Hospital inpatient services;

(d) evaluating and reporting whether Hospital inpatient services proposed to be performed or actually performed by Allied Health Practitioners and other professionals are inconsistent with the rendering of quality medical care and with the responsibilities of Members;

(e) evaluating and reporting on the effectiveness of supervision requirements imposed upon Allied Health Practitioners and other professionals who are rendering Hospital inpatient services;

(f) periodically evaluating and reporting on the efficiency and effectiveness of Hospital inpatient services performed by Allied Health Practitioners and other professionals; and

(g) Standardizing procedures as follows:

(1) Identifying functions and/or procedures that require the formulation and adoption of standardized procedures under Section 2725 of the Business and Professions Code in order for them to be performed by registered nurses in the Hospital, and initiating the preparation of such standardized procedures in accordance with this Section 9.7;

(2) Reviewing and approving all such standardized procedures covering practice by registered nurses in the Hospital; and

(3) Recommending policies and procedures for the authorization of registered nurses employed by the Hospital to perform the identified functions and/or procedures, which may be administered by the CIDP or, by delegation, the Hospital director of nursing.

9.7-3 MEETINGS

The CIDP shall meet as often as necessary at the call of its chair but at least annually. It shall maintain a record of its proceedings and it shall submit reports of its activities and recommendations to the Medical Executive Committee.

9.8 BYLAWS COMMITTEE

9.8-1 COMPOSITION

The Bylaws Committee shall be composed of a chair and additional two (2) members, together with representation from Hospital Administration.

9.8-2 DUTIES

The duties of the Bylaws Committee shall include:

(a) Providing review of the Medical Staff Bylaws, the Medical Staff Rules and Regulations and Medical Staff policies and procedures and recommend changes or revisions;

(b) Reviewing proposed changes to the Medical Staff Bylaws and the Medical Staff Rules and Regulations from the standing committees for appropriateness, placement and legality, recommending changes to the appropriate committee and recommending acceptance or rejection of proposed changes to the Medical Executive Committee;

(c) Serving as the Physician Well-Being Committee and investigating reports of incident(s) in which a Member may be impaired, or ill to the extent that it affects his/her ability to practice medicine with skill and safety to patients, in accordance with the Practitioner Health Policy.

9.8-3 MEETINGS

The Bylaws Committee shall meet as often as necessary at the call of its chair.

ARTICLE X: MEETINGS

10.1 MEETINGS

10.1-1 ANNUAL MEETING

There shall be an annual meeting of the Medical Staff, which shall be held in June of each year. The Chief of Staff, or such other officers or committee chairs as the Chief of Staff or the Medical Executive Committee may designate, shall present reports on actions taken during the preceding Medical Staff Year and on other matters of interest and importance to the Members. Notice of the annual Medical Staff meeting shall be given to the Members at least fifteen (15) days prior to the meeting.

10.1-2 REGULAR MEETINGS

Regular meetings of the Medical Staff shall be held at least ten (10) times per year, except that the annual meeting of the Medical Staff shall constitute the regular meeting during the month in which it occurs. The date, place and time of the regular meetings of the Medical Staff shall be determined by the Medical Executive Committee, and adequate notice shall be given to the Members.

10.1-3 AGENDA

The order of business at any meeting of the Medical Staff shall be determined by the Chief of Staff and the Medical Executive Committee. The agenda shall include, insofar as feasible, the following:

(a) a reading and acceptance of the minutes of the last regular and all special meetings of the Medical Staff held since the last regular meeting:

(b) administrative reports from the Chief of Staff, Medical Staff committees, and the Chief Executive Officer;

(c) the election of officers, when required by these Bylaws;

(d) reports by responsible officers and committees on the overall results of patient care audits and other quality review, evaluation, and monitoring activities of the Medical Staff and on the fulfillment of other required Medical Staff functions;

(e) old business; and

(f) new business.

10.1-4 SPECIAL MEETINGS

Special meetings of the Medical Staff may be called at any time by the Chief of Staff or the Medical Executive Committee, or shall be called upon the written request of ten percent (10%) of the members of the Active Staff. The person calling or requesting the special meeting shall state the purpose of such meeting in writing. The meeting shall be scheduled by the Medical Executive Committee within thirty (30) days after receipt of such request. No later than ten (10) days prior to the meeting, notice shall be mailed or delivered to the Members, which notice shall include the stated purpose of the meeting. No business shall be transacted at any special meeting except the business stated in the notice calling the meeting.

10.2 COMMITTEE MEETINGS

10.2-1 REGULAR MEETINGS

Except as otherwise specified in these Bylaws, the chair of each Medical Staff committee may establish the times for the holding of regular meetings of such chair's committee. Each chair shall make every reasonable effort to ensure the meeting dates are disseminated to the members of such Medical Staff committee with adequate notice.

10.2-2 SPECIAL MEETINGS

A special meeting of any Medical Staff committee may be called by the chair thereof, the Medical Executive Committee, or the Chief of Staff, and shall be called by written request of one-third (1/3) of the current members of such Medical Staff committee who are eligible to vote.

10.3 QUORUM

10.3-1 MEDICAL STAFF MEETINGS

The presence of one-third (1/3) of the total members of the Active Staff at any regular or special meeting in person or through written ballot shall constitute a quorum for transacting general business and electing or removing of Medical Staff officers. The quorum requirements for amending these Bylaws or the Medical Staff Rules and Regulations are set forth in Section 13.2 below.

10.3-2 COMMITTEE MEETINGS

A quorum of one-third (33 1/3%) of the voting members shall be required for meetings of the Medical Executive Committee and the Service Committees.

10.4 VOTING AND MANNER OF ACTION

10.4-1 VOTING

Unless otherwise specified in these Bylaws, only Members may vote in Medical Staff elections and at Medical Staff and Service Committee meetings, and all duly appointed members of any other Medical Staff committee are entitled to vote on committee matters, except as may otherwise be specified in these Bylaws.

10.4-2 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business, notwithstanding the withdrawal of members, so long as any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be specifically required by these Bylaws. Committee action may be conducted by telephone conference, which shall be deemed to constitute a meeting for the matters discussed in such telephone conference. Valid action may be taken by a committee without a meeting if it is acknowledged by a writing setting forth the action so taken and if such writing is signed by at least one-third (1/3) of the members entitled to vote.

10.5 MINUTES

Except as otherwise specified herein, minutes of meetings shall be prepared and retained. They shall include, at a minimum, a record of the attendance of members and the vote taken on significant matters. A copy of the minutes shall be signed by the presiding officer of the meeting and forwarded to the Medical Executive Committee.

10.6 ATTENDANCE REQUIREMENTS

10.6-1 REGULAR ATTENDANCE

Except as stated below, each member of the Active Staff and each member of the Provisional Staff who qualifies for membership under criteria applicable to the Active Staff shall be required to attend:

(a) At least thirty percent (30%) of all general Medical Staff meetings duly convened pursuant to these Bylaws; and

(b) At least thirty percent (30%) of all meetings of each committee to which such member of the Active Staff or the Provisional Staff is assigned.

Each member of the Consulting Staff or the Courtesy Staff and each member of the Provisional Staff who qualifies for membership under criteria applicable to the Courtesy Staff or the Consulting Staff may attend Medical Staff meetings, but are not required to do so. Practitioners with temporary Clinical Privileges under Section 6.1-3 are excluded from meetings requirements.

10.6-2 ABSENCE FROM MEETINGS

Any Member who is compelled to be absent from any Medical Staff or committee meeting shall promptly provide to the regular presiding officer thereof the reason for such absence. Unless excused for good cause by the presiding officer of the committee, or, in the case of Medical Staff meetings, the Secretary-Treasurer, the failure to meet the attendance requirements may be grounds for removal from such committee or for corrective action.

10.6-3 SPECIAL ATTENDANCE

At the discretion of the chair or the regular presiding officer, when a Member's practice or conduct is scheduled for discussion at a regular committee meeting, the Member may be requested to attend. If a suspected deviation from standard clinical practice is involved, the notice shall be given at least seven (7) calendar days prior to the meeting and shall include the time and place of the meeting and a general indication of the issue involved. Failure of a Member to appear at any meeting to

which notice was given, unless excused by the Medical Executive Committee upon a showing of good cause, shall be a basis for corrective action.

10.7 CONDUCT OF MEETINGS

Unless otherwise specified, meetings shall be conducted according to Robert's Rules of Order; provided, however, that technical or non-substantive departures from such rules shall not invalidate action taken at such a meeting.

10.8 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.

ARTICLE XI: CONFIDENTIALITY, IMMUNITY AND RELEASES

11.1 AUTHORIZATION AND CONDITIONS

By applying for, or exercising, Clinical Privileges within the Hospital, an Applicant or Member:

(a) 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;

(b) authorizes persons and organizations to provide information concerning the Applicant or Member to the Medical Staff.

(c) agrees to be bound by the provisions of this Article XI and to waive all legal claims against any representative of the Medical Staff or the Hospital who would be immune from liability under Section 11.3; and

(d) acknowledges that the provisions of this Article XI 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.

11.2 CONFIDENTIALITY OF INFORMATION

11.2-1 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 Medical Executive Committee, including information regarding any Applicant or Member, shall, to the fullest extent permitted by law, be confidential.

11.2-2 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 Medical Executive Committee may undertake such corrective action as it deems appropriate.

11.3 IMMUNITY FROM LIABILITY

11.3-1 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.

11.3-2 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.

11.4 ACTIVITIES AND INFORMATION COVERED

The confidentiality and immunity provided by this Article XI 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:

(a) application for appointment, reappointment, or Clinical Privileges;

(b) corrective action;

(c) hearings and appellate reviews;

(d) utilization reviews;

(e) other committee or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and

(f) queries and reports concerning the National Practitioner Data Bank, peer review organization, the Medical Board of California, and similar queries and reports.

11.5 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 XI. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article XI.

ARTICLE XII: GENERAL PROVISIONS

12.1 MEDICAL STAFF RULES AND REGULATIONS

The Medical Staff shall initiate and adopt such Medical Staff Rules and Regulations as it may deem necessary for the proper conduct of its work and shall periodically review and revise the Medical Staff Rules and Regulations to comply with current Medical Staff practice. Recommended changes to the Medical Staff Rules and Regulations shall be submitted to the Medical Executive Committee for review and evaluation prior to presentation for consideration by the Medical Staff as a whole under such review or approval mechanism as the Medical Staff shall establish in the Medical Staff Rules and Regulations. Following adoption by the Medical Staff, the Medical Staff Rules and Regulations shall become effective upon approval of the Board of Directors, which approval shall not be withheld unreasonably. The Medical Staff Rules and Regulations shall be reviewed (and may be revised if necessary) at least once every three (3) years. Applicants and Members shall be governed by the Medical Staff Rules and Regulations as

are properly initiated and adopted. If there is a conflict between these Bylaws and the Medical Staff Rules and Regulations, these Bylaws shall prevail. The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff Rules and Regulations.

12.2 DUES OR ASSESSMENTS

The Medical Executive Committee shall have the power to recommend the amount of annual dues or assessment, if any, for each category of Medical Staff membership, subject to the approval of the Medical Staff, and to determine the manner of expenditure of such funds received.

12.3 AUTHORITY TO ACT

Any Member who acts in the name of the Medical Staff without proper authority shall be subject to such disciplinary action as the Medical Executive Committee may deem appropriate.

12.4 DIVISION OF FEES

Any division of fees by Members is forbidden and any such division of fees shall be cause for termination of Medical Staff membership.

12.5 NOTICES

Except where specific notice provisions are otherwise provided in these Bylaws, any and all notices, demands and requests required or permitted to be mailed shall be in writing properly sealed, and shall be sent through the United States Postal Service, first-class postage prepaid. An alternative delivery mechanism may be used if it is reliable and as expeditious and if evidence of its use is obtained. Notice to the Medical Staff, Medical Staff officers or Medical Staff committees, shall be addressed as follows:

Name and proper title of addressee, if known or applicable
Name of committee
[c/o Medical Staff coordinator or Chief of Staff]
Banner Lassen Medical Center
1800 Spring Ridge Drive
Susanville, California 96130

Mailed notices to an Applicant, a Member, or other party, shall be to the addressee at the address as it last appears in the official records of the Medical Staff or the Hospital.

12.6 DISCLOSURE OF INTEREST

All nominees for election or appointment to Medical Staff offices, as committee chairs, or to the Medical Executive Committee shall, at least twenty (20) days prior to the date of election or appointment, disclose in writing to the Medical Executive Committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware that could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff.

12.7 NOMINATION OF MEDICAL STAFF REPRESENTATIVES

Candidates for positions as Medical Staff representatives to local, state and national hospital and medical staff sections should be filled by such selection process as the Medical Staff may determine. Nominations for such positions shall be made by a nominating committee appointed by the Medical Executive Committee.

12.8 CONFIDENTIALITY OF MEDICAL STAFF CREDENTIALS FILES

The following applies to records of the Medical Staff and the Medical Staff committees responsible for the evaluation and improvement of patient care:

(a) The records of the Medical Staff and the Medical Staff committees responsible for the evaluation and improvement of the quality of patient care rendered in the Hospital shall be maintained as confidential.

(b) Access to such records shall be limited to duly appointed officers and committees of the Medical Staff for the sole purpose of discharging Medical Staff responsibilities and subject to the requirement that confidentiality be maintained.

(c) Information that is disclosed to the Board of Directors or its appointed representatives in order that the Board of Directors may discharge its lawful obligations and responsibilities shall be maintained by the Board of Directors as confidential.

(d) Information contained in the credentials file of any Member may be disclosed with the Member's consent, or to any Medical Staff or professional licensing board, or as required by law. However, any disclosure outside of the Medical Staff shall require the authorization of the Chief of Staff and the appropriate Service chair and notice to the Member.

(e) A Member shall be granted access to such Member's credentials file, subject to the following provisions:

(1) timely notice of such request shall be made by the Member to the Chief of Staff or the Chief of Staff's designee;

(2) the Member may review, and receive a copy of, only those documents provided by, or addressed personally to, the Member. A summary of all other

information, including peer review committee findings, letters of reference, proctoring reports, and complaints, shall be provided to the Member, in writing, by the designated Medical Staff officer within a reasonable period of time, as determined by the designated Medical Staff officer. Such summary shall disclose the substance, but not the source, of the information summarized;

(3) the review by the Member shall take place in the Medical Staff office, during normal work hours, with a Medical Staff officer or designee present.

(f) In the event of a request for a hearing pursuant to Article VII, access to such Member's credentials file shall be governed by Section 7.4-1.

ARTICLE XIII: ADOPTION AND AMENDMENT OF THESE BYLAWS

13.1 PROCEDURE

Upon the request of (a) the Medical Executive Committee, the Chief of Staff, the Chief Executive Officer, or the Bylaws Committee, after approval of the Medical Executive Committee, or (b) upon timely written petition signed by at least ten percent (10%) of the Members in good standing who are entitled to vote, consideration shall be given to the adoption, amendment, or repeal of these Bylaws. Such action shall be taken at a regular or special meeting of the Medical Staff, provided that (1) written notice of the proposed change was sent to all Members on or before the last regular or special meeting of the Medical Staff, and such changes were offered at such prior meeting, and (2) notice of the next regular or special meeting at which action is to be taken included notice that a change to these Bylaws would be considered. Both notices shall include the exact wording of the existing language of these Bylaws, if any, and the proposed change(s).

13.2 ACTION ON BYLAWS CHANGE

The presence of two-thirds (2/3) of the total members of the Active Staff at any regular or special meeting in person or through written ballot shall constitute a quorum for the purposes of enacting a change in these Bylaws or in the Medical Staff Rules and Regulations. The change shall require an affirmative vote of greater than two-thirds (2/3) of the Members voting in person or by written ballot.

13.3 APPROVAL

Changes in these Bylaws that are adopted by the Medical Staff shall become effective following approval by the Board of Directors, which approval shall not be withheld unreasonably. Members shall be provided with copies of any revisions to these Bylaws, the Medical Staff Rules and Regulations, and applicable Medical Staff policies. If approval is withheld, the reasons for doing so shall be specified by the Board of Directors in writing,

and shall be forwarded to the Chief of Staff, the Medical Executive Committee and the Bylaws Committee.

13.4 EFFECT OF THESE BYLAWS

Upon adoption and approval, as provided in this Article XIII, and in consideration of the mutual promises and agreements contained in these Bylaws, the Hospital and the Medical Staff agree that these Bylaws shall constitute a binding relationship between the Hospital and the Medical Staff.

13.5 SUCCESSOR IN INTEREST/AFFILIATIONS

In the event of a proposed sale or transfer of the Hospital, the Board of Directors or the transferee will advise the Medical Staff of any provisions of these Bylaws that may be problematic. A joint conference committee will meet and confer in good faith as required by California law before any amendment is made to these Bylaws.

13.6 CONSTRUCTION OF TERMS AND HEADINGS

The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope of or affect any of the substantive provisions of these Bylaws. These Bylaws apply with equal force to both genders wherever either term is used.

13.7 FREQUENCY OF REVIEW

The Bylaws Committee shall review these Bylaws as needed, based on revisions in regulations and practices, but in no event less frequently than once every three (3) years, and shall recommend any changes to the Medical Executive Committee and the Board of Directors.

13.8 PRECEDENCE OF BYLAWS

The Medical Staff Rules and Regulations, any Medical Staff policies and any clinical practice policies developed by and applicable only to, the Hospital shall not be inconsistent with these Bylaws. In the event of a conflict between such documents and these Bylaws, these Bylaws shall govern and control.

MEDICAL STAFF BYLAWS

ADOPTED by the Medical Staff on _____, 2017.

Chief of Staff

Secretary

APPROVED by the Board of Directors on February 9, 2017.

Chair

Secretary