

PRESBYTERIAN HEALTHCARE

POLICY ON APPOINTMENT, REAPPOINTMENT AND CLINICAL PRIVILEGES

**APPROVED BY THE BOARD OF TRUSTEES
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ARTICLE I - DEFINITIONS

The following definitions shall apply to terms used in this policy:

"Presbyterian Healthcare", "Presbyterian Hospitals" or "Hospital" means, collectively, The Presbyterian Hospital (Charlotte, North Carolina), Presbyterian Orthopedic Hospital (Charlotte, North Carolina), Presbyterian Hospital Matthews (Matthews, North Carolina), Presbyterian Hospital Huntersville (Huntersville, North Carolina) and any other hospitals, facilities or services affiliated, owned, controlled or operated by the foregoing hospitals or by Novant Health Southern Piedmont Region, LLC, unless otherwise indicated. Rowan Health Services Inc., and any subsidiary, is specifically excluded from this definition.

"Board", "Board of Trustees" or "Trustees" means the Novant Health Southern Piedmont Region, LLC Board of Trustees, who have the overall responsibility for the conduct of the Presbyterian Hospitals, unless otherwise indicated.

"President of the Hospital" or "President" means the individual appointed by the Board of Trustees to act on its behalf in the overall administrative management of Novant Health Southern Piedmont Region, LLC, and as used herein, the term "President" may also include the President's designated representative.

"Chief of Staff" or "SPR Chief of Staff" means the Chief of the Medical Staff of Presbyterian Healthcare, unless otherwise stated. "Campus Chief of Staff" means the Chief of the Medical Staff of the Campus Hospital.

"Medical Board" means the SPR Medical Board (or the SPR Medical Board Executive Committee acting for the Medical Board) of the Medical Staff of Presbyterian Healthcare, unless otherwise stated.

"Medical Staff" or "Staff" means the formal organization of physicians and oral surgeons who are privileged to attend patients in the Hospitals.

"Physicians" shall be interpreted to include both doctors of medicine ("M.D.'s") and doctors of osteopathy ("D.O.'s").

"Oral Surgeon" shall be interpreted to refer to oral surgeons who have successfully completed a postgraduate program in oral surgery accredited by a nationally recognized accrediting body approved by the United States Office of Education, and who have a doctor of dental surgery or doctor of dental medicine.

"Allied Health Practitioner Level I" shall be interpreted to refer to those classes of health care professionals, other than physicians and dentists, who are approved by the Board, who have been licensed or certified by their respective licensing or certifying agencies and who provide independent professional services in the hospital.

"Allied Health Practitioner Level II" shall be interpreted to refer to those classes of advanced practice health care professionals, other than physicians and dentists, who are approved by the Board, who are licensed or certified by their respective licensing or certifying agencies, and who

provide service under the supervision of a sponsoring physician who is presently appointed to the Medical Staff.

"Allied Health Practitioner Level III" shall be interpreted to refer to those classes of health care professionals, other than physicians, dentists, and advanced practice practitioners, who are approved by the Board, who are licensed or certified by their respective licensing or certifying agencies, and who provide service under the supervision of a sponsoring physician who is presently appointed to the Medical Staff.

"Appointee" means a physician or oral surgeon who has been granted Medical Staff appointment and clinical privileges by the Board to practice at the hospital.

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

ARTICLE II - APPOINTMENT TO THE MEDICAL STAFF

Part II-A: Qualifications For Appointment

Section II-A-1. General

Appointment to the Medical Staff is a privilege which shall be extended only to professionally competent individuals who continuously meet the qualifications, standards, and requirements set forth in this policy and in such policies as are adopted from time to time by the Board. All individuals practicing medicine and oral surgery in this hospital, unless excepted by specific provisions of this policy, must first have been appointed to the Medical Staff, and granted such clinical privileges as are applicable to their practice and/or specialty.

Section II-A-2. Specific Qualifications

Only physicians and dentists who satisfy the following conditions shall be qualified for appointment to the Medical Staff:

- (a) are currently licensed to practice in North Carolina and/or South Carolina as appropriate to practice location(s);
- (b) are located (office and residence) within the geographic service area of the hospital as defined by the hospital, close enough to provide timely care for their patients;
- (c) possess current, valid professional liability insurance coverage from an insurance company licensed or approved to do business in this state, in the amount of one million/three million, unless the Board of Trustees specifies otherwise;
- (d) have completed a program that renders the person eligible for board certification by an ABMS (American Board of Medical Specialties) member board, AOS (American Osteopathic Association), or (ABOMS) American Board of Oral and

Maxillofacial Surgery. Physicians appointed to staff prior to January 1, 1989 are not required to be board certified. For those appointed to staff between January 1, 1989 and June 30, 2007, board or subspecialty certification must be achieved within ten years of appointment. For those appointed to the Medical Staff after July 1, 2007, board or subspecialty certification must be achieved within five years of the completion of the residency or fellowship training program. Recertification, when required by the certifying board, must be achieved within three years of such requirement in order to maintain Medical Staff appointment for all those who are required to be certified; and;

(e) can document their:

- (1) background, experience, training, and current clinical competence;
- (2) adherence to the ethics of their profession;
- (3) good reputation and character, including physical health and mental and emotional stability; and
- (4) ability to work harmoniously with others sufficiently to convince the hospital that all patients treated by them at the hospital will receive quality care and that the hospital and its Medical Staff will be able to operate in an orderly manner.

Section II-A-3. No Entitlement to Appointment

No individual shall be entitled to appointment to the Medical Staff or to the granting of particular clinical privileges in the hospital merely by virtue of the fact that such individual (a) is licensed to practice a profession in this or any other state; (b) is a member of any particular professional organization; (c) has had in the past, or currently has, Medical Staff appointment or privileges at any hospital, or (d) resides in the geographic service area of the hospital as defined by the hospital.

Section II-A-4. Non-Discrimination Policy

No individual shall be unlawfully discriminated against in the granting, restriction or denial of medical staff or clinical privileges on the basis of age, sex, race, creed, religion, color, national origin, or other status protected by law.

Part II-B: Conditions Of Appointment

Section II-B-1. Duration of Initial Provisional Appointment

- (a) All initial appointments to the Medical Staff regardless of the category of the staff to which the appointment is made and all initial clinical privileges shall be provisional for a period of at least twelve (12) months from the date of the appointment or longer if recommended by the Credentials Committee.
- (b) During the term of this provisional appointment, the appointee shall be evaluated by the chairperson of the department or departments in which the individual has clinical privileges, the relevant committees of the Medical Staff, and the hospital as to the individual's clinical competence and general behavior and conduct in the hospital.

- (c) If the appointee has not met standards set forth by the Medical Staff at the end of their first year, the chairperson may recommend extension of the provisional period for an interval not to exceed one year. The chairperson must identify the reason for the extension and should refer further review to the Credentials Committee if any grounds for referral as outlined in Article III, Part C., Section 1, of this Policy, have been identified. If on completion of the renewed provisional period, the appointee still has not accumulated a hospital practice sufficient to provide a satisfactory review of his/her patient care, the chairperson may recommend a change in staff category better suited to the appointee's activity level. If any problems which have been identified through the Credentials Committee investigative procedure have not been corrected, the chairperson may recommend to the Credentials Committee termination of appointment and clinical privileges.
- (d) Clinical privileges shall be adjusted to reflect clinical competence at the end of the provisional period, or sooner if warranted.
- (e) Continued appointment after the provisional period shall be conditioned on an ongoing evaluation of the factors to be considered for reappointment.

Section II-B-2. Duties of Appointees

Appointment to the Medical Staff shall require that each appointee assume such reasonable duties and responsibilities as the Board of Trustees or the Medical Staff shall require.

Section II-B-3. Participation in Organized Health Care Arrangement

All individuals holding Medical Staff appointment and/or clinical privileges at the Presbyterian Hospital and Presbyterian Medical Care Corp and applicants for same shall, as a condition of their appointment or reappointment, be required to participate in an Organized Health Care Arrangement (OHCA). By participation in the OHCA, the members of the Medical and Allied Health Staff agree to follow the Novant Health Joint Notice of Privacy Practices while practicing in a Novant facility. Further, members of the Medical and Allied Health Staff agree to follow related Novant Health policies that govern the use and disclosure of Protected Health Information (PHI) with regard to any PHI received as part of membership on the Medical and/or Allied Health Staff.

Section II-B-4. Commitment for Smoke-free Campus

In keeping with the commitment to the promotion of a health lifestyle by the hospital and the Medical Staff, the use of tobacco products should be avoided. The Medical Staff supports the change to tobacco free campuses. In keeping with a uniform commitment to the tobacco free campuses, members of the Medical Staff like all others on campus are expected to refrain from the use of tobacco products on hospital grounds. Any Medical Staff member who has a documented violation of the tobacco free policy will be referred by the Vice President of Medical Affairs or the Department/Division Chair to the Credentials Committee for action according to the Policy on Appointment/Reappointment and Clinical Privileges in section III-C-1.

Part II-C: Application For Initial Appointment And Clinical Privileges

Section II-C-1. Information

Applications for appointment to the Medical Staff shall be in writing, and shall be submitted on forms approved by the President of the Hospital or a designee, upon recommendation of the Credentials Committee. These forms shall be obtained from the office of the President of the Hospital or a designee. The application shall contain a request for the specific clinical privileges desired by the applicant, including a statement as to whether the applicant intends to practice at the Hospital and shall require detailed information concerning the applicant's professional qualifications including:

- (a) the names and complete addresses of at least two (2) physicians, dentists, or other practitioners, as appropriate, who have had recent extensive experience in observing and working with the applicant, and who can provide adequate information pertaining to the applicant's present professional competence and character. Said references may not be associated or about to be associated with the applicant in professional practice or personally related to the applicant. At least one (1) reference shall be from the same specialty area as the applicant;
- (b) the names and complete addresses of the department chairpersons of any and all hospitals or other institutions at which the applicant worked or trained (i.e., the individuals who served as chairpersons at the time the applicant worked in the particular department). If the number of hospitals the applicant has worked in is great, or if a number of years have passed since the applicant worked at a particular hospital, the Credentials Committee and the Board of Trustees may take such into consideration;
- (c) information as to whether the applicant's Medical Staff appointment or clinical privileges have ever been voluntarily or involuntarily relinquished, denied, revoked, suspended, reduced, or not renewed at any other hospital or health care facility;
- (d) information as to whether the applicant has ever withdrawn his/her application for appointment, reappointment or clinical privileges, or resigned from the Medical Staff before final decision by a hospital's or health care facility's governing board;
- (e) information as to whether the applicant's membership in any local, state, or national professional society, is or has ever been suspended, modified, terminated, restricted, challenged or is currently being challenged, or voluntarily or involuntarily relinquished;
- (f) information as to whether the applicant's license to practice any profession in any state, or Drug Enforcement Administration license is or has ever been voluntarily or involuntarily suspended, modified, terminated, restricted, challenged or is currently being challenged. The submitted application shall include a list or copy of all the applicant's current licenses to practice, as well as copies of Drug Enforcement Administration license, medical or dental school diploma, and certificates from all post graduate training programs completed;
- (g) information as to whether the applicant has currently in force professional liability insurance coverage, the name of the insurance company and the amount and classification of such coverage, whether said insurance coverage covers the clinical

privileges the applicant seeks to exercise at the hospital and whether applicant has ever been denied or refused professional liability insurance coverage or otherwise been dropped by a carrier;

- (h) information concerning the applicant's professional liability litigation experience, specifically information concerning any final judgments or settlements;
- (i) information concerning any professional misconduct proceedings and any malpractice actions involving the applicant in this state or any other state, which may be closed or still pending, including the following information: (1) the substance of the allegations; (2) the substance of the findings; (3) the ultimate disposition; and (4) any additional information concerning such proceedings or actions as the Credentials Committee may deem appropriate;
- (j) information concerning the suspension, termination or voluntary or involuntary relinquishment for any period of time of the right or privilege to participate in Medicare, Medicaid or any other government sponsored program or any private or public medical insurance program;
- (k) a consent to the release of information from the applicant's present and past professional liability insurance carriers;
- (l) information on the applicant's physical and mental health, including information concerning whether the applicant is medically qualified, with or without reasonable accommodation, to perform the functions of a physician or oral surgeon in accordance with the hospital policies and applicable standards of care;
- (m) information as to whether the applicant has ever been convicted, charged or accused of a crime with details about any such instance;
- (n) information on the citizenship and/or visa status of the applicant;
- (o) the applicant's signature, and
- (p) information to confirm the applicant's identity (i.e. federal or state government issued photo I.D.)
- (q) documentation of negative PPD skin testing within one year of application; or with history of a positive PPD skin test report, documentation of subsequent chest radiograph with no radiographic evidence of active tuberculosis, or documentation of completed course of anti-tuberculous therapy. Additional information may be requested in the event of a positive PPD skin test report.
- (r) documentation of administration of Hepatitis B vaccine within the past ten (10) years; or documentation of a positive hepatitis B antibody titer within the past ten (10) years; or completion of the "Hepatitis B Declination" form.
- (s) such other information as the Board of Trustees may require.

Section II-C-2. Undertakings and Requirements

(a) Undertakings:

The following undertakings shall be applicable to every Medical Staff applicant for staff appointment as a condition of consideration of such application and as a condition of continued Medical Staff appointment if granted;

- (1) an obligation upon appointment to the Medical Staff to provide continuous care and supervision to all patients within the hospital for whom the individual has responsibility;
- (2) an agreement to accept committee assignments and such other reasonable duties and responsibilities as shall be assigned;
- (3) an agreement to provide to the hospital, with or without request, new or updated information that is pertinent to any question on the application form as such information becomes available to the individual; failure to provide such information may result in automatic resignation of privileges;
- (4) a statement that the applicant has had an opportunity to read a copy of this policy, and the Bylaws, Rules and Regulations of the Medical Staff as are in force at the time of application, and that the applicant has agreed to be bound by the terms thereof in all matters without regard to whether appointment to the Medical Staff and/or clinical privileges are granted;
- (5) a statement of the applicant's willingness to appear for personal interviews in regard to the application;
- (6) a statement that any misrepresentation or misstatement in, or omission from the application whether intentional or not, shall constitute cause for automatic and immediate rejection of the application resulting in denial of appointment and clinical privileges. In the event that an appointment has been granted prior to the discovery of such misrepresentation, misstatement, or omission, such discovery may result in summary dismissal from the Medical Staff;
- (7) an obligation to use the hospital and its equipment sufficient to allow the hospital, through assessment by appropriate Medical Staff committees and department chairpersons, to evaluate the current competence of the individual; and
- (8) participate in ongoing and focused professional performance evaluations; and
- (9) an agreement that the hearing and appeal procedures set forth in this policy shall be the sole and exclusive remedy with respect to any professional review action taken at the hospital.

(b) Requirements:

The following requirements shall be applicable to every Medical Staff applicant for staff appointment as a condition of consideration of such application and as a condition of continued Medical Staff appointment, if granted

- (1) refrain from illegal fee splitting or other illegal inducements relating to patient referral;
- (2) refrain from delegating responsibility for diagnoses or care of hospitalized patients to any individual who is not qualified to undertake this responsibility or who is not adequately supervised;
- (3) refrain from deceiving patients as to the identity of an operating surgeon or any other individual providing treatment or services;
- (4) seek consultation whenever necessary;
- (5) abide by generally recognized ethical principles applicable to the applicant's profession; and
- (6) provide continuous care for patients in the hospital.

Each applicant requesting Medical Staff appointment shall specifically agree to these undertakings and requirements as part of the appointment process.

Section II-C-3. Burden of Providing Information

- (a) The applicant shall have the burden of producing information deemed adequate by the hospital for a proper evaluation of competence, character, ethics, and other qualifications, and of resolving any doubts about such qualifications.
- (b) The applicant shall have the burden of providing evidence that all the statements made and information given on the application are true and correct.
- (c) Until the applicant has provided all information required by the application or otherwise requested by the hospital, the application for appointment will be deemed incomplete and will not be processed. Should information provided in the initial application form change during the course of their application process or subsequent appointment, the applicant/appointee has the burden to provide information about such change to the Credentials Committee sufficient for the Credentials Committee's review and assessment.

Section II-C-4: Authorization to Obtain Information

The following statements, which shall be included on the application form and which form a part of this policy, are express conditions applicable to every Medical Staff applicant and to all others seeking clinical privileges at the hospital. By applying for appointment and/or clinical privileges, the applicant expressly accepts these conditions and agrees to be bound thereby, whether or not appointment or clinical privileges are granted. This acceptance applies throughout the term of appointment.

- (a) Immunity:

To the fullest extent permitted by law, the applicant releases from any and all liability, agrees not to sue and extends immunity to the hospital, its authorized

representatives, and any third parties as defined in subsection (d) below, with respect to any acts, communications or documents, recommendations, or disclosures involving the applicant as set forth below:

- (1) applications for appointment or clinical privileges, including temporary privileges;
- (2) evaluations concerning reappointment or changes in clinical privileges;
- (3) proceedings for suspension or reduction of clinical privileges or for revocation of Medical Staff appointment, or any other disciplinary sanction;
- (4) precautionary suspension;
- (5) hearing and appellate reviews;
- (6) medical care evaluations;
- (7) other activities relating to the quality of patient care or professional conduct;
- (8) matters or inquiries concerning the applicant's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, or behavior; or
- (9) any other matter that might directly or indirectly relate to the applicant's competence, to patient care, or to the orderly operation of this or any other hospital or health care facility.

(b) Authorization to Obtain Information:

The applicant specifically authorizes the hospital and its authorized representatives to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior, or any other matter reasonably having a bearing on the applicant's satisfaction of the criteria for initial and continued appointment to the Medical Staff. This authorization also covers the right to inspect or obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of said third parties that may be relevant to such questions. The individual also specifically authorizes said third parties to release said information to the hospital and its authorized representatives upon request.

(c) Authorization to Release Information:

The applicant specifically authorizes the hospital and its authorized representatives to release such information to other hospitals, health care facilities, managed care organizations and their agents, who solicit such information for the purpose of evaluating the applicant's professional qualifications pursuant to a request for appointment and/or clinical privileges.

(d) Definitions:

- (1) As used in this section, the term "hospital and its authorized representatives" means the hospital corporation and any of the following individuals who have any responsibility for obtaining or evaluating the applicant's credentials, or for acting upon that individual's application or conduct at the hospital: the members of its Board and their appointed representatives; the President of the Hospital or his/her designees; other hospital employees; consultants to the hospital; the hospital's attorney and his/her partners, associates or designees; and all appointees to the Medical Staff who have any responsibility for obtaining or evaluating the individual's credentials, or for acting upon that individual's application or conduct at the hospital.
- (2) As used in this section, the term "third parties" means all individuals, including appointees to the hospital's Medical Staff and appointees to the Medical Staffs of other hospitals, or other physicians or health practitioners, nurses, or other organizations, associations, partnerships, and corporations or government agencies, whether hospitals, health care facilities or not, from whom information has been requested by the hospital or its authorized representatives.

Part II-D: Procedure For Initial Appointment

Section II-D-1. Pre-Application Process

- (a) An application for appointment to the Medical Staff shall only be sent upon request to those individuals who, according to the Medical Staff bylaws and this policy, are eligible for appointment, who meet the threshold criteria for privileges as stated in this policy to provide care and treatment to patients for conditions and diseases for which the hospital has facilities and personnel, and who indicate an intention to utilize the hospital as required by the staff category to which they desire appointment. An individual requesting an application for appointment must provide information that they meet the basic qualifications for appointment consideration.
- (b) Only those individuals who meet the basic qualifications for consideration for appointment to the Medical Staff shall be given an application for appointment. Individuals who fail to meet the basic qualifications shall not be given an application and shall be so notified. An individual who fails to satisfy the basic qualifications for eligibility for appointment shall not be entitled to the hearing and appeal provisions set forth in this policy.

Section II-D-2. Submission of Application

- (a) The application for Medical Staff appointment shall be submitted by the applicant to the President of the Hospital or a designee. After reviewing the application to determine the application is complete, including all questions answered fully and completely, all references and information received, and after verifying the information provided in the application with the primary sources, the President of the Hospital or his designee shall transmit the completed application and all supporting materials to the appropriate department/division chairperson or chairpersons.

- (b) An application shall be deemed to be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified. An application shall become incomplete if the need arises for new, additional, or clarifying information anytime during the evaluation. Any application that continues to be incomplete ninety (90) days after the applicant has been notified of the additional information required shall be deemed to be withdrawn. It is the responsibility of the applicant to provide a complete application, including adequate responses from references. An incomplete application will not be processed.

Section II-D-3. Department/Division Chairperson Procedure

- (a) The Campus chairperson of each department/division in which the applicant seeks clinical privileges shall provide the Credentials Committee with a written report concerning the applicant's qualifications for appointment and specific written findings supporting the proposed delineation of the applicant's clinical privileges. As part of the process of making this report, the Campus department chairperson has the right to meet with the applicant to discuss any aspect of the application, including the applicant's qualifications and the requested clinical privileges.
- (b) The Campus department/division chairperson or his/her designee shall evaluate the applicant's education, training, and experience. Such evaluation shall include inquiries of the applicant's past and current department chairperson(s), residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others.
- (c) The Campus department chairperson shall be available to the Credentials Committee to answer any questions that may be raised with respect to that chairperson's report and findings.
- (d) In the event the Campus department chairperson is unavailable, these duties may be performed by the previous Campus department chairperson or the SPR department chairperson.

Section II-D-4. Credentials Committee Procedure

- (a) The Credentials Committee shall examine evidence of the applicant's character, professional competence, qualifications, prior behavior, and ethical standing and shall determine, through information contained in references given by the applicant and from other sources available to the committee, including the report and findings from the chairperson of each clinical department in which privileges are sought, whether the applicant has established and satisfied all of the necessary qualifications for appointment and for the clinical privileges requested.
- (b) As part of the process of making its recommendation, the Credentials Committee may require the applicant to undergo a physical and/or mental examination by a physician or physicians satisfactory to the Credentials Committee for the purpose of determining the applicant's ability to perform the privileges requested. The results of any such examination shall be made available to the committee for its consideration. Failure of an applicant to undergo such an examination within a reasonable time after being requested to do so in writing by the Credentials

Committee shall constitute a voluntary withdrawal of the application for appointment and clinical privileges, and all processing of the application shall cease.

- (c) The Credentials Committee may require the applicant to meet with the committee to discuss any aspect of the applicant's application, qualifications, or clinical privileges requested.
- (d) The Credentials Committee may use the expertise of the SPR or Campus department chairperson, or any member of the department, or an outside consultant, if additional information is needed regarding the applicant's qualifications.
- (e) If, after considering the report of the Campus department chairperson concerned, the Credentials Committee's recommendation for appointment is favorable, the Credentials Committee shall recommend provisional department assignment. All recommendations to appoint, including provisional appointment, must specifically recommend the clinical privileges to be granted, which may be qualified by any probationary or other conditions or restrictions.

Section II-D-5. Credentials Committee Report

- (a) Not later than ninety (90) days from receipt of a completed application, including all required and requested information, the Credentials Committee shall send its recommendation and written findings in support thereof to the SPR Medical Board Executive Committee or SPR Medical Board. The Credentials Committee shall make one of the following recommendations:
 - (1) recommend appointment to the Medical Staff;
 - (2) recommend deferral of the application further consideration; or
 - (3) recommend denial of the Medical Staff appointment.
- (b) The Chairperson of the Credentials Committee shall be available to the SPR Medical Board, and to the Board of Trustees, to answer any questions that may be raised with respect to the Credentials Committee's recommendation.

Section II-D-6. Medical Board Procedure

- (a) At its next regular meeting after receipt of the completed application, and the written findings and recommendation of the Credentials Committee, the Medical Board or the Medical Board Executive Committee acting for the Medical Board, shall determine whether to recommend to the Board of Trustees that the applicant be appointed to the Medical Staff, that the application be deferred for further consideration, or that the application for staff appointment or clinical privileges be denied. If the recommendation of the Medical Board is to approve the applicant for appointment, the Medical Board shall transmit its recommendation to the Board of Trustees along with the findings and recommendation of the Credentials Committee. All recommendations to appoint must also specifically recommend the clinical privileges to be granted, which may be qualified by any probationary or other conditions or restrictions relating to such clinical privileges.

- (b) If the recommendation of the Medical Board is to defer the application for further consideration, it must be followed up within sixty (60) days by a subsequent recommendation to the Board of Trustees for appointment to the Medical Staff with specified clinical privileges, or for denial of the application for staff appointment.
- (c) If the Medical Board has determined to make a recommendation contrary to the recommendation of the Credentials Committee, the Medical Board shall either:
 - (i) remand the matter to the Credentials Committee for its further investigation and preparation of responses to specific questions raised by the Medical Board prior its final recommendation; or
 - (ii) set forth in its report and recommendation clear and convincing reasons, along with supporting information, for its disagreement with the Credentials Committee's recommendation, and forward its recommendation together with the Credentials Committee's findings and recommendation to the Board of Trustees.
- (d) If the recommendation of the Medical Board would entitle the applicant to request a hearing pursuant to this policy, it shall be forwarded to the President of the Hospital who shall promptly notify the applicant in writing, by certified mail, return receipt requested. The President of the Hospital shall hold the recommendation until the hearing and appeals process is complete, or until the individual has waived his or her right to a hearing and appeal, after which the President of the Hospital shall forward the recommendation of the Medical Board, together with the complete application and all supporting documentation, to the Board of Trustees.

Part II-E: Clinical Privileges

Section II-E-1. General

- (a) Medical Staff appointment or reappointment as such shall not confer any clinical privileges or right to practice at the hospital. Each individual who has been appointed to the Medical Staff shall be entitled to exercise only those clinical privileges specifically granted by the Board of Trustees.
- (b) The granting of clinical privileges shall carry with it acceptance of the obligations of such privileges including emergency department and other rotational obligations, and clinical privileges shall be voluntarily relinquished only in the manner that provides for the orderly transfer of such obligations.
- (c) Board certification is recognized as an excellent benchmark for the delineation of clinical privileges and the pursuit of board certification is required for all applicants for staff privileges. For those appointed to the Medical Staff after January 1, 1989, certification must be achieved within ten years of appointment, and recertification, when required, must be achieved within three years of such requirement in order to maintain Medical Staff appointment.
- (d) The clinical privileges recommended to the Board of Trustees shall be based upon consideration of the following:

- (1) the applicant's education, training, experience, demonstrated current competence, judgment, references, utilization patterns, and health status;
 - (2) availability of qualified physicians or other appropriate appointees to provide back-up medical coverage for the applicant in case of the applicant's illness or unavailability;
 - (3) adequate levels of professional liability insurance coverage with respect to the clinical privileges requested;
 - (4) the hospital's available resources and personnel;
 - (5) any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;
 - (6) any information concerning the voluntary or involuntary termination, lapse or relinquishment of Medical Staff appointment or the voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital or health care facility; and
 - (7) other relevant information, including the written report and findings by the chairperson of each of the clinical departments in which such privileges are sought.
- (e) The applicant shall have the burden of establishing qualifications for and competence to exercise the clinical privileges requested.
- (f) The reports of the chairperson of the clinical department in which privileges are sought shall be forwarded to the Credentials Committee and processed as a part of the initial application for staff appointment.

Section II-E-2. Clinical Privileges for Oral Surgeons

- (a) The scope and extent of surgical procedures that an oral surgeon may perform in the hospital shall be delineated and recommended in the same manner as other clinical privileges.
- (b) Surgical procedures performed by oral surgeons shall be under the overall supervision of the Chairperson of the Department of Oral Surgery. Adequate history and physical examinations shall be performed by a physician of the Medical Staff on each patient prior to oral surgery. An Oral Surgeon may perform his or her own history and physical examination on a patient in order to assess the medical, surgical and anesthetic risks of the proposed operative and other procedure. Any treatment or assessment not directly related to the oral surgery must be provided by a physician with appropriate clinical privileges.
- (c) The oral surgeon shall be responsible for the dental care of the patient, including the dental history and dental physical examination as well as all appropriate elements of the patient's record. Oral surgeons may write orders within the scope of their

license and consistent with the Medical Staff rules and regulations, and in compliance with hospital policy, Medical Staff bylaws and this policy.

Section II-E-3. Clinical Privileges After Age 65

- (a) The Credentials Committee shall specifically consider the capabilities of each appointee who has attained the age of 65 years and who has clinical privileges at the hospital. Recommendations by the Credentials Committee for continued clinical privileges for appointees between the ages 65 and 75 shall be based upon an evaluation of the individual's current knowledge and skills.
- (b) Upon attaining the age of 75, Medical Staff appointees shall no longer have clinical privileges to admit or care for patients at the hospital, unless an exception continuing such privileges is recommended by the Credentials Committee and the Medical Board and approved by the Board of Trustees. Medical Staff appointees requesting an exception will be required to submit a letter from their personal physician attesting that he or she has no health problems that impact their ability to practice. Additionally, individuals granted such an exception will be required to submit this information on an annual basis.
- (c) Absent an exception, as set forth in (b) above, upon attaining the age of 75, Medical Staff appointees shall automatically assume full Honorary Staff Status, with all of its attendant prerogatives.

Section II-E-4. Administrative and Medico-Administrative Officers

A physician or oral surgeon employed by the Hospital in a purely administrative capacity with no clinical duties or privileges is subject to the regular personnel policies of the Hospital and to the terms and conditions of his/her employment, and need not be an appointee to the Medical Staff. Individuals in administrative positions who desire Medical Staff membership or clinical privileges are subject to the same application process as all other applicants for membership or privileges.

Part II-F: Procedure For Temporary Clinical Privileges

Section II-F-1. Temporary Clinical Privileges for Applicants

Temporary privileges shall not routinely be granted to applicants. There are two circumstances in which the granting of temporary privileges would be acceptable:

- (1) to fulfill an important patient care need; and
- (2) when an applicant with a complete, clean application is awaiting review and approval of the Medical Board Executive Committee, Medical Board and the Board of Trustees.

In the first circumstance, temporary privileges may be granted by the President of the Hospital or his designee, on a case by case basis, after verification of current licensure and current competence, upon the recommendation of the applicable clinical chairperson or the Chief of Staff, when there is an important patient care need that mandates an immediate authorization to practice, for a limited period of time, while the full credentials information is verified and approved.

In the second circumstance, the President of the Hospital or his designee may, after receipt of a complete application for Medical Staff appointment, grant temporary admitting and clinical privileges to an applicant for a specific time period, not to exceed 120 days, after the following criteria are satisfied:

1. Verification of information as to licensure, training, DEA certification, competence, character, ethical standing and professional liability insurance has been received and reviewed;
2. Results of the National Practitioner Data Bank query have been obtained and evaluated, and
3. The applicant has been recommended for approval as a Category One applicant as defined by the Policy for Expedited Credentialing by the appropriate Department Chairperson and the Credentials Committee.

In exercising temporary privileges, the applicant shall act under the supervision of the chairperson or appropriate designee of the department in which the applicant has requested primary privileges.

Section II-F-2. Temporary Clinical Privileges for Non-Applicants

Temporary admitting and clinical privileges for care of a specific patient or patients may be granted by the President of the Hospital with the concurrence of either the chairperson of the department concerned, the Chairperson of the Credentials Committee or the SPR or Campus Chief of Staff to a physician who is not an applicant for appointment in the same manner and upon the same conditions as set forth in Section I of this Part, provided that the President of the Hospital shall first obtain such individual's signed acknowledgment to be bound by the hospital bylaws, this policy, the Medical Staff bylaws, and the Medical Staff rules and regulations then in force in all matters relating to temporary clinical privileges. Such privileges shall be restricted to a period of 30 days, after which time these privileges automatically expire and the physician or oral surgeon shall be required to apply for appointment to the Medical Staff before being allowed to attend additional patients.

Section II-F-3. Special Requirements

Special requirements of supervision and reporting may be imposed by the department chairperson concerned on any individual granted temporary clinical privileges. Temporary privileges shall be immediately terminated by the President of the Hospital or his designee upon notice of any failure by the individual to comply with such special conditions.

Section II-F-4. Locum Tenens

- (a) The President of the Hospital, with the concurrence of either the chairperson of the department, the Chairperson of the Credentials Committee, or the SPR or Campus Chief of Staff, may grant an individual serving as a locum tenens for an appointee of the Medical Staff, temporary admitting and clinical privileges to attend patients of that appointee for a period not to exceed one year. Such privileges may be renewed one time not to exceed a total of two years. This shall be done in the same manner and upon the same conditions as set forth in Section I of this Part, provided that the President of the Hospital shall first obtain such individual's signed

acknowledgment that the individual has had an opportunity to read copies of the hospital bylaws, this policy, the Medical Staff bylaws, and Medical Staff rules and regulations which are then in force, and agrees to be bound by the terms thereof in all matters relating to temporary clinical privileges.

- (b) The individual serving as a locum tenens must complete a request for clinical privileges form and must have in force and effect a current license to practice in North Carolina and/or South Carolina as appropriate to practice location, a DEA license, if applicable, and professional liability insurance in an amount and terms acceptable to the hospital.
- (c) Under certain conditions, a Medical Staff appointee may request locum tenens privileges be granted to a senior resident, currently completing his/her residency in an accredited residency program. These privileges may include patient coverage, rounds, and/or surgical privileges compatible with the resident's training and under supervision by a Medical Staff appointee of the same specialty. These privileges may be granted for a period of one month and may be renewed. Renewals may not exceed more than six months total.

Section II-F-6. Termination of Temporary Clinical Privileges

- (a) The President of the Hospital may, at any time after receiving a recommendation from the SPR or Campus Chief of Staff, or the Chairperson of the department responsible for the individual's supervision, terminate temporary admitting privileges. Clinical privileges shall then be terminated when the individual's inpatients are discharged from the hospital. However, where it is determined that the care or safety of such patients would be endangered by continued treatment by the individual granted temporary privileges, a summary termination of temporary clinical privileges may be imposed by the President of the Hospital or his designee, the department chairperson, or the SPR or Campus Chief of Staff, and such termination shall be immediately effective.
- (b) The appropriate department chairperson or the SPR or Campus Chief of Staff shall assign to a Medical Staff appointee responsibility for the care of the terminated individual's patients until said patients are discharged from the hospital, giving consideration wherever possible to the wishes of the patient in the selection of the substitute.
- (c) The granting of any temporary admitting and clinical privileges is a courtesy on the part of the hospital. Neither the granting, denial, or termination of such privileges shall entitle the individual concerned to any of the procedural rights provided in this policy with respect to hearings or appeals.
- (d) Temporary privileges shall be automatically terminated at such time as the Credentials Committee recommends unfavorably with respect to the applicant's appointment to the staff. At the Credentials Committee's discretion, temporary clinical privileges shall be modified to conform to its recommendation that the applicant be granted different permanent privileges from the temporary privileges so granted.

Part II-G: Emergency Clinical Privileges

- (1) For the purpose of this section, an "emergency" is defined as the condition which could result in serious or permanent harm to a patient and in which any delay in administering treatment would add to that harm or danger.
- (2) In an emergency, a physician who is not currently appointed to the Medical Staff shall be permitted by the hospital to exercise clinical privileges to the degree permitted by his/her license.
- (3) Similarly, in an emergency, a physician currently appointed to the Medical Staff shall be permitted by the hospital to exercise clinical privileges not specifically granted to that appointee to the degree permitted by his/her license. When the emergency situation no longer exists, such physician must request temporary privileges necessary to continue to treat the patient. In the event such temporary privileges are denied or not requested, the patient shall be assigned by the SPR or Campus Chief of Staff to an appointee of the staff with appropriate clinical privileges. The wishes of the patient shall be considered in the selection of a substitute physician.
- (4) Physicians acting in an emergency shall be assisted by hospital personnel in doing everything possible, within the scope of his/her license, to save the life of patient or prevent serious harm.

Part II-H: Emergency Privileges In The Event Of A Disaster

- (1) Physicians who do not possess Medical Staff privileges at Presbyterian Healthcare may be granted emergency privileges at the Hospital during any officially declared emergency; whether it is local, state or national.
- (2) In the case of an officially declared emergency, the President/CEO (or his/her designee) after conference with the SPR Chief of Staff (or his/her designee), shall have the authority to grant emergency privileges, applicable to the emergency situation, to a physician, regardless of whether he/she is a member of the Medical Staff or has delineated clinical privileges. The granting of emergency privileges shall be based upon the opinion of the SPR Chief of Staff and the Executive Vice President of Medical Affairs (or his/her designee) as to the qualifications and competence of the practitioner to appropriately exercise the emergency privileges.
- (3) All physicians requesting emergency privileges are to be referred to the Medical Staff Services Office for processing. The following information must be available in order for emergency privileges to be granted. While disaster privileges are granted on a case-by-case basis, volunteers considered eligible to act as licensed independent practitioners in the organization must at a minimum present a valid government-issued photo identification issued by a state or federal agency (e.g. driver's license or passport) and at least one of the following:
 - a. A current picture hospital ID card that clearly identifies professional designation.
 - b. A current license to practice.

- c. Primary source verification of license. Valid North Carolina or South Carolina Medical License as appropriate (depending on the extremity of the disaster, out of state medical licensure may be accepted if so declared by the State or Federal authorities);
 - d. Photo identification such as a driver's license or I.D. from another hospital;
 - e. Current hospital affiliation(s) where the physician holds active staff privileges;
 - f. I.D. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT) or MRC, ESAR-VHP, or other recognized state or federal organizations or groups;
 - g. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in a disaster circumstances (such authority having been granted by a federal, state, or municipal entity); or
 - h. Identification by current hospital or Medical Staff member(s) with who possesses personal knowledge regarding practitioner's identify volunteer's ability to act as a licensed independent practitioner during a disaster.
- (4) Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization. In extraordinary circumstances that primary source verification cannot be completed in 72 hours (e.g. no means of communication or a lack of resources), it is expected that it be done as soon as possible. In this extraordinary circumstance, there must be documentation of the following: why primary source verification could not be performed in the required time frame; evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and an attempt to rectify the situation as soon as possible. Primary source verification of licensure would not be required if the volunteer practitioner has not provided care, treatment and services under the disaster privileges. Verification of the above information should be done by the Medical Staff Services Office as soon as feasible. A record of this information will be retained in the Medical Staff Services Office.
- (5) A physician's emergency privileges will be immediately terminated in the event that any information received through the emergency verification process indicates any adverse information or suggests the person is not capable of rendering services in an emergency.
- (6) The Medical Staff oversees the professional practice of volunteer licensed independent practitioners. If feasible, the physician will be paired with a currently credentialed Medical Staff member and should act only under the direct supervision of such person.
- (7) The physician's privileges will be for the period needed during the duration of the disaster only. They will automatically be cancelled at the end of the needed services.

- (8) Emergency privileges in no way implies membership to the Medical Staff and does not afford the physician any rights as outlined in the Bylaws of the Medical Staff.

Medical Staff coordination is accomplished by the Chief of Staff, Executive Vice President of Medical Affairs, Incident Manager, or designee who will assign physicians to appropriate departments and/or service areas as requested by those departments.

ARTICLE III - ACTIONS AFFECTING MEDICAL STAFF APPOINTEES

Part III-A: Procedure For Reappointment

Section III-A-1. Application

- (a) Each current appointee who is eligible to be reappointed to the Medical Staff shall be responsible for completing an application for reappointment on a form approved by the President of the Hospital upon recommendation of the Credentials Committee. To be eligible for reappointment to the same Medical Staff category an individual must have met the requirements for current appointment to that category at the hospital during the previous appointment term. Courtesy Staff and Consulting Staff appointees who have had no clinical activity during the previous appointment period must provide the hospital with sufficient clinical information to allow the hospital to adequately evaluate their current competence.
- (b) The President of the Hospital will have reappointment applications provided to all eligible applicants in a timely manner which will allow the applicant sufficient time to complete and submit the reappointment application within the time frame outlined below. Reappointment applications will be sent to each eligible applicant six (6) months prior to the expiration of the current appointment.
- (c) The reappointment application shall be submitted to the Medical Staff Office at least four (4) months prior to the expiration of the appointee's current appointment period. If the application has not been received by the designated due date, late fees will apply.
- (d) The practitioner's application will be deemed complete only when all pertinent required items are received by the Medical Staff Office. It is the responsibility of the applicant to ensure that the Medical Staff Office has received all appropriate documents.
- (e) Failure to submit a complete application within the designated time-frame will be considered a voluntary resignation from the Medical Staff and will result in the automatic expiration of the appointee's appointment and clinical privileges at the end of the appointee's appointment period. The applicant will then have to apply as a new appointee.
- (f) Members of the Medical Staff who have had no clinical activity during the previous appointment period may be considered to have voluntarily resigned from the Medical Staff unless they justify in writing a compelling reason to continue on the Medical Staff.

- (g) Reappointment, if granted by the Board of Trustees, shall be for a period of not more than two (2) years, with approximately one-half of the staff reappointed in even numbered years and the other half of the staff reappointed in odd numbered years. If a completed application for reappointment is submitted to the hospital in a timely fashion and the Board of Trustees has not acted on it prior to the expiration of the appointee's current term of appointment, the President of the Hospital may grant temporary admitting and clinical privileges to the applicant, until such time as the Board of Trustees acts on the reappointment application. Temporary privileges may be granted for unusual circumstances if deemed necessary by the Credentials Committee.

Section III-A-2. Factors to be Considered

Each recommendation concerning reappointment of an individual to the Medical Staff shall be based upon such appointee's:

- (a) ethical behavior, current clinical competence, and clinical judgment in the treatment of patients, including any professional performance evaluations;
- (b) participation in staff duties, as required by Medical Staff bylaws;
- (c) compliance with the hospital bylaws and policies and with the Medical Staff bylaws and rules and regulations;
- (d) behavior at the hospital, including cooperation with Medical Staff and hospital personnel as it relates to patient care, the orderly operation of this hospital, and general attitude toward patients, the hospital and its personnel;
- (e) physical, mental, and emotional health;
- (g) capacity to satisfactorily treat patients as indicated by the results of the hospital's quality assessment activities or other reasonable indicators of continuing qualifications;
- (h) satisfactory completion of relevant continuing education requirements that directly relate to the practitioner's area of practice as imposed by North Carolina licensure requirements, and adopted by this hospital;
- (i) current professional liability insurance status and pending malpractice challenges, including claims, lawsuits, judgments and settlements;
- (j) current licensures and registrations, including currently pending challenges to any license or registration or any voluntary or involuntary relinquishment of any license or registration;
- (k) voluntary or involuntary termination of Medical Staff appointment or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital or health care facility;
- (l) criminal background activity, including driving records; and

- (m) other reasonable indicators of continuing qualifications and relevant findings from the hospital's quality assessment activities.
- (n) those applicants who have a history of a positive PPD skin test shall be required to complete the Presbyterian Healthcare Employee Health form, "Evaluation for PPD Positive Reactors," and comply with the terms thereof; or provide documentation of subsequent chest radiograph with no radiographic evidence of active tuberculosis, or provide documentation of a completed course of anti-tuberculous therapy.

Section III-A-3. Undertakings and Requirements

(a) Undertakings:

The following undertakings shall be applicable to every Medical Staff appointee for staff reappointment as a condition of consideration of such application and as a condition of continued Medical Staff appointment if granted:

- (1) an obligation upon appointment to the Medical Staff to provide continuous care and supervision to all patients within the hospital for whom the individual has responsibility;
- (2) an agreement to accept committee assignments and such other reasonable duties and responsibilities as shall be assigned;
- (3) an agreement to provide to the hospital, with or without request, new or updated information that is pertinent to any question on the application form as such information becomes available to the individual;
- (4) a statement that the appointee has had an opportunity to read a copy of this policy, and the bylaws and rules and regulations of the Medical Staff as are in force at the time of application, and that the appointee has agreed to be bound by the terms thereof in all matters without regard to whether reappointment to the Medical Staff and/or renewed clinical privileges are granted;
- (5) a statement of the appointee's willingness to appear for personal interviews in regard to the application;
- (6) a statement that any misrepresentation or misstatement in, or omission from the application whether intentional or not, shall constitute cause for automatic and immediate rejection of the application resulting in denial of reappointment and renewed clinical privileges. In the event that reappointment has been granted prior to the discovery of such misrepresentation, misstatement, or omission, such discovery may result in summary dismissal from the Medical Staff;
- (7) an obligation to use hospital facilities and equipment sufficient to allow assessment by appropriate Medical Staff committees and department chairpersons of the current competence of the individual; and
- (8) participate in ongoing and focused professional performance evaluations; and

- (9) an agreement that the hearing and appeal procedures set forth in this policy shall be the sole and exclusive remedy with respect to any professional review action taken at this hospital.

(b) Requirements:

The following requirements shall be applicable to every Medical Staff appointee for staff reappointment as a condition of consideration of such application and as a condition of continued reappointment, if granted:

- (1) refrain from illegal fee splitting or other illegal inducements relating to patient referral;
- (2) refrain from delegating responsibility for diagnoses or care of hospitalized patients to any individual who is not qualified to undertake this responsibility or who is not adequately supervised;
- (3) refrain from deceiving patients as to the identity of an operating surgeon or any other individual providing treatment or services;
- (4) seek consultation whenever necessary;
- (5) abide by generally recognized ethical principles applicable to the applicant's profession; and
- (6) provide continuous care for patients in the hospital.

Each individual requesting reappointment shall specifically agree to these undertakings and requirements as part of the reappointment process.

Section III-A-4. Burden of Providing Information

- (a) The appointee shall have the burden of producing information deemed adequate by the hospital for a proper evaluation of competence, character, ethics, and other qualifications, and of resolving any doubts about such qualifications.
- (b) The appointee shall have the burden of providing evidence that all the statements made and information given on the application for reappointment are true and correct.
- (c) Until the appointee has provided all information requested by the hospital, the application for reappointment will be deemed incomplete and will not be processed. Should information provided in the application for reappointment change during the course of the appointment term, the appointee has the burden to provide information about such change to the Credentials Committee sufficient for the Credentials Committee's review and assessment.

Section III-A-5. Authorization to Obtain Information

The following statements, which shall be included on the application form and which form a part of this policy, are express conditions applicable to every Medical Staff appointee, and to all others seeking clinical privileges at the hospital. By applying for reappointment and/or renewed clinical privileges, the appointee expressly accepts these conditions during the processing and consideration of the application, whether or not reappointment or renewed clinical privileges are granted. This acceptance applies throughout the term of appointment.

(a) Immunity:

To the fullest extent permitted by law, the appointee releases from any and all liability, covenants not to sue and extends absolute immunity to the hospital, its authorized representatives, and any third parties as defined in subsection (d) below, with respect to any acts, communications or documents, recommendations, or disclosures involving the appointee as set forth below:

- (1) applications for appointment or clinical privileges, including temporary privileges;
- (2) evaluations concerning reappointment or changes in clinical privileges;
- (3) proceedings for suspension or reduction of clinical privileges or for revocation of Medical Staff appointment, or any other disciplinary sanctions;
- (4) summary or precautionary suspension;
- (5) hearings and appellate reviews;
- (6) medical care evaluations;
- (7) other activities relating to the quality of patient care or professional conduct;
- (8) matters or inquiries concerning the appointee's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, or behavior; or
- (9) any other matter that might directly or indirectly relate to the appointee's competence, to patient care, or to the orderly operation of this or any other hospital or health care facility.

(b) Authorization to Obtain Information:

The appointee specifically authorizes the hospital and its authorized representatives to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior, or any other matter reasonably having a bearing on the appointee's satisfaction of the criteria for continued appointment to the Medical Staff. This authorization also covers the right to inspect or obtain any and all communications, reports, records, statements, documents, recommendations, or disclosures of said third parties that may be relevant to such questions. The individual also specifically authorizes said third

parties to release said information to the hospital and its authorized representatives upon request and agrees to cooperate with and assist the Hospital and its authorized representatives in obtaining said information. Failure of the Physician to cooperate with and assist the Hospital and its authorized representatives may be a factor to be considered in determining Physician qualification for appointment and reappointment.

(c) Authorization to Release Information:

The appointee specifically authorizes the hospital and its authorized representatives to release such information to other hospitals, health care facilities and their agents, who solicit such information for the purpose of evaluating the appointee's professional qualifications pursuant to a request for appointment and/or clinical privileges.

(d) Definitions:

- (1) As used in this section, the term "hospital and its authorized representatives" means Hospital, as defined in Article I, and any of the following individuals who have any responsibility for obtaining or evaluating the appointee's credentials, or for acting upon that individual's application or conduct at the hospital: the members of its Board of Trustees and their appointed representatives; the President of the Hospital or his/her designees; other hospital employees; consultants to the hospital; the hospital's attorney and his/her partners, associates or designees; and all appointees to the Medical Staff who have any responsibility for obtaining or evaluating the individual's credentials, or for acting upon that individual's application or conduct at the hospital.
- (2) As used in this section, the term "third parties" means all individuals, including appointees to the hospital's Medical Staff and appointees to the Medical Staffs of other hospitals, or other physicians or health practitioners, nurses, or other organizations, associations, partnerships, and corporations or government agencies, whether hospitals, health care facilities or not, from whom information has been requested by the hospital or its authorized representatives.

Section III-A-6. Department Chairperson Procedure

- (a) No later than two (2) months prior to the end of the current appointment period, the President of the Hospital or his designee shall make available to the Campus chairperson of each department a current list of all appointees who have clinical privileges in that department, together with a listing of the clinical privileges each holds, accompanied by their applications for reappointment.
- (b) The Campus department chairperson shall provide the Credentials Committee with a written report concerning each individual seeking reappointment. The Campus chairperson shall include in each written report, when applicable, the reasons for any changes recommended in staff category or clinical privileges, and the reasons for non-reappointment. The chairperson of the department concerned shall be

available to the Credentials Committee to answer any questions that may be raised with respect to any such report.

- (c) In the event the Campus department chairperson is unavailable, these duties may be performed by the previous Campus department chairperson or the SPR department chairperson.

Section III-A-7. Credentials Committee Procedure

- (a) The Credentials Committee, after receiving the reports from each department chairperson, shall review all available pertinent information, including all information provided from other committees of the Medical Staff and from hospital management, for the purpose of determining its recommendations for staff reappointment, for change in staff category, and for the renewed granting of clinical privileges for the ensuing appointment period.
- (b) As part of the process of making its recommendation, the Credentials Committee may require an individual currently seeking reappointment to undergo a physical and/or mental examination by a physician or physicians satisfactory to the Credentials Committee for the purpose of determining the applicant's ability to perform the privileges requested. The Credentials Committee may also require such an examination during the appointment period to aid it in determining whether clinical privileges should be continued. The results of such examination shall be made available to the Credentials Committee for its consideration. Failure of an individual to undergo such an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall constitute a voluntary relinquishment of all clinical privileges until such time as the Credentials Committee has received the examination results and has had a reasonable opportunity to evaluate them and make a recommendation thereon.
- (c) The Credentials Committee shall have the right to require the appointee to meet with the committee to discuss any aspect of the individual's reappointment application, qualifications, or clinical privileges requested.
- (d) The Credentials Committee may use the expertise of the SPR or Campus department chairperson, or any member of the department, or an outside consultant, if additional information is needed regarding the appointee's qualifications for reappointment.
- (e) The Credentials Committee shall forward written findings and recommendations to the Medical Board in time for the Medical Board to consider the individual's reappointment at its regularly scheduled meeting before the expiration of the applicant's appointment period. If, after considering the report of the Campus department chairperson concerned, the Credentials Committee's recommendation is favorable, it shall recommend reappointment and the specific clinical privileges to be granted, which may be qualified by any probationary or other conditions or restrictions, as appropriate.
- (f) Where the Credentials Committee recommends non-reappointment, non-promotion of an eligible current appointee, or a change in clinical privileges, the reason for such shall be stated.

- (g) The Chairperson of the Credentials Committee shall be available to the Medical Board, and the Board of Trustees, to answer any questions that may be raised with respect to the recommendation.

Section III-A-8: Medical Board Procedure

- (a) The Medical Board, after receiving the reports from each department chairperson and the recommendation of the Credentials Committee, shall review all available pertinent information, including all information provided from other committees of the Medical Staff and from hospital management, for the purpose of determining its recommendations. Thereafter, the Medical Board shall transmit its written reports and recommendations concerning the reappointment, clinical privileges and, where applicable, change in staff category, of each person currently holding a Medical Staff appointment, to the Board of Trustees in time for the Board of Trustees to consider reappointments at its final scheduled meeting in each reappointment cycle. The Chairperson of the Medical Board shall be available to the Board of Trustees, or its committee, to answer any questions that may be raised with respect to the recommendations.
- (b) If, during the processing of a particular individual's reappointment, it becomes apparent to the Medical Board or its Chairperson that the committee is considering a recommendation that would deny reappointment, deny a requested change in staff category or clinical privileges, or reduce clinical privileges, the Chairperson of the Medical Board shall notify the individual of the general tenor of the possible recommendation and ask if the individual desires to meet with the committee prior to any final recommendation by the committee. At such meeting, the affected individual shall be informed of the general nature of the evidence supporting the action contemplated and shall be invited to discuss, explain or refute it. This interview shall not constitute a hearing and none of the procedural rules provided in this policy with respect to hearings shall apply nor shall minutes of the discussion in the meeting be kept. However, the committee shall indicate as part of its report to the Board of Trustees whether such a meeting occurred.
- (c) If the Medical Board has determined to make a recommendation contrary to the recommendation of the Credentials Committee, the Medical Board shall either:
 - (1) remand the matter to the Credentials Committee for its further investigation and preparation of responses to specific questions raised by the Medical Board prior to its final recommendation, or
 - (2) set forth in its report and recommendation substantive reasons, along with supporting information, for its disagreement with the Credentials Committee's recommendation, and forward its recommendation, together with the Credentials Committee's findings and recommendation, to the Board of Trustees.
- (d) If the recommendation of the Medical Board would entitle the Medical Staff appointee to request a hearing pursuant to this policy, the recommendation shall be forwarded to the President of the Hospital who shall promptly notify the individual in writing, by certified mail, return receipt requested. The President of the Hospital shall hold the recommendation until the hearing and appeals process is complete,

or until the individual has waived his or her right to a hearing and appeal, after which the President of the Hospital shall forward the recommendation of the Medical Board, together with all supporting documentation, to the Board of Trustees, or its committee.

Part III-B. Procedures For Requesting Increase In Clinical Privileges

Section III-B-1. Application for Increased Clinical Privileges

Whenever, during the term of appointment to the Medical Staff, increased clinical privileges are desired, the appointee requesting increased privileges shall apply in writing to the President of the Hospital or his designee. The application shall state in detail the specific additional clinical privileges desired and the appointee's relevant recent training and experience which justify increased privileges. This application shall be transmitted by the President of the Hospital or his designee to the appropriate department chairperson. Thereafter, it will be processed in the same manner as an application for initial clinical privileges if the request is made during the term of appointment, or as a part of the reappointment application if the request is made at that time.

Section III-B-2. Factors to be Considered

Recommendations for an increase in clinical privileges made to the Board of Trustees shall be based upon:

- (a) relevant recent training;
- (b) observation of patient care provided;
- (c) review of the records of patients treated in this or other hospitals, if available;
- (d) results of the hospital's quality assessment activities; and
- (e) other reasonable indicators of the individual's continuing qualifications for the privileges in question, including any professional performance evaluations.

The recommendation for such increased privileges may carry with it such requirements for supervision or consultation or other conditions, for such periods of time as are thought necessary.

Part III-C: Procedure For Other Questions Involving Medical Staff Appointees

Section III-C-1. Grounds for Action

Whenever, on the basis of information and belief, the SPR or Campus Chief of Staff, the Chairperson of a clinical department, the Chairperson or a majority of any Medical Staff committee, the Chairperson of the Board of Trustees or the President of the Hospital or his designee has cause to question:

- (a) the clinical competence of any Medical Staff appointee;

- (b) the care or treatment of a patient or patients or management of a case by any Medical Staff appointee;
- (c) the known or suspected violation by any Medical Staff appointee of applicable ethical standards or the bylaws, policies, rules or regulations of the hospital or its Board of Trustees or Medical Staff, including, but not limited to the hospital's quality assessment, risk management, and utilization review programs; or
- (d) behavior or conduct on the part of any Medical Staff appointee that is considered lower than the standards of the hospital or disruptive to the orderly operation of the hospital or its Medical Staff, including the inability of the appointee to work harmoniously with others;

a written request for an investigation of the matter shall be addressed to the Credentials Committee making specific reference to the activity or conduct which gave rise to the request. The Credentials Committee may also initiate an investigation on its own motion. The Chairperson of the Credentials Committee shall promptly notify the Medical Board in writing of all such requests and investigations and keep the President of the Hospital and Medical Board fully informed of all action taken in connection therewith.

Section III-C-2. Investigative Procedure

- (a) The Credentials Committee shall meet as soon as possible after receiving the request for an investigation.
- (b) The Credentials Committee may, in the exercise of its discretion, determine that the complaint is frivolous and take no other action.
- (c) The Credentials Committee shall provide the individual being investigated an opportunity to respond in person or in writing to the Credentials Committee regarding the information contained in the request for an investigation and the Committee may thereafter make a recommendation based on the information contained in the request and the meeting with or written response from the individual being investigated.
- (d) If the request for an investigation does not contain sufficient information to warrant a recommendation as outlined in (c) above, the Credentials Committee shall immediately investigate the matter, appoint a subcommittee to do so, or appoint an ad hoc investigating committee. In the event the Credentials Committee appoints an ad hoc investigating committee, that committee shall consist of up to three (3) persons, who may or may not hold appointments to the Medical Staff. This committee shall not include partners, associates or relatives of the individual being investigated.

The individual being investigated shall have an opportunity to meet with the investigating committee before it makes its recommendation. At this meeting (but not, as a matter of right, in advance of it) the individual shall be informed of the general nature of the evidence supporting the question being investigated and shall be invited to discuss, explain, or refute it. This interview shall not constitute a hearing, and none of the procedural rules provided in this policy with respect to

hearings shall apply. A summary of such Interview shall be made by the investigating committee and included with its report to the Credentials Committee.

- (e) The Credentials Committee, its subcommittee or the ad hoc investigating committee shall have available to it the full resources of the Medical Staff and the Hospital, as well as the authority to use outside consultants, if needed. The committee may also require a physical and mental examination of the individual being investigated by a physician or physicians satisfactory to the committee, and shall require that the results of such examination be made available to the committee for its consideration.
- (f) If a subcommittee or ad hoc investigating committee is used, the Credentials Committee may accept, modify, or reject the recommendation it receives from that committee.

Section III-C-3. Suspension of Privileges

- (a) At any time during the investigation the Credentials Committee, with the approval of the President of the Hospital, may suspend all or any part of the clinical privileges of the individual being investigated. This suspension shall be deemed to be administrative in nature, and shall be for the protection of hospital patients. The suspension shall remain in effect, without appeal, during the investigation only and shall not indicate the validity of the charges. If such a suspension is placed into effect, the investigation shall be completed within fourteen (14) days of the suspension or reasons for the delay shall be transmitted to the Medical Board and the Board of Trustees. Thereafter, the Board of Trustees may consider whether the suspension should be lifted.
- (b) In the event of suspension of privileges, the appropriate department chairperson, or if unavailable, the Chief of Staff, shall immediately assign to another staff appointee with appropriate clinical privileges responsibility for the care of the patients of the suspended appointee until the suspension has been lifted or such patients are discharged from the hospital. Whenever possible, in the selection of a substitute physician, consideration should be given to a patient's wishes.

Section III-C-4. Procedure Thereafter

- (a) In acting after the investigation, the Credentials Committee shall transmit its recommendation to the Medical Board. The Chairperson of the Credentials Committee shall be available to the Medical Board to answer any questions that may be raised with respect to the recommendation.
- (b) Thereafter, the Medical Board may make any of the following recommendations:
 - (1) that no action is justified;
 - (2) issuance of a written warning;
 - (3) issuance of a letter of reprimand;
 - (4) imposition of terms of probation;

- (5) imposition of a general consultation requirement;
 - (6) reduction of clinical privileges;
 - (7) suspension of clinical privileges for a term;
 - (8) revocation of Medical Staff appointment;
 - (9) imposition of a mandatory concurring consultation requirement; or
 - (10) such other recommendation as it deems necessary or appropriate.
- (c) If the Medical Board has determined to make a recommendation contrary to the recommendation of the Credentials Committee, the Medical Board shall either:
- (1) remand the matter to the Credentials Committee for its further investigation and preparation of responses to specific questions raised by the Medical Board prior to its final recommendation; or
 - (2) set forth in its report and recommendation substantive reasons, along with supporting information, for its disagreement with the Credentials Committee's recommendation, and forward its recommendation together with the Credentials Committee's findings and recommendation to the Board of Trustees.
- (d) If the Medical Board's recommendation would adversely affect the clinical privileges of the individual being investigated as set forth in Article IV, Part A, Section 1, of this policy, the recommendation shall be forwarded to the President of the Hospital who shall promptly notify the individual in writing, by certified mail, return receipt requested. The President of the Hospital shall hold the recommendation until the hearing and appeals process is complete, or until the individual has waived his or her right to a hearing, and appeal, after which the President of the Hospital shall forward the recommendation of the Medical Board to the Board of Trustees, or its committee.
- (e) If the Medical Board's recommendation would not adversely affect the clinical privileges of the individual being investigated as set forth in Article IV, Part A, Section 1, of this policy, the individual shall not be entitled to a hearing, and the recommendation shall take effect immediately without action of the Board of Trustees and without the right of appeal to the Board of Trustees. A report of the action taken and reasons therefor shall be made to the Board of Trustees and the action shall stand unless modified by the Board of Trustees.
- (f) In the event the Board of Trustees determines to consider modification of the action of the Medical Board and such modification would entitle the individual to a hearing, as set forth in Article IV, Part A, Section 1, of this policy, it shall so notify the affected individual, through the President of the Hospital, and shall take no final action thereon until the hearing and appeals process is complete, or until the individual has waived his or her right to a hearing and appeal.

Part III-D: Precautionary Suspension Of Clinical Privileges

Section III-D-1. Grounds for Precautionary Suspension

- (a) The SPR or Campus Chief of Staff, the Chairperson of a clinical department, the Chairperson of the Credentials Committee, or President of the Hospital or his designee shall each have the authority to suspend all or any portion of the clinical privileges of a Medical Staff appointee or other individual whenever failure to take such action may result in imminent danger to the health and/or safety of any individual or to the orderly operations of the hospital. Such precautionary suspension shall be deemed an interim precautionary step in the professional review activity related to the ultimate professional review action that will be taken with respect to the suspended individual, but is not a professional review action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension.
- (b) A precautionary suspension shall become effective immediately upon imposition, shall immediately be reported in writing to the President of the Hospital, the Chief of Staff, and the Chairperson of the Credentials Committee, and shall remain in effect unless or until modified by the President of the Hospital or the Board of Trustees.

Section III-D-2. Credentials Committee Procedure

- (a) Any individual who exercises authority under Section I of this Part to suspend clinical privileges as a precaution shall immediately report this action to the Chairperson of the Credentials Committee so that appropriate further action can be taken in the matter.
- (b) An investigation of the matter resulting in precautionary suspension shall be completed within a reasonable time period not to exceed fourteen (14) days, or reasons for the delay shall be transmitted to the Board of Trustees so that the Board of Trustees may consider whether the suspension should be lifted. In the event the suspension is lifted, the Credentials Committee shall take such further action as is required and in the manner specified in Part C of this Article.

Section III-D-3. Care of Suspended Individual's Patients

- (a) Immediately upon the imposition of a precautionary suspension, the appropriate department chairperson or, if unavailable, the SPR or Campus Chief of Staff, shall assign to another individual with appropriate clinical privileges responsibility for care of the suspended individual's patients still in the hospital. This assignment shall be effective until such time as the patients are discharged. The wishes of the patient shall be considered in the selection of the assigned appointee.
- (b) It shall be the duty of all Medical Staff appointees to cooperate with the SPR or Campus Chief of Staff, the department chairperson concerned, the Credentials Committee and the President of the Hospital in enforcing all suspensions.

Part III-E: Other Actions

Section III-E-1. Failure to Complete Medical Records

Failure to complete medical records in accordance with Section IV, "Medical Records", of the Rules & Regulations will result in the temporary suspension of the staff member's privileges to post elective surgical/invasive procedures or schedule elective admissions. Reinstatement to the original status on the Medical Staff shall occur upon completion of all their delinquent records. Should a member have four (4) suspensions or a total of ninety (90) days of suspension within a consecutive twelve month period, this shall be considered a voluntary resignation from the medical staff. The practitioner may reapply for medical staff membership after completing all medical records.

Section III-E-2. Action by State Licensing Agency

Action by the appropriate state licensing board or agency revoking or suspending an individual's professional license, or the loss or lapse of a state license to practice for any reason, shall result in the voluntary relinquishment of all hospital clinical privileges as of that date, until the matter is resolved. In the event the individual's license is only partially restricted, the clinical privileges that would be affected by the license restriction shall be similarly restricted.

Section III-E-3. Failure to be Adequately Insured

If at any time an appointee's professional liability insurance coverage lapses, falls below the required minimum, is terminated or otherwise ceases to be in effect (in whole or in part), the appointee's clinical privileges that would be affected shall be voluntarily relinquished or restricted as applicable as of that date until the matter is resolved and adequate professional liability insurance coverage is restored.

Section III-E-4. Failure to Satisfy Continuing Education Requirements

- (a) Failure to satisfy such continuing education requirements as defined by the North Carolina Medical Board shall render an individual ineligible for reappointment to the Medical Staff. Such failure shall be documented and evidence of such made available to the Credentials Committee when reviewing applications for reappointment.
- (b) Any appointee who has been deemed ineligible for reappointment for failure to satisfy continuing education requirements shall be entitled to meet with a Committee to be designated by the Medical Board before final action is taken. This meeting with the committee shall not be conducted under the procedural rules provided in this policy.
- (c) If reappointment is refused by the Board of Trustees, the individual shall be eligible to reapply for staff appointment, and the application shall be processed in the same manner as if it were an initial application.

Section III-E-5. Failure to follow Invasive Procedural Site Verification and Pause Policy

If a physician declines or refuses to lead the pre-procedure pause as outlined in the policy, the supervisory staff in the area will be notified and the information will be forwarded promptly to the appropriate manager. The Manager will convey the information to the Vice President

of Medical Affairs, OR Medical Director and the Chief of the Medical Staff or, if appropriate, the Campus Chief of Staff. Violations will be handled as follows:

A. Pre-procedure pause:

- i. Upon the first occurrence, the physician will be verbally notified by the VP of Medical Affairs, of the violation. This verbal notification, either in person or by telephone, will be documented by a certified letter from the Chief of Staff of the facility where the infraction occurred and will be placed in the practitioner's credentials file.
- ii. Upon a second occurrence, the physician will be verbally notified by the VP of Medical Affairs that the physician's elective operating and/or procedure privileges have been suspended for seven (7) calendar days, effectively immediately. The verbal notification will be documented by a certified letter, confirming the suspension, from the Chief of Staff of the facility where the infraction occurred and will be placed in the practitioner's credentials file.
- iii. Upon a third occurrence, the physician will be verbally notified by the VP of Medical Affairs that the physician's operating and/or procedure privileges have been suspended until such time as the physician appears before the Credentials Committee following an investigation conducted pursuant to Part III-C. This notification will be documented by a certified letter from the Chief of Staff of the facility where the infraction occurred confirming the suspension and the need for the suspended physician to appear before the Credentials Committee. The certified letter will be placed in the practitioner's credentials file. The physician will be required to secure a replacement to fulfill any call obligation that may occur during the suspension period.

B. Consent. If a practitioner refused to sign a consent prior to the procedure, the practitioner's patients will not be placed in the procedure room until the consent is signed for a period of three months from the date of the refusal.

The appeals process as set forth in Part IV will apply to all suspensions of fourteen (14) days or greater.

Section III-E-6. Procedure for Leave of Absence

- (a) Individuals appointed to the Medical Staff may, for good cause, be granted a leave of absence by the Board of Trustees for a definitely stated period of time not to exceed one (1) year. Absence for longer than one year shall constitute voluntary resignation of Medical Staff appointment and clinical privileges unless an exception is made by the Board of Trustees.
- (b) Requests for a leave of absence shall be made to the Chairperson of the department in which the individual applying for leave holds clinical privileges, and shall state the beginning and ending dates of the requested leave. The department chairperson shall transmit the request together with a recommendation to the Credentials Committee, for action by the Medical Board and the Board of Trustees.

- (c) At the conclusion of the leave of absence, the individual may be reinstated, upon filing a written statement with the President of the Hospital or his designee summarizing the professional activities undertaken during the leave of absence. The individual shall also provide such other information as may be requested by the hospital at that time.
- (d) If the leave was for medical reasons, then the individual must submit a report from his or her attending physician indicating that the Medical Staff appointee is physically and/or mentally capable of resuming a hospital practice. The individual shall also provide such other information as may be requested by the hospital at that time. After considering all relevant information, the Credentials Committee shall then make a recommendation to the Medical Board and the Board of Trustees for final action.
- (e) In acting upon the request for reinstatement, the Board of Trustees may approve reinstatement either to the same or a different staff category, and may limit or modify the clinical privileges to be extended to the individual upon reinstatement.

Part III-F: Confidentiality And Reporting

Actions taken and recommendations made pursuant to this Article shall be treated as confidential in accordance with such policies regarding confidentiality as may be adopted by the Board of Trustees. In addition, reports of actions taken pursuant to this policy shall be made by the President of the Hospital to such governmental agencies as may be required by law.

Part III-G: Peer Review Protection

All minutes, reports, recommendations, communications, and actions made or taken pursuant to this policy are deemed to be covered by the provisions of N.C. Gen. Statutes 90-14.13, 131E-87 or 131E-95 or the corresponding provisions of any other federal or state statute providing protection to peer review or related activities. Furthermore, the committees and/or panels charged with making reports, findings, recommendations or investigations pursuant to this policy shall be considered to be acting on behalf of the hospital and its Board of Trustees when engaged in such professional review activities and thus shall be deemed to be "professional review bodies" and/or "medical review committees" as those terms are defined in the Health Care Quality Improvement Act of 1986 and/or North Carolina State Statutes.

ARTICLE IV - HEARING AND APPEAL PROCEDURES

Part IV-A: Initiation Of Hearing

Section IV-A-1. Grounds for Hearing

- (a) An applicant or an individual holding a Medical Staff appointment shall be entitled to request a hearing whenever an unfavorable recommendation has been made by the Medical Board or the Board of Trustees regarding the following:

- (1) denial of initial Medical Staff appointment;
 - (2) denial of requested advancement in Medical Staff category;
 - (3) denial of Medical Staff reappointment;
 - (4) revocation of Medical Staff appointment;
 - (5) denial of requested initial clinical privileges;
 - (6) denial of requested increased clinical privileges;
 - (7) decrease of clinical privileges;
 - (8) suspension of clinical privileges; or
 - (9) imposition of mandatory concurring consultation requirement.
- (b) No other recommendations except those enumerated in (a) of this section shall entitle the individual to request a hearing.
- (c) The affected individual shall also be entitled to request a hearing before the Board of Trustees enters a final decision, in the event the Board of Trustees should determine, without a similar recommendation from the Medical Board, to take any action set forth above.
- (d) The hearing shall be conducted in as informal a manner as possible, subject to the rules and procedures set forth in this policy.
- (e) Neither voluntary relinquishment of clinical privileges, as provided for elsewhere in this policy, nor the imposition of any general consultation or observation requirement, nor the imposition of a requirement for retraining, additional training, or continuing education, shall constitute grounds for a hearing, but shall take effect without hearing or appeal.

Part IV-B: The Hearing

Section IV-B-1. Notice of Recommendation

When a recommendation is made which would, according to this policy, entitle an individual to a hearing prior to a final decision of the Board of Trustees, the affected individual shall promptly be given notice by the President of the Hospital, in writing, certified mail, return receipt requested. This notice shall contain:

- (a) a statement of the recommendation made and the general reasons for it;
- (b) notice that the individual has the right to request a hearing on the recommendation within thirty (30) days of receipt of this notice; and
- (c) a copy of this Article outlining the rights in the hearing as provided for in this policy.

Section IV-B-2. Request for Hearing

Such individual shall have thirty (30) days following the date of the receipt of such notice within which to request the hearing. Said request shall be made by written notice to the President of the Hospital. In the event the affected individual does not request a hearing within the time and in the manner herein above set forth, that individual shall be deemed to have waived the right to such hearing and to have accepted the action involved, and such action shall thereupon become effective upon final Board of Trustees action.

Section IV-B-3. Notice of Hearing and Statement of Reasons

- (a) The President of the Hospital shall schedule the hearing and shall give written notice, certified mail, return receipt requested, to the person who requested the hearing. The notice shall include:
- (1) the time, place, and date of the hearing;
 - (2) a proposed list of witnesses who will give testimony or present evidence at the hearing in support of the Medical Board or the Board of Trustees;
 - (3) the names of the Hearing Panel members/Hearing Officer, if known; and
 - (4) a statement of the specific reasons for the recommendation as well as the list of patient records and information supporting the recommendation. This statement of reasons, and the list of supporting patient record numbers and other supporting information, may be amended at any time, even during the hearing, so long as the additional material is relevant, and the individual and the individual's counsel have sufficient time to study this additional information and rebut it.
- (b) The hearing shall begin as soon as practicable, but no sooner than thirty (30) days after the notice of the hearing unless an earlier hearing date has been specifically agreed to in writing by the parties.

Section IV-B-4. Witness List

- (a) Within ten (10) days after receiving notice of the hearing, the individual requesting the hearing shall provide a written list of the names and addresses of the individuals expected to offer testimony or present evidence on his or her behalf.
- (b) The affected individual's witness list, as well as the witness list of the Medical Board or the Board of Trustees shall include a brief summary of the nature of the anticipated testimony. Pursuant to the discretion of the Hearing Panel Chairperson, the witness list of either party may be supplemented or amended at any time during the course of the hearing, provided that notice of the change is given to the other party. The Hearing Panel Chairperson shall have the authority to limit the number of witnesses as set forth below.

Section IV-B-5. Hearing Panel, Hearing Panel Chairperson and Presiding Officer

- (a) Hearing Panel

- (1) When a hearing is requested, the President of the Hospital, acting for the Board of Trustees and after considering the recommendations of the Chief of Staff (and that of the Chairperson of the Board of Trustees, if the hearing is occasioned by a Board of Trustees determination) shall appoint a Hearing Panel which shall be composed of not less than three (3) members. The majority of the Hearing Panel shall be composed of Medical Staff appointees who shall not have actively participated in the consideration of the matter involved at any previous level, or of physicians and/or lay persons who are not connected with the hospital, or any combination of such persons.
- (2) The Hearing Panel shall not include any individual who is in direct economic competition with the affected person or any such individual who is professionally associated with or related to the affected individual. Knowledge of the underlying matter shall not preclude any individual from serving as a member of the Hearing Panel.

(b) Hearing Panel Chairperson

- (1) The President of the Hospital may appoint one of the Hearing Panel members as Chairperson of the Hearing Panel. The Chairperson shall be entitled to one vote.
- (2) The Hearing Panel Chairperson shall:
 - (i) act to insure that all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process;
 - (ii) maintain decorum throughout the hearing;
 - (iii) determine the order of procedure throughout the hearing;
 - (iv) have the authority and discretion, in accordance with this policy, to make rulings on all questions which pertain to matters of procedure and to the admissibility of evidence;
 - (v) act in such a way that all information reasonably relevant to the continued appointment or clinical privileges of the individual requesting the hearing is considered by the Hearing Panel in formulating its recommendations; and
 - (vi) conduct argument by counsel on procedural points outside the presence of the hearing panel unless the panel wishes to be present.
- (3) The Hearing Panel Chairperson may be advised by legal counsel to the hospital.

(c) Presiding Officer

- (1) In lieu of a Hearing Panel Chairperson, the President of the Hospital may appoint an attorney at law or other qualified person as Presiding Officer. Such Presiding Officer may be legal counsel to the hospital, but must not act as a prosecuting officer, or as an advocate for either side at the hearing. The Presiding Officer may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but shall not be entitled to vote on its recommendations. Legal counsel may thereafter continue to advise the Board of Trustees on the matter.
- (2) The Presiding Officer shall have the authority of and perform all the functions assigned to the Hearing Panel Chairperson.

Section IV-B-6. Hearing Officer

- (a) As an alternative to the Hearing Panel described in Section 5 of this Part, the President of the Hospital, after consulting with the Chief of Staff (and Chairperson of the Board of Trustees if the hearing was occasioned by a Board of Trustees determination) may instead appoint a Hearing Officer to perform the functions that would otherwise be carried out by the Hearing Panel. The Hearing Officer shall preferably be an attorney at law or some other individual capable of conducting the hearing.
- (b) The Hearing Officer may not be any individual who is in direct economic competition with the individual requesting the hearing, and shall not act as a prosecuting officer or as an advocate to either side at the hearing. In the event a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the "Hearing Panel," "Hearing Panel Chairperson," or "Presiding Officer" shall be deemed to refer instead to the Hearing Officer, unless the context would clearly otherwise require.

Part IV-C: Hearing Procedure

Section IV-C-1. Pre-Hearing Discovery

- (a) There is no right to pre-hearing discovery. The individual requesting the hearing shall be entitled, upon specific request, to the following, subject to a stipulation signed by both parties that such documents shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing:
 - (1) copies of, or reasonable access to, all patient medical records referred to in the Statement of Reasons, at his or her expense;
 - (2) reports of experts relied upon by the Credentials Committee or the Medical Board of Trustees; and
 - (3) copies of any other documents relied upon by the Credentials Committee or the Medical Board.

Disclosure of any documents hereunder shall not constitute a waiver of the protections provided by State or Federal peer review statutes. Intentional disclosure

of such records by the physician or the physician's representative in contravention of the procedures or applicable law shall constitute independent grounds for disciplinary action up to and including termination of Medical Staff privileges. Any and all documents produced hereunder shall be returned or destroyed upon the completion of the hearing.

- (b) Prior to the hearing, on dates set by the Hearing Panel Chairperson or agreed upon by counsel for both sides, each party shall provide the other party with a list of proposed exhibits. All objections to documents or witnesses, to the extent then reasonably known, shall be submitted in writing in advance of the hearing. The Hearing Panel Chairperson shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.
- (c) Neither the affected individual, nor his/her attorney, nor anyone else on his/her behalf shall contact hospital employees appearing on the hospital's witness list, unless such is specifically agreed upon by counsel.

Section IV-C-2. Failure to Appear

Failure, without good cause, of the individual requesting the hearing to appear and proceed at such a hearing shall be deemed to constitute voluntary acceptance of the recommendations or actions pending, which shall take effect immediately and shall become final upon adoption by the Board of Trustees.

Section IV-C-3. Record of Hearing

The Hearing Panel shall maintain a record of the hearing by a reporter present to make a record of the hearing or a recording of the proceedings. The cost of such reporter shall be borne by the hospital, but copies of the hearing transcript shall be provided to the individual requesting the hearing at that individual's expense. The Hearing Panel may, but shall not be required to, order that oral evidence shall be taken only on oath or affirmation administered by any person designated by such body and entitled to notarize documents in this State.

Section IV-4-3. Rights of Both Sides

- (a) At a hearing both sides shall have the following rights, subject to reasonable limits determined by the Hearing Panel Chairperson:
 - (1) to representation by an attorney or other person of choice;
 - (2) to have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof;
 - (3) to call, examine, and cross-examine witnesses;
 - (4) to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law; and
 - (5) to submit a written statement at the close of the hearing.

- (b) Any individual who requests a hearing and who does not testify in his/her own behalf may be called and examined as if under cross-examination.

Section IV-C-5. Admissibility of Evidence

The hearing shall not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. Hearsay evidence shall not be excluded merely because it constitutes hearsay. Any relevant evidence 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. Each party shall have the right to submit a memorandum of points and authorities, and the Hearing Panel may request such a memorandum to be filed, following the close of the hearing. The Hearing Panel may interrogate the witnesses, call additional witnesses, or request documentary evidence if it deems it appropriate.

Section IV-C-6. Official Notice

The Hearing Panel Chairperson shall have the discretion to accept into evidence without proof, or take official notice of any matter, either technical or scientific, which relates to the issues under consideration, and which could have been accepted into evidence by a judge in this State. Participants in the hearing shall be advised what matters will be so accepted into evidence and the record of the hearing should also reflect this. Either party may request that a matter be officially noticed and may refute a matter that was officially noticed by evidence to the contrary. Additional time shall be granted to present rebuttal evidence of any evidence admitted on official notice if the request for such is reasonable.

Section IV-C-7. Postponements and Extensions

Postponements and extensions of time beyond any time limit set forth in this policy may be requested by anyone but shall be permitted only by the Hearing Panel, its Chairperson or the entity which appointed the Hearing Panel on a showing of good cause.

Part IV-D: Hearing Conclusion, Deliberations, And Recommendations

Section IV-D-1. Burden of Proof

- (a) The Board of Trustees or the Medical Board, depending on whose recommendation initially prompted the hearing, shall come forward first with evidence in support of its recommendation. Thereafter, the burden shall shift to the individual who requested the hearing to come forward with evidence.
- (b) After all the evidence has been submitted by both sides, the Hearing Panel shall recommend in favor of the Medical Board or the Board of Trustees, unless it finds that the individual who requested the hearing has proved that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by substantial evidence.

Section IV-D-2. Basis of Decision

The decision of the Hearing Panel shall be based on the evidence produced at the hearing. This evidence may consist of the following:

- (a) oral testimony of witnesses;
- (b) memorandum of points and authorities presented in connection with the hearing;
- (c) any information regarding the individual who requested the hearing so long as that information has been admitted into evidence at the hearing and the person who requested the hearing had an opportunity to comment on and, by other evidence, refute it;
- (d) any and all applications, references, and accompanying documents;
- (e) other documented evidence, including medical records; and
- (f) any other evidence that has been admitted.

Section IV-D-3. Adjournment and Conclusion

The Hearing Panel Chairperson may adjourn the hearing and reconvene the same at the convenience and with the agreement of the participants without special notice. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed.

Section IV-D-4. Deliberations and Recommendation of the Hearing Panel

Within twenty (20) days after final adjournment of the hearing, the Hearing Panel shall conduct its deliberations outside the presence of any other person (except the Presiding Officer, if one is appointed) and shall render a recommendation, accompanied by a report, which shall contain a concise statement of the reasons justifying the recommendation made and shall deliver such report to the President of the Hospital.

Section IV-D-5. Disposition of Hearing Panel Report

Upon its receipt, the President of the Hospital shall forward the Hearing Panel's report and recommendation, along with all supporting documentation, to the Board of Trustees for further action. The President of the Hospital shall also send a copy of the report and recommendation, certified mail, return receipt requested, to the individual who requested the hearing, and to the Medical Board for information and comment.

Part IV-E: Appeal Procedure

Section IV-E-1. Time for Appeal

Within ten (10) days after notice of the Hearing Panel's recommendation, either party may request an appellate review. The request shall be in writing, and shall be delivered to the President of the Hospital either in person or by certified mail, and shall include a brief statement of the reasons for appeal. If such appellate review is not requested within ten (10) days as provided herein, both parties shall be deemed to have accepted the recommendation involved and it shall thereupon take effect immediately and shall become final upon adoption by the Board of Trustees.

Section IV-E-2. Grounds for Appeal

The grounds for appeal shall be as follows that:

- (a) there was substantial failure to comply with this policy and/or the hospital or Medical Staff bylaws in the matter which was the subject of the hearing so as to deny due process or a fair hearing; or
- (b) the recommendations were made arbitrarily, capriciously or with prejudice; or
- (c) the recommendations were not supported by substantial evidence.

Section IV-E-3. Time, Place and Notice

Whenever an appeal is requested as set forth in the preceding sections, the Chairperson of the Board of Trustees shall, within ten (10) days after receipt of such request, schedule and arrange for an appellate review. The affected individual shall be given notice of the time, place, and date of the appellate review. The date of appellate review shall be not less than ten (10) days, nor more than thirty (30) days from the date of receipt of the request for appellate review; provided, however, that when a request for appellate reviews from an appointee who is under a suspension then in effect the appellate review shall be held as soon as the arrangements may reasonably be made and not more than fourteen (14) days from the date of receipt of the request for appellate review. The time for appellate review may be extended by the Chairperson of the Board of Trustees for good cause.

Section IV-E-4. Nature of Appellate Review

- (a) The Chairperson of the Board of Trustees shall appoint a Review Panel composed of not less than three (3) persons, either members of the Board of Trustees or others, including but not limited to reputable persons outside the hospital, to consider the record upon which the recommendation before it was made.
- (b) The Review Panel may accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that any opportunity to admit it at the hearing was denied, and then only at the discretion of the Review Panel.
- (c) Each party shall have the right to present a written statement in support of its position on appeal, and in its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral argument. The Review Panel shall recommend final action to the Board of Trustees.
- (c) The Board of Trustees may affirm, modify or reverse the recommendation of the Review Panel or, in its discretion, refer the matter for further review and recommendation.

Section IV-E-5. Final Decision of the Board of Trustees

Within thirty (30) days after receipt of the Review Panel's recommendation, the Board of Trustees shall render a final decision in writing and shall deliver copies thereof to the affected individual and to the Chairpersons of the Credentials Committee and Medical Board, in person or by certified mail, return receipt requested.

Section IV-E-6. Further Review

Except where the matter is referred for further action and recommendation in accordance with this Part, the final decision of the Board of Trustees following the appeal shall be effective immediately and shall not be subject to further review. Provided, however, if the matter is referred for further action and recommendation, such recommendation shall be promptly made to the Board of Trustees in accordance with the instructions given by the Board of Trustees. This further review process and the report back to the Board of Trustees shall in no event exceed thirty (30) days in duration except as the parties may otherwise stipulate.

Section IV-E-7. Right to One Appeal Only

No applicant or Medical Staff appointee shall be entitled as a matter of right to more than one (1) appellate review on any single matter which may be the subject of an appeal. In the event that the Board of Trustees ultimately determines to deny initial Medical Staff appointment or reappointment to an applicant, or to revoke or terminate the Medical Staff appointment and/or clinical privileges of a current appointee, that individual may not apply for Medical Staff appointment or for those clinical privileges at this hospital for a period of five (5) years, unless the Board of Trustees provides otherwise.

ARTICLE V - ALLIED HEALTH PROFESSIONALS

Part V-A: Allied Health Practitioners, Category I

Section V-A-1. Qualifications

- (a) Dentists, Podiatrists, Psychologists (Ph.D and Psy.D), Chiropractors and Optometrists, who meet the qualifications outlined in their respective Credentialing Policies and who are approved by the Board of Trustees, are eligible to practice as Category I Allied Health Practitioners.
- (b) Each such individual shall submit an application on a form provided by the hospital. Each applicant shall be evaluated by the Credentials Committee which shall make a recommendation to the Medical Board regarding the applicant's privileges. Thereafter, the Medical Board shall make a recommendation regarding the applicant's privileges and that recommendation shall be forwarded to the Board of Trustees for final action.
- (c) Each such individual must provide evidence of current, valid professional liability insurance coverage in such terms and in amounts satisfactory to the hospital.
- (d) Each such individual must be able to document their:
 1. background, experience, training, and current clinical competence;

2. adherence to the ethics of their profession;
3. current licensure;
4. good reputation and character, including physical health and mental and emotional stability; and
5. ability to work harmoniously with others sufficiently to convince the hospital that all patients treated by them at the hospital will receive quality care and that the hospital and its staff will be able to operate in an orderly manner.

Section V-A-2. Conditions of Practice

- (a) A Category I Allied Health Practitioner shall practice at the discretion of the Board of Trustees, and thus may be terminated by the Board of Trustees and shall not be covered by the due process provisions of this policy or the corporate bylaws. Disputed issues regarding the privileges or functioning of the Category I Allied Health Practitioner may be brought to the Chairperson of the department which has overall supervisory responsibility for the Category I Allied Health Practitioner. Further appeal may be directed to the Chief of Staff and ultimately to the President of the Hospital whose decision regarding a dispute will be final.
- (b) A Category I Allied Health Practitioner shall not be entitled to the rights, privileges, and responsibilities of appointment to the Medical Staff and may only engage in acts within the delineation of clinical privileges specifically granted by the Board of Trustees. They shall be located within the geographic service area of the hospital, close enough to fulfill their responsibilities, and to provide timely care for their consults in the hospital.
- (c) A Category I Allied Health Practitioner must file an application for renewed clinical privileges at least every two years on forms provided by the hospital. The review process shall be the same for reapplication as for initial application.

Part V-B: Allied Health Practitioner, Category II

Section V-B-1. Qualifications

- (a) Physician Assistants, Nurse Practitioners, Nurse Anesthetists, and Nurse Midwives, who meet the qualifications outlined in their respective Credentialing Policies and who are approved by the Board of Trustees and who provide services under the supervision of physicians who are presently appointed to the Medical Staff are eligible to practice as Category II Allied Health Practitioners.
- (b) Each such individual must be able to document their:
 1. background, experience, training, and current clinical competence;
 2. adherence to the ethics of their profession;
 3. current licensure;
 4. good reputation and character, including physical health and mental and emotional stability; and
 5. ability to work harmoniously with others sufficiently to convince the hospital that all patients treated by them at the hospital will receive quality care and that the hospital and its staff will be able to operate in an orderly manner.

Section V-B-2. Selection Procedure

- (a) To the extent the Board of Trustees determines to permit such Category II Allied Health Professionals to act at the hospital, the Credentials Committee shall make a recommendation to the Medical Board regarding the clinical privileges or the scope of each such individual's activities at the hospital. Thereafter, the Medical Board shall make a recommendation regarding the Category II Allied Health Professional's clinical privileges or scope of practice and that recommendation shall be forwarded to the Board of Trustees for final action.
- (b) No such individual shall provide services at the hospital as a Category II Allied Health Professional unless and until the Credentials Committee and the Medical Board have received, on a form provided by the hospital, sufficient information about the qualifications of that individual to permit those Committees to make recommendations regarding the clinical privileges or scope of activities the individual will be permitted to undertake at the hospital. The form shall be prepared by the individual's sponsoring physician, if appropriate, and signed by both the sponsoring physician and the individual.
- (c) The Medical Board, on the recommendation of the Credentials Committee and chairperson of the applicable department, shall recommend to the Board of Trustees the clinical privileges or the scope of practice each Category II Allied Health Professional is permitted to undertake at the hospital. This delineated privileges or the scope of practice shall be final with no right of hearing or appeal, provided, however, that the physician seeking to sponsor the Category II Allied Health Professional at the hospital shall have the opportunity to appear before the Medical Board and discuss the proposed clinical privileges or scope of practice before any final action is taken on it by the Board of Trustees. The Category II Allied Health Professional may act at the hospital pursuant to the approved delineation only so long as he remains an employee of or is supervised by the physician who is currently appointed to the Medical Staff and who initially requested privileges for the Category II Allied Health Professional.

Section V-B-3. Conditions of Practice

- (a) Category II Allied Health Professionals shall practice at the hospital at the discretion of the Board of Trustees and may be terminated by the Board of Trustees. Appeal of such termination is available to the Allied Health Professional through his/her Sponsoring Physician as outlined in Article V, Part B, Section 3(b).
- (b) Category II Allied Health Professionals shall not be entitled to the rights, privileges, and responsibilities of appointment to the Medical Staff and may only engage in acts within the delineated clinical privileges or scope of practice specifically granted by the Board of Trustees. Grievances may be referred by the Category II Allied Health Professional's Sponsoring Physician to the Chairperson of the department to which the Sponsoring Physician is appointed. Further appeal may be directed to the Chief of Staff and ultimately to the President of the Hospital whose decision regarding the dispute will be final.

- (c) Any activities permitted by the Board of Trustees to be done at the hospital by a Category II Allied Health Professional shall specify which of those activities must be performed in the presence of the sponsoring physician.
- (d) Should any physician or hospital employee who is licensed or certified by the state have any question regarding the clinical competence or authority of the Category II Allied Health Professional either to act or to issue instructions outside the physical presence of the sponsoring physician in a particular instance, such physician or hospital employee has the right to require that the Category II Allied Health Professional's sponsoring physician validate, either at the time or within 48 hours, the orders of the Category II Allied Health Professional. Any act or instruction of the Category II Allied Health Professional shall be delayed until such time as the physician or hospital employee can be certain that the act is clearly within the clinical privileges or scope of the Category II Allied Health Professional's activities as permitted by the Board of Trustees. At all times the sponsoring physician will remain responsible for all acts of the Category II Allied Health Professional while at the hospital.
- (e) Category II Allied Health Professionals must file applications for renewed permission to practice at the hospital at least every two years on forms provided by the hospital. The review process shall be the same for re-application as for initial application.
- (f) The number of Category II Allied Health Professionals acting under the supervision of one physician, as well as the acts they may undertake, shall be consistent with applicable state statutes and regulations, the rules and regulations of the Medical Staff and the policies of the Board of Trustees.
- (g) It shall be the responsibility of the physician sponsoring the Category II Allied Health Profession to assure that professional liability insurance for the Category II Allied Health Professional is provided in amounts required by the Board of Trustees and that such liability insurance covers any activities of the Category II Allied Health Professional at the hospital, and to furnish evidence of such to the hospital. The Category II Allied Health Professional shall act at the hospital only while such coverage is in effect.
- (h) Individuals who are employees of the hospital shall not be permitted to practice at the hospital as Category II Allied Health Practitioners, but shall be governed by such hospital policies, manuals and descriptions as may be established from time to time by the President of the Hospital or other appropriate designees. Where applicable, the President of the Hospital shall consult appropriate Medical Staff appointees and/or committees regarding the qualifications of those hospital employees whose responsibilities require the delineation of clinical duties. This does not apply to employed physician assistants or advanced nurse practitioners, or other such category as required. Category II Allied Health Professionals who are employees of the Hospital and who hold privileges will have their privileges held in abeyance until the hospital HR grievance process is completed.
- (i) Category II Allied Health Professionals shall report any change in sponsorship or state approval within seventy-two (72) hours of notification.

- (j) At the loss of sponsorship, all privileges for Category II Allied Health Professionals are inactive. If a new sponsor is obtained within 90 days, the Allied Health Professional is eligible to request a transfer of privileges to the new sponsor. The privileges will be returned to an active status once the transfer has been processed and approved.

Part V-C: Allied Health Practitioner, Category III

Section V-C-1. Qualifications

- (a) Certified Clinical Social Workers, Licensed Practicing Counselors, Masters Level Psychologists, Perfusionists, Clinical Psychiatric Nurse Specialists, Surgical Nurse Assistants, Nurse Assistants, Perfusionists, Rounding Nurses, Scrub Techs, Dental Assistants, Operating Room Technicians, and other allied Health Practitioners, who meet the qualifications outlined in their respective Credentialing Policies and who are approved by the Board of Trustees and who provide services under the supervision of physicians who are presently appointed to the Medical Staff are eligible to practice as Category III Allied Health Practitioners.
- (b) Each such individual must be able to document their:
 - 6. background, experience, training, and current clinical competence;
 - 7. adherence to the ethics of their profession;
 - 8. good reputation and character, including physical health and mental and emotional stability; and
 - 9. ability to work harmoniously with others sufficiently to convince the hospital that all patients treated by them at the hospital will receive quality care and that the hospital and its staff will be able to operate in an orderly manner.

Section V-C-2. Selection Procedure

- (a) To the extent the Board of Trustees determines to permit such Category III Allied Health Professionals to act at the hospital, the Credentials Committee shall make a recommendation to the Medical Board regarding the clinical privileges or the scope of each such individual's activities at the hospital. Thereafter, the Medical Board shall make a recommendation regarding the Category III Allied Health Professional's clinical privileges or scope of practice and that recommendation shall be forwarded to the Board of Trustees for final action.
- (b) No such individual shall provide services at the hospital as a Category III Allied Health Professional unless and until the Credentials Committee and the Medical Board have received, on a form provided by the hospital, sufficient information about the qualifications of that individual to permit those Committees to make recommendations regarding the clinical privileges or scope of activities the individual will be permitted to undertake at the hospital. The form shall be prepared by the individual's sponsoring physician, if appropriate, and signed by both the sponsoring physician and the individual.
- (c) The Medical Board, on the recommendation of the Credentials Committee and chairperson of the applicable department, shall recommend to the Board of

Trustees the clinical privileges or the scope of practice each Category III Allied Health Professional is permitted to undertake at the hospital. This delineated privileges or the scope of practice shall be final with no right of hearing or appeal, provided, however, that the physician seeking to sponsor the Category III Allied Health Professional at the hospital shall have the opportunity to appear before the Medical Board and discuss the proposed clinical privileges or scope of practice before any final action is taken on it by the Board of Trustees. The Category III Allied Health Professional may act at the hospital pursuant to the approved delineation only so long as he remains an employee of or is supervised by the physician who is currently appointed to the Medical Staff and who initially requested privileges for the Category III Allied Health Professional.

Section V-C-3. Conditions of Practice

- (a) Category III Allied Health Professionals shall practice at the hospital at the discretion of the Board of Trustees and may be terminated by the Board of Trustees. Appeal of such termination is available to the Allied Health Professional through his/her Sponsoring Physician as outlined in Article V, Part B, Section 3(b).
- (b) Category III Allied Health Professionals shall not be entitled to the rights, privileges, and responsibilities of appointment to the Medical Staff and may only engage in acts within the delineated clinical privileges or scope of practice specifically granted by the Board of Trustees. Grievances may be referred by the Category III Allied Health Professional's Sponsoring Physician to the Chairperson of the department to which the Sponsoring Physician is appointed. Further appeal may be directed to the Chief of Staff and ultimately to the President of the Hospital whose decision regarding the dispute will be final.
- (c) Any activities permitted by the Board of Trustees to be done at the hospital by a Category III Allied Health Professional shall specify which of those activities must be performed in the presence of the sponsoring physician.
- (d) Should any physician or hospital employee who is licensed or certified by the state have any question regarding the clinical competence or authority of the Category III Allied Health Professional either to act or to issue instructions outside the physical presence of the sponsoring physician in a particular instance, such physician or hospital employee has the right to require that the Category III Allied Health Professional's sponsoring physician validate, either at the time or within 48 hours, the orders of the Category III Allied Health Professional. Any act or instruction of the Category III Allied Health Professional shall be delayed until such time as the physician or hospital employee can be certain that the act is clearly within the clinical privileges or scope of the Category III Allied Health Professional's activities as permitted by the Board of Trustees. At all times the sponsoring physician will remain responsible for all acts of the Category III Allied Health Professional while at the hospital.
- (e) Category III Allied Health Professionals must file applications for renewed permission to practice at the hospital at least every two years on forms provided by the hospital. The review process shall be the same for re-application as for initial application. Additionally, the Category III Allied Health Professional must undergo an annual performance evaluation.

- (f) The number of Category III Allied Health Professionals acting under the supervision of one physician, as well as the acts they may undertake, shall be consistent with applicable state statutes and regulations, the rules and regulations of the Medical Staff and the policies of the Board of Trustees.
- (g) It shall be the responsibility of the physician sponsoring the Category III Allied Health Profession to assure that professional liability insurance for the Category III Allied Health Professional is provided in amounts required by the Board of Trustees and that such liability insurance covers any activities of the Category III Allied Health Professional at the hospital, and to furnish evidence of such to the hospital. The Category III Allied Health Professional shall act at the hospital only while such coverage is in effect.
- (h) Category III Allied Health Professionals shall report any change in sponsorship or state approval within seventy-two (72) hours of notification.
- (i) At the loss of sponsorship, all privileges for Category III Allied Health Professionals are inactive. If a new sponsor is obtained within 90 days, the Allied Health Professional is eligible to request a transfer of privileges to the new sponsor. The privileges will be returned to an active status once the transfer has been processed and approved.
- (j) Individuals who are employees of the hospital shall not be permitted to practice at the hospital as Category III Allied Health Practitioners, but shall be governed by such hospital policies, manuals and descriptions as may be established from time to time by the President of the Hospital or other appropriate designees. Where applicable, the President of the Hospital shall consult appropriate Medical Staff appointees and/or committees regarding the qualifications of those hospital employees whose responsibilities require the delineation of clinical duties. This does not apply to employed physician assistants or advanced nurse practitioners, or other such category as required. Category III Allied Health Professionals who are employees of the Hospital and who hold privileges will have their privileges held in abeyance until the hospital HR grievance process is completed.

ARTICLE VI - AMENDMENTS

- (a) This policy may be amended by a majority vote of the members of the Medical Board present and voting at any meeting of that Committee where a quorum exists, provided that the written recommendations concerning the proposed amendments shall have first been received and reviewed by both the Credentials Committee and the Medical Board. No such amendment shall be effective unless and until it has been approved by the Board of Trustees.
- (b) This policy may also be amended by the Board of Trustees on its own motion provided that any such amendment is first submitted to the Credentials Committee and Medical Board of the Medical Staff for review and comment at least thirty (30) days prior to any final action by the Board of Trustees on such amendment. Instances where such action by the Board of Trustees is warranted shall include:

- (1) action to comply with changes in federal and state laws that affect this hospital and the hospital corporation, including any of its entities, and
- (2) action to comply with state licensure requirements, JCAHO Accreditation Standards, and Medicare/Medicaid Conditions of Participation for Hospitals.

ARTICLE VII - ADOPTION

This policy is adopted and made effective upon approval of the Board of Trustees, superseding and replacing any and all other Medical Staff bylaws, rules and regulations, or hospital policies pertaining to the subject matter thereof, and henceforth all activities and actions of the Medical Staff and of each individual exercising clinical privileges at the hospital shall be taken under and pursuant to the requirements of this policy.