BYLAWS
OF THE MEDICAL STAFF OF
WARM SPRINGS SPECIALTY HOSPITAL AT LULING

PREAMBLE

WHEREAS, Warm Springs Rehabilitation Foundation, Inc. d/b/a Warm Springs Specialty Hospital at Luling, is a non-profit corporation organized under the laws of the State of Texas; and

WHEREAS, its purpose is to operate a long term acute care hospital providing inpatient and outpatient care, education, and research; and

WHEREAS, the objective of patient care is to enable patients to maximize their functioning to be as independent as possible or achieve goal directed potential through a comprehensive multi-disciplinary program addressing the medical, physical, psychological, and vocational needs of the patient; and

WHEREAS, it is recognized that the Medical Staff desires to provide patient care in the Hospital at the generally recognized professional level of quality, that the Medical Staff is a component of the Hospital and must work with and is subject to the ultimate authority of the Governing Body, and that the cooperative efforts of the Medical Staff, management, and the Governing Body are necessary to fulfill the Hospital's goal of providing the desired quality of care to its patients;

THEREFORE, the physicians, dentists, and podiatrists practicing in the Hospital shall carry out the functions delegated to the Medical Staff by the Governing Body in conformity with these Bylaws.

ARTICLE I
IDENTIFICATION AND DEFINITIONS

A. NAME, LOCATION AND DURATION

The name of the Association shall be the Medical Staff of Warm Springs Specialty Hospital at Luling, located in Luling, Caldwell County, Texas. This Association shall continue only for the duration of the appointments of the members of the Medical Staff.

B. DEFINITIONS

1. Facility Administrator means the person appointed by the Chief Executive Officer, with the approval of the Governing Body, to supervise the operations of the Hospital under the direction and guidance of the Chief Executive Officer.
2. Chief Executive Officer means the individual appointed by the Governing Body to act in its behalf in the overall management of the Hospital.
3. Clinical Privileges means the permission granted to a Practitioner to render specific diagnostic, therapeutic, medical, surgical, dental, or podiatric services to patients in the Hospital.
4. Executive Committee or Medical Executive Committee means the committee designated in Article VI.
5. Governing Body means the Board of Directors of the facility or its committee to which performance of specified duties has been delegated.
6 Hospital means any present inpatient and/or outpatient facility operated as a part of the Luling Warm Springs Long Term Care Hospital medical complex.
7. Medical Director means the Medical Staff member under a contract with Post Acaute Medical, LLC, to provide medical administrative duties at the Hospital to ensure that services meet the needs of the patients served and provide medical consultation to ancillary and supportive staff.
8. Medical Staff means the formal organization of all Practitioners who are given Clinical Privileges and attend to patients in the Hospital.

9. Practitioners means doctors of allopathic or osteopathic medicine and, doctors of dentistry or podiatry, appropriately licensed under the laws of the State of Texas to provide patient care services within the limits of their license.
10. President means the Medical Staff member elected in accordance with these Bylaws to serve as the head of the Medical Staff.
11. Professional Medical Staff Year means the calendar period from January 1 through December 31st of each year.
12. Rules and Regulations mean the Medical Staff rules and regulations as from time to time adopted by the Medical Staff pursuant to Article XVI of these Bylaws.

ARTICLE II
PURPOSES AND RESPONSIBILITIES

A. PURPOSE

The purpose of the Association is to bring the Practitioners and Allied Health Professionals who practice at the Hospital together into a cohesive body to promote good patient care. To this end, among other activities, it will assist in screening applicants for Medical Staff membership, review Clinical Privileges of members, evaluate and assist in improving the work done by the Medical Staff, provide education, and offer advice to the Facility Administrator and the Chief Executive Officer.

B. RESPONSIBILITIES

To accomplish the purposes enumerated above, it is the obligation and responsibility of the Medical Staff to participate in the Hospital's performance improvement program by conducting all required and necessary activities for assessing and improving the effectiveness and efficiency of medical, rehabilitation [long term] care provided within the Hospital, including, but without limitation:

1. Evaluate. Evaluate Medical Staff and Hospital performance through valid and reliable measurement systems based on objective, clinically sound criteria.
2. Monitor. Engage in the ongoing monitoring of critical aspects of care and enforcement of Medical Staff and Hospital policies.
3. Credential. Evaluate Practitioner credentials for official and continuing membership in the Medical Staff organization and for the delineation of Clinical Privileges for each individual Practitioner in the Hospital.
4. Educate. Arrange for Medical Staff participation in programs designed to meet the educational needs of its members and/or support staff; develop, or participate in, and monitor the Medical Staff's education and training programs and clinical and laboratory research activities.
5. Manage. Assure that medical and health care at the Hospital are appropriately employed for meeting patients' medical, social, rehabilitative and emotional needs consistent with sound health care resource utilization practices.
6. Appoint and Privilege. Make recommendations to the Governing Body concerning appointments and reappointments to the Medical Staff, including membership category and service assignments, Clinical Privileges, specified services and corrective action in accordance with the procedures established by these Bylaws and the Rules and Regulations.
7. Standardize. Maintain sound professional practices and an atmosphere conducive to the treatment and long term care of patients and to teaching and research.
8. Document. Develop, administer, and recommend amendments to these Bylaws, and the Rules and Regulations.
9. Enforce. Enforce compliance with these Bylaws the Rules and Regulations and **all standards, policies and procedures of the Hospital and the Governing Body** and exercise the authority

granted by these Bylaws as necessary to fulfill the foregoing responsibilities in a proper and timely manner.

ARTICLE III
MEDICAL STAFF MEMBERSHIP

A. NATURE OF MEDICAL STAFF MEMBERSHIP

Membership on the Medical Staff of the Hospital is a privilege which shall be extended only to competent Practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws regardless of age, sex, race, creed, color or national origin. Practitioners holding Medical Staff membership are not employees, agents or servants of the Hospital. While the Practitioners on the Medical Staff are required to follow the rules, and policies and procedures of the Hospital, the Hospital does not and cannot control the details of the Practitioners' work.

B. QUALIFICATIONS

The Medical Staff shall be composed of Practitioners who are graduates of accredited medical, osteopathic, podiatry, or dental schools and who can provide evidence of the following:

1. Licensure. A currently valid license issued by the State of Texas.

2. Training / Experience. Background, professional education, and relevant training in Clinical Privileges being requested.

3. Current Competence. Documented and demonstrated competence and experience with clinical results which would assure a continuing ability to provide optimally achievable patient care and services.

4. Attitude. A willingness and capability based on current attitude and evidence of past performance to:
    a. Harmoniously work with and relate to other Medical Staff members, residents and students, members of other health disciplines, Hospital administration and employees, visitors and the community in general, in a cooperative, professional manner that is essential for maintaining an environment appropriate to quality patient care; and
    b. Participate equitably in the discharge of Medical Staff obligations appropriate to the Practitioner's Medical Staff membership category, including cooperating with peer review activities; and
    c. Adhere strictly to the professional ethics of their profession including without limitation, prohibitions against: fee splitting, delegating the responsibility for diagnosis or care of patients to a Practitioner not qualified to undertake that responsibility and failing to obtain informed patient consent to treatment.

5. <u>Ability to Perform Clinical Privileges Requested/Health Status</u>. Being free of or having under adequate control any significant physical or behavioral impairment that may interfere with, or present a substantial possibility of interfering with, the qualifications required under the general qualifications sections hereof such that patient care is or is likely to be adversely affected.

6. <u>Professional Liability Insurance</u>. Having in force professional liability insurance in not less than the minimum amount of $100,000 per occurrence, $300,000 aggregate coverage.

Medical Staff membership or particular Clinical Privileges shall not be denied on the basis of any criterion unrelated to efficient delivery of quality patient care, to professional ability and judgment, or to community need, including but not limited to sex, race, creed, color and national origin.

No Practitioner is automatically entitled to membership on the Medical Staff or to the exercise of particular Clinical Privileges merely because he is licensed to practice in this or any other state; a member of any professional organization; certified by any clinical board; a member of the faculty of a medical school; or had, or presently has, staff membership or privileges at another health care facility or in another practice setting. Nor is any Practitioner automatically entitled to appointment, reappointment, or particular Clinical Privileges merely because he had, or presently has, staff membership or those particular privileges at this Hospital.

C. BASIC OBLIGATIONS OF MEDICAL STAFF MEMBERSHIP

Each member of the Medical Staff, regardless of his assigned Medical Staff category, and each Practitioner exercising temporary privileges under these Bylaws, shall:

1. Provide his patients with care at the generally recognized professional level of quality and efficiency;
2. Abide by these Bylaws, the Rules and Regulations and all standards, policies and procedures of the Hospital and the Governing Body;
3. Discharge such Medical Staff, committee and Hospital functions for which he is responsible by Medical Staff category assignment, appointment, election or otherwise;
4. Prepare and complete in a timely and legible fashion the medical and other required records for all patients he admits or in any way provides care to in the Hospital;
5. Abide by generally recognized standards of professional ethics;
6. Seek consultation whenever necessary;
7. Satisfy the continuing education requirements established by the Medical Staff; and
8. Immediately notify the President or Facility Administrator of the revocation, suspension, or lapse of his professional license or the imposition of terms of probation or limitation of practice by any state licensing agency; or loss or restriction, whether voluntary or involuntary, of privileges at any hospital or other health care institution; or of any adverse malpractice judgment or settlement of greater than $50,000; or the commencement of a formal investigation or the filing of charges, by the Health and Human Services Commission or any law enforcement agency or health regulatory agency of the United States or the State of Texas or any other state; or the cancellation or restriction of his professional liability coverage; or the revocation, suspension or voluntary relinquishment or lapse of his DEA or DPS certification.

D. TERM OF APPOINTMENT

1. <u>Initial Appointment</u>. All initial appointments to the Active or Courtesy Medical Staff, pursuant to Governing Body and Medical Staff actions shall be for one provisional year in accordance with Article IV, Section C. All other initial appointments to the Medical Staff, and all modifications of

membership status or Clinical Privileges pursuant to Governing Body and Medical Staff actions will be for not more than two years.

2. Reappointment. Reappointment to any category of the Medical Staff shall be for a period of not more than two years.

3. Procedure. Initial appointments and reappointments to the Medical Staff shall be made by the Governing Body. The Governing Body shall act on appointments, reappointments, or revocation of appointments only after there has been a recommendation from the Medical Staff as provided in these Bylaws. In the event the Medical Staff fails to act in 90 days, the Governing Body may act without such recommendation on the basis of documented evidence of the applicant's or Medical Staff member's professional and ethical qualifications obtained from reliable sources other than the Medical Staff.

4. Limitations. Appointment to the Medical Staff shall confer on the appointee only such Clinical Privileges as have been granted by the Governing Body in accordance with these Bylaws.

E. OBSERVATION REQUIREMENT

1. Initial Appointments to the Medical Staff. Except as otherwise determined by the Governing Body, all initial appointments to the Medical Staff shall be subject to a period of observation. Each initial appointee's performance shall be observed by the Medical Director or a committee of the Medical Staff, to determine his eligibility for continued Medical Staff membership and the Medical Staff category to which he was initially appointed and for exercising the Clinical Privileges initially granted. In the case of employment of a Medical Director who is not already a member of the Medical Staff, observation of performance of any medical administrative activities shall be by the Facility Administrator and the President who will provide the necessary statements as required.

2. Focused Professional Practice Evaluation. During the period of observation, appointees will be subject to focused professional practice evaluation. In the case of provisional members of the Medical Staff, the Medical Director or a member of the Medical Staff designated by the Executive Committee will conduct a concurrent or retrospective review of a representative number of cases via the medical record to assure the adequacy of the chart as a medical-legal document, assure the adequacy of the chart for use in patient care evaluation in that the chart properly describes the condition and progress of the patient, review the therapy and tests provided and the results thereof, and assure that the chart is sufficiently complete at all times so as to facilitate continuity of care and communications between all those providing patient care services in the Hospital. In the case of members of the Medical Staff who do not admit patients, focused review will be performed by appropriate committees of the Medical Staff who will review the timeliness and appropriateness of consultations performed. The reviewer(s) will provide the Executive Committee with written evaluations of the applicants' performance. Other methods of evaluating a practitioner's professional practice may also be incorporated into the monitoring plan at the discretion of the Medical Executive Committee, depending on the privileges requested. These methods may include, but are not limited to, monitoring clinical practice patterns, simulation, external peer review, and discussion with other individuals involved in the care of each patient (e.g. consulting physicians, nursing or administrative personnel).

3. Required Documentation. An initial appointee shall remain subject to observation until the following is furnished to the Executive Committee:
    a. A statement signed by the President or his designee, or the Medical Staff committee member assigned as a reviewer that the appointee meets all of the qualifications, has discharged all the responsibilities, and has not exceeded or abused the prerogatives of the Medical Staff category to which he was appointed;

b. a statement signed by the Medical Director or a committee of the Medical Staff, that he has satisfactorily demonstrated his ability to exercise the Clinical Privileges initially granted to him, or that the appointee has not had enough cases to be evaluated, and recommending that the Governing Body, on advice of the Medical Staff, extend the term of the observation period.

4. Modification of Membership Status or Privileges. Any current Medical Staff member who requests a change in Medical Staff category or the granting of additional Clinical Privileges will also be subject to observation in accordance with procedures similar to those for initial appointments.

5. Term of Observation Period. An observation period for initial appointment or for a modification of membership status or Clinical Privileges shall extend for no more than one calendar year from the date of appointment or modification of medial staff category or privileges. If an initial appointee fails within that period to satisfy the requirements of provisional status as outlined in these Bylaws, his Medical Staff membership and/or Clinical Privileges as applicable, shall automatically terminate. If a Medical Staff member requesting modification fails to furnish the required documentation within that period, the change in Medical Staff category or clinical unit assignment, or additional privileges, as applicable, shall automatically terminate. In either case of automatic termination, the affected Practitioner shall not be entitled to the procedural rights in Article VIII hereof.

F. LEAVES OF ABSENCE

1. Leave status. A Medical Staff member may obtain a voluntary leave of absence from the Medical Staff by submitting written notice to the Executive Committee through the Facility Administrator stating the approximate period of time of the leave, which may not exceed two years. During the period of the leave, the Medical Staff member's Clinical Privileges, prerogatives and responsibilities shall be suspended.

2. Termination of Leave. At least 30 days prior to the termination of the leave, or at any earlier time, the Medical Staff member may request reinstatement of his Clinical Privileges and prerogatives by submitting to the Facility Administrator a written notice to that effect, along with a written summary of his activities during the leave, for transmittal to the Executive Committee. The Executive Committee shall make a recommendation to the Governing Body concerning the reinstatement of the member's Clinical Privileges and prerogatives at the termination of the leave. If the recommendation of the Executive Committee is to deny reinstatement, or if the Governing Body, after a receipt of a recommendation from the Executive Committee to grant reinstatement, proposes to deny reinstatement, the Practitioner shall be entitled to the procedural rights as provided in Article VIII as would apply in the instance of an adverse recommendation or action concerning non-reappointment. Failure without good cause, to request reinstatement shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of Medical Staff membership, Clinical Privileges, and prerogatives and shall constitute a waiver of any procedural rights provided in Article VIII hereof. Thereafter, the procedures provided in Article V for appointment shall be followed if the Practitioner wishes to apply again for Medical Staff membership and Clinical Privileges.

ARTICLE IV
CATEGORIES OF THE MEDICAL STAFF

A. THE MEDICAL STAFF

The Medical Staff shall be divided into Active, Provisional, Consulting, Courtesy and Honorary categories.

1. Qualifications Generally. Every Practitioner who seeks or enjoys Medical Staff membership must satisfy, at the time of appointment and continuously thereafter, the basic qualifications set forth in Article III, as well as any additional qualifications that attach to the Medical Staff category to which he seeks appointment or of which he is a member.
2. Limitation on Prerogatives. The prerogatives set forth under Medical Staff categories and for Allied Health Professionals are general in nature and may be subject to limitations by special conditions attached to a Practitioner's Medical Staff membership or to other sections of these Bylaws and by other policies of the Hospital. The prerogatives of dentist and podiatrist members of the Medical Staff are limited to those for which they have demonstrated the requisite level of medical education, training, experience and ability.

B. ACTIVE STAFF

1. Qualifications.
   The Active Staff shall consist of Practitioners each of whom:
   a. Meets the basic qualifications set forth in Article III of these Bylaws;
   b. Has completed, unless specifically exempt, the requirements under the provisional status of these Bylaws and any other Governing Body requirements and has shown satisfactory performance at this level;
   c. Is able to provide continuous care to his patients by living and practicing near the facility and/or providing on-call coverage by another qualified physician member of the medical staff.
   d. Regularly admits to, or is otherwise regularly involved in the care of patients at the Hospital; and
   e. Has qualifications and demonstrates expertise by reason of board certification or eligibility in his appropriate specialty, and/or demonstrated adequate expertise in the management of the facility's patients by training and experience.

2. Prerogatives.
   The prerogatives of an Active Staff member shall be to:
   a. Admit patients in accordance with state law without limitation, unless otherwise provided in the Rules and Regulations;
   b. Exercise such Clinical Privileges as are granted to him pursuant to Article VI;
   c. Vote on all matters presented at general and special meetings of the Medical Staff or committees of which he is a member, unless otherwise provided; and
   d. Hold office in the Medical Staff organization and committees of which he is a member, unless otherwise provided.

3. Responsibilities.

Each member of the Active Staff shall:

a. Meet the responsibilities pertaining to basic obligations of individual Active Staff membership;
b. Retain responsibility within his area of professional competence for the continuous care and supervision of each patient in the Hospital for whom he is providing services, or arrange a suitable alternative for such care and supervision;
c. Contribute to the organizational and administrative affairs of the Medical Staff, faithfully performing the duties of any office or position to which elected or appointed;
d. Participate actively in the patient care audit, utilization review and other quality evaluation and monitoring activities required of the Medical Staff;
e. Discharge the recognized functions of Medical Staff membership by engaging in the Medical Staff's teaching and continuing education programs, services for charity patients as required, giving consultation to other Medical Staff members consistent with his Clinical Privileges, supervising Practitioners during the provisional period, and fulfilling other Medical Staff functions as may reasonably be required of Medical Staff members;
f. Satisfy the requirements set forth in Article XIII (Medical Staff Meetings) for attendance at meetings of the Medical Staff and committees of which he is a member; and
g. Admit a minimum of two patients per year to the Hospital.

C. PROVISIONAL STAFF

1. Qualifications. The Provisional Staff shall consist of Practitioners each of whom:
   a. Meets the qualifications specified in Article IV, Section B. for members on the Medical Staff; and
   b. Is eligible for advancement to Active Staff membership and will in the ordinary course of events, be advanced to Active Staff status after serving the time specified for the provisional period.

2. Observation. Each newly appointed Provisional Staff member shall be observed by the Medical Director or a committee of the Medical Staff during the provisional status period in order to determine his performance and clinical competence in accordance with Article III, Section E.

3. Provisional Period. All initial appointments to the Medical Staff, except Consulting and Honorary, shall be Provisional. The provisional period shall not exceed one calendar year from the date of appointment, at which time the failure to advance an appointee from Provisional to Active Staff status shall be a termination of his Medical Staff appointment.

4. Prerogatives. The prerogatives of a Provisional Staff member shall be to:
   a. Admit patients to the Hospital under the same conditions as specified for Active Staff members;
   b. Exercise such Clinical Privileges as are granted to him pursuant to Article VI;
   c. Attend meetings of the Medical Staff and any Medical Staff or Hospital education programs; and
   d. Vote on all matters presented at meetings of the Medical Staff committees of which he is a member, under the same limitations as may be established for Active Staff members. Provisional Staff members are not eligible to hold office in the Medical Staff organization, to vote at general and special meetings of the Medical Staff or to chair any committee.

5. Responsibilities. Each member of the Provisional Staff is required to discharge the same

responsibilities as those specified for members of the Active Staff. Failure to fulfill these obligations is grounds for denial of advancement to Active Staff status.

Each member of the Provisional Staff is required to admit at least two patients in the provisional time period to allow appropriate clinical review and performance improvement review, as well as to meet observation requirements set forth in Article III, Section E.

D. CONSULTING STAFF

1. Qualifications.

   Consulting Staff shall consist of Practitioners each of whom must:

   a. meet the basic qualifications set forth in Article III.

   b. be recognized by the medical community as an authority within his specialty.

2. Prerogatives.

   Prerogatives of a Consulting Staff member shall be to:

   a. Consult on patients by invitation of an Active Staff member; and

   b. Attend by invitation all such meetings that he may wish to attend as a non-voting member. Consulting Staff members will not admit patients to the Hospital nor be the provider of record to any patient within the Hospital. Consulting Staff shall not hold office or be eligible to vote.

3. Responsibilities.

   Consulting Staff responsibility shall be limited solely to consultation rendered and ramifications thereof.

4. Consulting Staff by Contractual Agreement.

   a. Some members of the Consulting Staff may be required through contractual agreement to act as clinical director of a specified program based on his knowledge, experience, certification or eligibility for certification that he be recognized as an authority within his specialty.

   b. Duties of this category may include, but not be limited to; clinical direction of a program with approval by the Medical Staff and the Governing Body; participation in licensure and accreditation surveys, formulation of reports, synthesis of documents; performance improvement, safety, and development of policies and procedures regarding patient sensitive issues and consultation with the Medical Staff within that program; and serving as ex-officio-non-voting members of Hospital ad hoc committees to enhance patient care and orderly operation of the Hospital.

E. COURTESY STAFF

1. Qualifications.

   The Courtesy Staff shall consist of Practitioners, each of whom:

   a. Meets the basic qualifications set forth in Article III;

   b. Is located closely enough to the Hospital or otherwise arranges to provide continuous care to his/her patients;

   c. Admits not more than two patients per year to the Hospital; and

   d. Is a member of the active or provisional staff of another hospital where he/she actively participates in a patient care audit program and other quality maintenance activities similar to those required of the Active Staff.

2. Prerogatives.

Prerogatives of a Courtesy Staff member shall be to:

a. Admit patients to the Hospital within the limitations and under the same conditions as specified for Active and Provisional Staff members. At time of full Hospital occupancy or of shortage of beds or other facilities, as determined by the Medical Director, the admitting privileges of Courtesy Staff members shall be subordinate to those of Active and Provisional Staff members;

b. Exercise such clinical privileges as are granted to him/her pursuant to Article VI; and

c. Attend meetings of the Medical Staff and any Staff or Hospital or clinic education program upon request.

3. Ineligibility.

Courtesy Staff members shall not be eligible to vote or to hold office in the Medical Staff organization.

4. Responsibilities.

Each member of the Courtesy Staff shall be required to discharge the basic responsibilities specified in Article III, and further, shall retain responsibility within his/her area of professional competence for the care and supervision of each patient in the Hospital for whom he/she is providing services, or arrange a suitable alternative for such care and supervision

F. HONORARY STAFF

1. Qualifications.

The Honorary Staff shall consist of Practitioners recognized for their outstanding reputations, their noteworthy contributions to health care and medical sciences, or their previous long-standing service as members of the Medical Staff.

2. Prerogatives.

Honorary Staff members are not eligible to admit patients to the Hospital or to exercise Clinical Privileges within the Hospital. They may, however, attend Medical Staff meetings and any Medical Staff or Hospital education meetings. Honorary Staff members shall not be eligible to vote or hold office in the Medical Staff organization.

3. Responsibilities.

Each member of the Honorary Staff shall be required to discharge the basic responsibilities specified in Article III with reference to conforming to generally recognized standards of professional ethics.

G. ALLIED HEALTH PROFESSIONALS

1. Qualifications.

Allied Health Professionals (AHPs) holding a license, certificate or such other legal credentials, if any, as required by Texas law, which authorize the AHPs to provide certain professional services, are not eligible for Medical Staff membership. Such AHPs are eligible for Clinical Privileges in the Hospital only if they:

a. Hold a license, certificate or other legal credential as a Psychologist, Nurse Practitioner, Licensed Master Social Worker, Licensed Professional Counselor, or Physician's Assistant;

b. Document their experience, background, training, demonstrated ability, judgment, and physical and mental health status with sufficient adequacy to demonstrate that any patient treated by them will receive care of the generally recognized professional level of quality

and efficiency established by the Hospital, and that they are qualified to exercise privileges within the Hospital;

c. Are determined, on the basis of documented references, to adhere strictly to the lawful ethics of their respective professions; to work cooperatively with others in the Hospital setting; and to be willing to commit to and regularly assist the Hospital in fulfilling its obligations related to patient care within the areas of their professional competence and credentials; and

d. Have appropriate malpractice insurance as determined by the Governing Body.

2. Delineation of Categories of AHPs Eligible to Apply for Clinical Privileges. For each of the eligible AHP categories listed above, the Governing Body shall identify the Clinical Privileges and prerogatives that may be granted to qualified AHPs in that category. The Governing Body shall secure recommendations from the Medical Staff as to the Clinical Privileges, prerogatives, terms and conditions which may be granted and apply to those categories and the Clinical Privileges, prerogatives, terms and conditions for each such AHP category, when approved by the Executive Committee and the Governing Body, shall be set forth in the Rules and Regulations.

3. Procedures for Granting Clinical Privileges. An AHP must apply and qualify for Clinical Privileges. Practitioners who desire to supervise or direct AHPs to provide dependent services must apply and qualify for privileges to supervise approved AHPs. Applications for initial granting of Clinical Privileges and renewal thereof, shall be submitted and processed in a parallel manner to that provided in Articles VI and VII for Practitioners unless otherwise specified in the Rules and Regulations. An AHP who has a license or certification in an AHP category other than those identified as eligible for Clinical Privileges in the manner required by Article VI, Section J, Paragraph 2 above may not apply for Clinical Privileges, but may submit a written request to the Facility Administrator asking that the Executive Committee consider and recommend to the Governing Body that such category be eligible to apply for Clinical Privileges. An AHP who belongs to a field of practice for which there is no licensure or certification may submit a written request to the Facility Administrator, asking that the Executive Committee consider and recommend to the Governing Body that such AHP be eligible to apply for Clinical Privileges. The Governing Body shall consider such request either before or at the time of its next routine review of the categories of AHPs. Each AHP, unless otherwise specified in the Rules and Regulations, shall be subject to terms and conditions paralleling those specified in Article III, as they may logically be applied to AHPs and appropriately tailored to the particular AHP's profession.

4. Prerogatives - The prerogatives, which may be extended to an AHP shall be defined in the Rules and Regulations or Hospital policies; such prerogatives may include provision of specified patient care services under the supervision or direction of a physician, dentist, or podiatry member of the Medical Staff and consistent with the practice privileges granted to the AHP and within the scope of the AHP's licensure or certification;

5. Responsibilities

Each AHP shall:

a. Meet those responsibilities specified in the Rules and Regulations, and if not so specified, meet those responsibilities specified in Article III, Paragraph B as are generally applicable to more limited practice of the AHP:

b. Retain appropriate responsibility within his area of professional competence for the care and supervision of each patient in the Hospital for whom he is providing services;

c. Be involved in patient care audit and other quality review, evaluation, and monitoring activities appropriate to AHPs.

6. Physician Assistants

Physician Assistants will apply for Clinical Privileges as indicated above and using the same procedures for appointment and reappointment to the Medical Staff as identified for Medical Staff applicants in Article V, VI. A Physician Assistant has the same procedural rights on initial application and on modification or revocation of Clinical Privileges as granted to physician members of the Medical Staff. Procedures in Article VII, Corrective Action, and Article VIII, Hearing and Appellate Review will apply to Physician Assistants.

Under direct physician supervision, the Physician Assistant may:

a. Admit and discharge patients.

b. Elicit a medical history, perform an appropriate physical exam, and record this data in the patient's medical records.

c. Transmit physician orders in the medical records for lab tests, therapeutic interventions, medications, and consultations by signing such orders "V/O Dr.________/________, PA-C". The physician will countersign such orders, with the exception of orders for outpatient therapy.

d. Assist in making Hospital rounds, attend patient conferences and Medical Staff meetings as directed by his supervising physician.

Prior to services being provided by a Physician Assistant, the patient will sign a consent form agreeing to such services limited to the specific Clinical Privileges delineated in the initial application. Physician Assistants will initially be granted clinical privileges on a provisional basis for a period of one year, before advancement to an active status.

ARTICLE V
PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

A. GENERAL PROCEDURE

The Medical Staff shall investigate and consider each application for appointment or reappointment to the Medical Staff and each request for modifications of Medical Staff membership status or Clinical Privileges and shall transmit recommendations thereon to the Governing Body.

B. APPLICATION FOR INITIAL APPOINTMENT

1. Application Form. Each application for appointment to the Medical Staff shall be in writing, submitted on a form prescribed by the Governing Body after consultation with the Medical Staff. Each application for Medical Staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgment of every Medical Staff member's obligation to provide continuous care and supervision of his patients, to abide by these Bylaws and the Rules and Regulations, to accept committee assignments, and to accept consultation assignments. When a Practitioner requests an application form he shall be given a copy of these Bylaws and the Rules and Regulations and summaries of other Hospital and Medical Staff policies relating to clinical practice in the Hospital.

2. Content. The application form shall include:

a. A statement that the applicant has received and read the Bylaws and the Rules and Regulations and the applicable policies and procedures of the Hospital (or summaries thereof) and that applicant agrees to be bound by the terms thereof if applicant is granted Medical Staff status and/or Clinical Privileges, and to be bound by the terms thereof in all matters relating to consideration of applicant's application without regard to whether or not the application is granted.

b. Detailed information concerning the applicant's qualifications, including, without being limited to, information confirming satisfaction of the basic qualifications specified in Article III herein.

c. A statement whereby the applicant agrees that, if an adverse ruling is made with respect to his Medical Staff status and/or Clinical Privileges requested, he will exhaust the administrative remedies afforded by these Bylaws before resorting to legal action.

d. Statements notifying the applicant of the scope and extent of the authorization, confidentiality, immunity and release provisions of these Bylaws.

e. Evidence, as required by the Hospital, for example, a photograph, that the applicant is the person named in the application.

C. EFFECTIVE APPLICATION

1. Content. By applying to the Medical Staff, each applicant:

a. Signifies his willingness to appear for interviews in regard to his application;

b. Authorizes Hospital representatives to consult with others who have been associated with him and/or who may have information bearing on his competence and qualifications, whether or not such other persons are listed as references by the applicant; and authorizes such persons consulted with to provide such information;

c. Consents to the inspection by Hospital representatives of all records and documents that may in the reasonable opinion of any Hospital representative be material to an evaluation of the applicant's professional qualifications and ability to carry out the Clinical Privileges requested and professional ethical qualifications for Medical Staff membership;

d. Releases from liability all Medical Staff and Hospital representatives for their acts performed without malice in connection with evaluating the applicant and applicant's credentials;

e. Releases from liability all individuals, corporations and organizations who provided information, including otherwise privileged or confidential information, to the Hospital and Hospital representatives, without malice, concerning the applicant's ability, training, experience, background, professional ethics, character, physical and mental health, emotional stability and other qualifications for the requested Medical Staff status and Clinical Privileges;

f. Authorizes and consents to Hospital representatives providing other hospitals, professional associations and other organizations concerned with provider performance and the quality and efficiency of patient care with any information the Hospital may have concerning applicant, and releases the Hospital and hospital representatives from liability for so doing, providing that such furnishing of information is done without malice; and

g. Represents and warrants that all information provided by applicant is true, correct and complete in all material respects, and agrees to notify Hospital of any change in any of the information furnished to the Hospital in the application.

2. Representatives. For purposes of this Section, the term Hospital representative includes the Governing Body, its members and committees; the Chief Executive Officer, the Facility Administrator, and all Medical Staff members, and committees which have responsibility for collecting or evaluating the applicant's credentials or acting upon the application, and any authorized representative of any of the foregoing.

D. PROCESSING THE APPLICATION

1. Applicant's Burden. The applicant shall have the burden of producing adequate information for a proper evaluation of his experience, background, training, demonstrated ability to perform Clinical Privileges being requested and professional ethics, and upon request of the President, physical and mental health status, and of resolving any doubts about these or other basic qualifications specified in these Bylaws and of satisfying any reasonable request for information or clarification (including health examinations) made by appropriate Medical Staff or Hospital representatives. The withholding of requested information, or the providing of false or misleading information, shall, in and of itself, constitute a reason for denial of Medical Staff appointment.

2. Verification of the Information. The applicant shall deliver a completed application to the Facility Administrator or designee, who shall, in timely fashion, seek to collect or verify the references, licensure and other qualification evidence submitted, and to query the National Practitioner Data Bank. The Facility Administrator shall promptly notify the applicant of any problems in obtaining the information required and it shall then be the applicant's obligation to obtain the required information. When the collection and verification is accomplished, the Facility Administrator shall transmit the application and all supporting materials to the Executive Committee.

3. Executive Committee Action. The Executive Committee shall review the application, the supporting documentation, and other relevant information available to it. The Executive Committee may, in its discretion, conduct an interview with the applicant. This interview shall not constitute a hearing and none of the procedural rules provided in these Bylaws with respect to a hearing shall apply. The Executive Committee shall transmit to the Governing Board its written reports and recommendations as to approval or denial of, and any special limitations on, Medical Staff appointment, category of Medical Staff membership and prerogatives, and the scope of Clinical Privileges. If the Executive Committee requires further information about an applicant, it may defer transmitting its report until such information has been obtained. In case of deferral, the Executive Committee shall notify the applicant and the Facility Administrator in writing of the deferral and the reasons for it. Action to defer the application for further consideration must be followed up within 45 days by the written report described in this provision.

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

4. Effect of Executive Committee Action
   a. Favorable Recommendation: When the Executive Committee recommendation is favorable to the applicant, the Facility Administrator shall promptly notify the Governing Body for consideration at its next regularly scheduled meeting. The Governing Body may, in its discretion, review applications and supporting materials of any applicant. All supporting documentation shall include the application form and its accompanying information and the Executive Committee recommendations and reports.

b. Adverse Recommendation: When the Executive Committee recommendation is adverse to the applicant, the Facility Administrator shall give prompt written notice to the applicant by delivery either in person or by certified mail, return receipt requested, and the applicant shall then be entitled to such procedural rights as are provided for in Article VIII hereof. An adverse recommendation is defined as a recommendation to deny appointment, requested Medical Staff category, or requested Clinical Privileges, except that in the circumstance in which the applicant accepts the limitation, reduction or denial which otherwise is deemed adverse, such acceptance converts the adverse recommendation to a favorable recommendation, which shall be forwarded as provided in Section 5 (a) above.

6. Governing Body Action. Only the Governing Body has the power to take final action on an application for Medical Staff membership or Clinical Privileges. The fact that the Executive Committee has made a favorable recommendation shall not be deemed to confer Clinical Privileges where none existed before. The Governing Body's action at its next regularly scheduled meeting following the receipt of the report of the Executive Committee shall be in conformance with the following procedures:

a. On Favorable Executive Committee Recommendation: The Governing Body may, in whole or in part, adopt or reject a recommendation of the Executive Committee or refer the matter back to the Executive Committee for further consideration stating the reasons for such referral and setting a time limit in which a subsequent recommendation shall be made. If the Governing Body's action is adverse to the applicant as defined above in Section 5 (b), the Facility Administrator shall give prompt written notice to the applicant by delivery either in person or by certified mail, return receipt requested, and the applicant shall be entitled to the procedural rights provided in Article VIII.

b. Without Benefit of Executive Committee Recommendation: If the Governing Body does not receive an Executive Committee recommendation within a reasonable period of time, it may, after notifying the Executive Committee and after full investigation of all previous actions and determination that further delay is not justified, take action on its own initiative. If such action is favorable, it shall become effective as the final decision of the Governing Body. If such action is adverse, the Facility Administrator shall give prompt written notice to the applicant by delivery either in person or by certified mail, return receipt requested, and the applicant shall be entitled to the procedural rights provided in Article VIII hereof.

c. After Procedural Rights: In the case of an adverse Executive Committee recommendation pursuant to Article V, Section D, 5 (b) or an adverse first Governing Body decision pursuant to Article V, Section D, 6 (b), the Governing Body shall take final action in the matter after the applicant has exhausted or waived procedural rights as provided in Article VIII hereof. Action thus taken shall be the conclusive decision of the Governing Body.

7. Notice of Final Decision. Following the Governing Body's final decision, the Facility Administrator shall notify the applicant and Executive Committee. Such notice shall include the Medical Staff category to which the applicant is appointed, the Clinical Privileges the applicant may exercise, and any special conditions attached to the appointment.

8. Time Periods for Processing. All individuals and groups required to act on an application for

Medical Staff membership should do so in a timely manner consistent with their obligations to the orderly operation of the Hospital and the best interests of patient care. Absent some mitigating factor, ordinarily each completed application should be processed within the following time periods:

Individual and Group	Time
Executive Committee	Within 90 days of receipt of application
Governing Body Action	Within 90 days of Executive Committee Action
Facility Administrator Notification to Applicant	Within 10 days of Governing Body Action

These time periods are merely guidelines designed to assist those named in accomplishing their tasks. Consequently, they shall not be deemed to create any right for the applicant to have an application processed within these periods. If the provisions of Article VIII are activated, the time requirements provided therein shall govern the continued processing of the application.

9. Reapplication After Adverse Appointment Decision. An applicant who has received a final adverse decision regarding appointment or privileges shall not be eligible to reapply to the Medical Staff for a period of one-year following such adverse action. Any such reapplication following the one year period shall be processed as an initial application, and the applicant shall submit such additional information as the Medical Staff or Governing Body may require to demonstrate that the basis for the earlier adverse action no longer exists.

E. REAPPOINTMENT PROCESS

1. Reappointment Generally. Only the Governing Body has the power to take final action on reappointment to Medical Staff membership and renewal of Clinical Privileges. The fact that a Practitioner has had Medical Staff membership or Clinical Privileges in the past or that the Executive Committee and Community Advisory Board have made a favorable recommendation shall not be deemed to renew Medical Staff membership or Clinical Privileges in the absence of action by the Governing Body.

2. Application for Reappointment. The Facility Administrator shall, at least 6 months prior to the expiration date of the present Medical Staff appointment of each Medical Staff member, provide such Medical Staff member with a reappointment application form prescribed by the Governing Body. Each Medical Staff member who desires reappointment shall, at least 5 months prior to such expiration date, send his reappointment application to the Facility Administrator. Such reappointment application will contain, at a minimum the following information:
   a. Complete information to update the applicant's file on the items listed in Section B Article V;
   b. Documentation of satisfactory completion of continuing education requirements as may be imposed by law or the Medical Staff. The CME requirement for Medical Staff members shall be that of the Texas State Board of Medical Examiners.
   c. Request for additional Clinical Privileges must be supported by the type and nature of evidence, which would be necessary for such privileges to be granted in an initial application for the same.
   d. Any request for changes in Medical Staff category.

3. Failure to Reapply. Failure without good cause to return the form or to adequately complete the form, shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of membership and Clinical Privileges at the expiration of the member's current term. A Practitioner whose membership is so terminated is entitled to the procedural rights provided in Article VIII hereof for the sole purpose of determining the issue of good cause for failure to reapply.

4. Verification of Information. The Facility Administrator shall verify additional information submitted by the Medical Staff member and shall notify the Medical Staff member of any information, inadequacies or verification problems. The Medical Staff member shall then have the burden of producing adequate information and resolving any doubts concerning the information.

   The Facility Administrator shall collect for each Medical Staff member's credentials file all relevant information regarding the individual's professional and collegial activities, performance and conduct in this Hospital. Such information shall include without limitation: a query of the National Practitioner Data Bank, patterns of care as demonstrated in the findings of performance improvement activities, participation in relevant internal teaching and continuing education activities, timely and accurate completion of medical records, and compliance with these Bylaws, the Rules and Regulations and policies and procedures of the Hospital. When such collection and verification are accomplished, the Facility Administrator shall transmit the information form and supporting materials to the Executive Committee for review.

5. Executive Committee and Community Advisory Board Action. The Executive Committee and Community Advisory Board shall review the member's file and all other relevant information available to it and forward to the Governing Body a written report with recommendations for reappointment or non-reappointment and for Medical Staff category and Clinical Privileges.

6. Final Processing and Governing Body Action. Thereafter, the procedure provided in Article V, Section D (5-8) shall be followed. For purposes of reappointment, the terms "applicant" and "appointment" as used in those sections shall be read, respectively, as "Medical Staff member" and "reappointment".

7. Basis for Recommendations. Each recommendation concerning the reappointment of a Medical Staff member and the Clinical Privileges to be granted upon reappointment shall be based upon documented evidence of such members professional ability and clinical judgment in the treatment

of patients; his professional ethics; discharge of Medical Staff obligations; compliance with these Bylaws, the Rules and Regulations and policies and procedures of the Hospital; cooperation with Hospital personnel and other Practitioners and with patients; and other matters bearing on his ability and willingness to contribute to high quality patient care in the Hospital.

F. REQUESTS FOR MODIFICATION OF MEMBERSHIP STATUS OR PRIVILEGES

A Medical Staff member may, in connection with reappointment or at any other time, request modification of his Medical Staff category or Clinical Privileges by submitting a letter to the Executive Committee giving his reasons for making such a request, after consultation with the Medical Staff. The requester shall provide sufficient evidence of clinical competence for any additional privileges being requested. A modification application is processed in the same manner as a reappointment application.

G. EXPEDITED CREDENTIALING AND PRIVILEGING PROCESS

An expedited credentialing and privileging process may be used for initial appointments and reappointments and when granting privileges when certain criteria are met. To expedite initial appointments to membership and granting of privileges, reappointments to membership, or renewal or modification of privileges, the governing body may delegate authority to a committee of at least two voting members of the governing body. An applicant for privileges is eligible for the expedited process only if: there is verification of current licensure, relevant training or experience, current competence, ability to perform the clinical privileges requested, professional liability coverage in the required amounts, and favorable results of a National Practitioner Data Bank query. The applicant must also have a complete application, no current or previously successful challenges to licensure or registration, shall not have been subject to involuntary termination of medical staff membership at another institution, and shall not have been subject to any involuntary limitation, denial, or loss of clinical privileges. Any applicant for whom the hospital determines there has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant will be ineligible for the expedited process. Any applicant for whom the Medical Executive Committee makes a final recommendation that is adverse or has limitations is not eligible for the expedited process.

ARTICLE VI
CLINICAL PRIVILEGES

A. EXERCISE OF PRIVILEGES

Every Practitioner providing clinical services at the Hospital by virtue of Medical Staff membership or otherwise shall, in connection with such practice and except by otherwise provided in Section G. of this Article, be entitled to exercise only those Clinical Privileges specifically granted to the Practitioner by the Governing Body. Such Clinical Privileges must be within the scope of the license, certificate or other legal credentials authorizing Practitioner to practice in this state and shall be consistent with any restrictions thereon. Regardless of the level of Clinical Privileges granted, each Practitioner must obtain consultation when necessary for the safety of the Practitioner's patients or when required by the Rules and Regulations or other policies of the Medical Staff or by policies or procedures of the Hospital.

B. DELINEATION OF PRIVILEGES IN GENERAL

1. Request. Each application for appointment and reappointment to the Medical Staff must contain a request for the specific Clinical Privileges desired by the applicant. Request by a Medical Staff member pursuant to Article V Section F for modification of Clinical Privileges must be supported by documentation of additional training and/or experience supporting the request.

2. Basis for Privileges Determination. Requests for Clinical Privileges shall be evaluated on the basis of the Practitioner's education, training, experience, demonstrated competence, ability, and judgment, references and other relevant information. The basis for privileges determination to be made in connection with periodic reappointment or otherwise shall include observed clinical performance, whether the frequency of exercise of Clinical Privileges is sufficient to indicate current proficiency, and the documented results of the performance improvement/utilization management program and other quality review, evaluation and monitoring activities required to be conducted at the Hospital. Privileges determination shall also be based on pertinent information concerning clinical performance obtained from other sources, including but not limited to, other health care facilities where a Practitioner exercises clinical privileges. This information shall be added to and maintained in the credentials file established for each Medical Staff member.

3. Determination of Resource Availability. Prior to granting any requested privilege, the Medical Staff will determine that the necessary resources (including space, equipment, staffing, and financial resources) to support the privilege are currently available, or will be available within a specified time frame. This time frame will not exceed six months from the date the privilege was granted. If the Practitioner requests a privilege that is not delineated on the privilege form for his or her specialty, and/or for which no approved criteria exist (such as a new technology), the privilege will not be granted until the hospital and medical staff leadership have first evaluated whether or not the institution may offer the requested clinical service or procedure. The governing body has final approval regarding whether it will allow the specific procedure or provide the clinical service. The burden is on the applicant interested in performing the procedure or using the new technology to provide sufficient information to the MEC about resources, space, equipment, and types of personnel etc. necessary to support the new procedure or technology. Once the MEC has received this preliminary information, it will conduct its own due diligence and will forward its recommendations to the governing body. If a determination is made that the new technology or procedure will be offered, the MEC, or a designated subcommittee, will develop and recommend appropriate criteria for practitioners (training, education, and experience required) to the governing body. Once the board approves the criteria, the applicant may apply against the established criteria and any subsequent requests for the privilege will be processed accordingly. If a determination is made not to allow a specific procedure or technology, the applicant is notified that that particular service or procedure is not permitted in the institution. A decision regarding whether or not to allow the new privilege or technology will be made and communicated to the applicant requesting it within 180 days of the request.

4. Procedure. All requests for Clinical Privileges shall be processed pursuant to the procedures outlined in Article V.

C. SPECIAL CONDITIONS FOR DENTAL PRIVILEGES

Requests for Clinical Privileges from dentists shall be processed in the same manner specified in Article V. The scope and extent of procedures that each dentist may perform shall be specifically delineated and granted in the same manner as all other Clinical Privileges. Procedures performed by dentists shall be under the overall supervision of a designated physician Medical Staff member. The physician will state the specific service required of the dentist. When a dentist determines additional services are needed, a request from the attending physician can be initiated. Dentists will be able to write orders and make reports in progress notes of patients' medical records and are responsible for the part of the record that relates to dentistry.

D. SPECIAL CONDITIONS FOR PODIATRIC PRIVILEGES

Requests for Clinical Privileges from a podiatrist shall be processed in the manner specified in Article V. A podiatrist will be under the direct supervision of a physician member of the Medical Staff requesting the services. The scope and extent of procedures that each podiatrist may perform shall be specifically delineated and granted in the same manner as all other Clinical Privileges. The physician will state the specific service required of the podiatrist. When a podiatrist determines additional services are needed, a request from the attending physician can be initiated. Podiatrists will be able to write orders and make reports in progress notes of patients' medical records and are responsible for the part of the record that relates to podiatry.

E. SPECIAL CONDITIONS FOR APPROVED ALLIED HEALTH PROFESSIONAL SERVICES

Requests to perform specified patient care services from approved allied health professionals shall be processed in the manner specified in this Article. All allied health professionals are considered to be dependent individuals subject to any licensure requirements or other legal limitations, who exercise judgment within the areas of their professional competence; however, with regard to management of a patient in the Hospital, they participate directly with and are under the supervision of the physician member of the Medical Staff who has been accorded Clinical Privileges to provide such care and who has ultimate responsibility for the patient's care.

F. TEMPORARY PRIVILEGES

1. Circumstances. Upon the written concurrence of the President of the Medical Staff or his/her designee, the Facility Administrator may grant temporary admitting and/or Clinical Privileges in the following circumstances:

    a. Pendency of application: When a new applicant for Medical Staff membership or Clinical Privileges is waiting on a review and recommendation by the Executive Committee and approval by the Governing Body, temporary Clinical Privileges may be granted for a limited period of time not to exceed 120 days, provided there is verification of current licensure, relevant training or experience, current competence, ability to perform the Clinical Privileges requested, professional liability insurance coverage in the required amounts, and favorable results of a National Practitioner Data Bank query. The applicant must also have a complete application, no current or previously successful challenges to licensure or registration, shall not have been subject to involuntary termination of medical staff membership at another institution, and shall not have been subject to any involuntary limitation, reduction, denial, or loss of clinical privileges.

    b. To Fulfill an Important Patient Care Need: Upon written request for specified temporary Clinical Privileges, a Practitioner may be granted temporary Clinical Privileges on a case by case basis when there is an important patient care need that mandates an immediate authorization to practice, for a limited period of time, while full credentials information is verified and approved. In these circumstances, temporary Clinical Privileges will be granted only after verification of current licensure and current competence. Examples would include, but are not limited to: a situation where a physician becomes ill or takes a leave of absence and a Practitioner would need to cover his practice until he returns; a specific Practitioner has the necessary skills to provide care to a patient that another Practitioner currently privileged does not possess.

2. Special Requirements. Requirements of consultation and reporting may be imposed by the Medical Staff member responsible for the supervision of a Practitioner granted temporary Clinical Privileges. Before temporary Clinical Privileges are granted, the Practitioner must acknowledge in

writing to abide by these Bylaws, the Rules and Regulations, and the Hospital's policies and procedures in all matters relating to his temporary Clinical Privileges.

3. Termination. Upon discovery of any information or the occurrence of any event the nature of which raises a question about a Practitioner's professional qualifications or ability to exercise any or all of the temporary Clinical Privileges granted, the Facility Administrator, or the President of the Medical Staff may terminate any or all of such Practitioner's temporary Clinical Privileges. When the life or well being of a patient is determined to be endangered by continued treatment by the Practitioner, the termination may be effected immediately by any person entitled to impose summary suspension under Article VII. In the event of any such termination, the Practitioner's patients then in the Hospital shall be assigned to another Practitioner by the Medical Director or President of the Medical Staff, or Medical Staff member responsible for his supervision. The wishes of the patient shall be considered where feasible in choosing the substitute Practitioner.

4. Rights of a Practitioner with Temporary Clinical Privileges. Temporary Clinical Privileges granted under this Article are for the purpose of accommodating special temporary needs of Practitioners or their patients. Accordingly, neither the refusal to grant temporary Clinical Privileges nor the modification or termination of temporary Clinical Privileges shall entitle an affected Practitioner to a hearing or appeal under Article VIII of these Bylaws.

G. EMERGENCY PRIVILEGES

In case of an emergency in which serious permanent harm or aggravation of an injury or disease is imminent, or in which the life of a patient is in immediate danger and any delay in administering treatment could add to that danger, any Medical Staff member is authorized to the degree permitted by his license, and should be assisted to do everything possible to save the patient's life or to save the patient from serious harm, using every facility of the Hospital necessary including the calling for any consultation necessary or desirable, but regardless of Medical Staff category or level of Clinical Privileges. When an emergency situation no longer exists, such Medical Staff member must request the Clinical Privileges necessary to continue to treat the patient. In the event such Clinical Privileges are denied or the Practitioners does not desire to request them, the patient shall be assigned to an appropriate member of the Medical Staff.

H. DISASTER PRIVILEGES

1. Circumstances. When the Emergency Management Plan has been activated, the Administrator or President of the Medical Staff or his/her designee may grant Disaster Privileges to volunteer practitioners who are not members of the Medical Staff. The credentials verification process for Disaster Privileges is given the highest priority and is identical to the process established for granting Temporary Privileges to meet an important patient care need as established in Article VI, F.b. The Medical Staff, in conjunction with the hospital, establishes written procedures for identifying, granting privileges and managing licensed independent practitioners granted Disaster Privileges.

ARTICLE VII
CORRECTIVE ACTION

A. PURPOSE

The purpose of this Article is to provide for action whenever there are grounds to suspect that a Practitioner with Clinical Privileges has engaged in, made or exhibited acts, statements, demeanor or personal or professional conduct, either within or outside the Hospital which is, or is reasonably likely to be:

1. detrimental to patients' safety or to efficient delivery of quality patient care in the Hospital;
2. lower than the standards of the Medical Staff;
3. disruptive to the operation of the Hospital; or
4. in violation of these Bylaws or the Rules and Regulations, or policies or procedures of the Hospital.

In the event that a Medical Staff member is found to be unable to perform any or all of the Clinical Privileges granted him due to physical, psychiatric, or emotional illness, the matter will be referred to the Medical Executive Committee to be managed separately from the Medical Staff disciplinary functions, and according to policies established by the Governing Body.

B. REVOCATION OF MEMBERSHIP AND SUSPENSION OR REVOCATION OF PRIVILEGES

1. Criteria for Initiation. Whenever there is reason to believe that the activities or professional conduct of any Practitioner with Clinical Privileges warrants corrective action, such corrective action may be initiated by any Medical Director, the Chief Executive Officer, the Facility Administrator or the Governing Body. Initiation of corrective action pursuant to this Section does not preclude imposition of summary suspension as provided for in Section C below, nor does it require the prior imposition of such suspension.

2. Requests and Notices. All requests for corrective action shall be in writing, submitted to the Executive Committee and supported by reference to the specific conduct or activities which constitute the grounds for the request. The President shall promptly notify the Facility Administrator of the request for corrective action received by the Executive Committee and shall continue to keep him fully informed of all actions taken in connection therewith.

3. Investigation. After consideration of the request, the Executive Committee shall either reject the request and report the reasons for its decision to the Facility Administrator or appoint an ad hoc committee to conduct an investigation. The investigating committee may name such non-voting advisory members to assist in its investigation as it deems necessary. The Medical Staff member who is under investigation may be invited to discuss his alleged conduct with the investigating committee. Any such appearance shall be informal in nature and shall not constitute a hearing, and none of the procedural rules provided in Article VIII with respect to hearings shall apply. Within 30 days after the receipt of the request, the investigating committee shall forward a written report of the investigation to the Executive Committee.

4. Executive Committee Action. Within 30 days following receipt of the investigating committee report, the Executive Committee shall take action upon the request. Such action may include, without limitation:
   a. A finding clearing the Practitioner of the charges against the Practitioner;
   b. A warning, a letter of admonition, or a letter of reprimand to the Practitioner;
   c. A recommendation for terms of probation or requirements for consultation or direct supervision that do not include an actual limitation on, or reduction of the Medical Staff member's Clinical Privileges;
   d. A recommendation for a term of probation, reduction, suspension or revocation of Clinical Privileges;
   e. A recommendation for change in Medical Staff category or limitation of any Medical Staff prerogatives directly related to patient care;
   f. A recommendation for suspension or revocation of Medical Staff membership.

5. Governing Body. When the Executive Committee, after review of a report of investigation or after review of summary suspension imposed pursuant to Section C, 1, determines that no corrective action be taken, the Medical Director shall report such determination to the Governing Body. The Governing Body, in its discretion, may appoint a committee to conduct an investigation of the conduct that serves as the basis for the request for corrective action and, after receipt of the report of the investigation, take any such action as is set forth in Section B, 4.

6. Entitlement of Procedural Rights. Any action by the Executive Committee pursuant to Section B, 4, (d) (e) or (f), or any combination of such actions, or action by the Governing Body pursuant to Section B, 5, shall entitle the Medical Staff member to the procedural rights as provided in Article VIII, and the matter shall be processed in accordance with Article XV.

7. Re-evaluation and Probation. In the event that the action of the Executive Committee is to impose terms of probation, the committee shall reevaluate its action and the performance of the Practitioner under the terms of the probation within a time prescribed by it, but, in no event longer than six months from its initial action, it shall take such further action including extending the period of probation, as is then appropriate.

C. SUMMARY SUSPENSION

1. Summary Suspension Generally. Whenever a Medical Staff member willfully disregards or grossly violates these Bylaws, the Rules and Regulations, Hospital policies or procedures or his conduct requires that immediate action be taken to protect the life of any patient(s) or to reduce the substantial likelihood of immediate injury or damage to the health or safety of any patient, employee, or other person present in the Hospital, or the conduct of the Medical Staff member materially disrupts the operation of any department or unit of the Hospital, the Medical Director, Facility Administrator, or the Chief Executive Officer shall each have the authority to summarily suspend the Medical Staff membership status or all or any portion of the Clinical Privileges of such Medical Staff member or allied health professional. Such summary suspension shall become effective immediately upon imposition, and the officer or committee that imposes the suspension shall notify the Facility Administrator of such action. The Facility Administrator shall promptly give special notice of the suspension to the Medical Staff member and to the Executive Committee if it has not imposed the suspension.

2. Provision for Patient Care. Immediately upon the imposition of summary suspension, the President shall have the authority to provide for alternative medical coverage for the patients of the suspended Practitioner still in the Hospital at the time of such suspension. The wishes of the patient shall be considered in the selection of such alternative Practitioner.

3. Executive Committee Action. As soon as reasonably possible after such summary suspension, a meeting of the Executive Committee shall be convened to review and consider the action taken. The Executive Committee shall recommend to the Governing Body modification, continuation, or termination of the terms of the summary suspension.

4. Procedural Rights. Unless the Executive Committee recommends immediate termination of the suspension and cessation of all further corrective action, the Medical Staff member shall be entitled to the procedural rights provided in Article VIII, and, the matter shall be processed in accordance with the provision of Article XV. If the Executive Committee recommends termination of the suspension and cessation of all further corrective action, the suspension shall remain in

effect until the Governing Body has reviewed the recommendation and taken action to terminate the suspension. If the Governing Body, after such review, decides to continue the suspension, the Medical Staff member shall be entitled to the procedural rights provided in Article VIII, and the matter shall be processed in accordance with the provisions of Article XV. If the Executive Committee recommends less restrictive terms of suspension, the original suspension shall remain in effect until the Governing Body has reviewed the recommendation and taken action to terminate the suspension. If the Governing Body, after such review, decides to continue the suspension, either original or as modified, the Medical Staff member shall be entitled to the procedural rights provided in Article VIII, and the matter shall be processed in accordance with the provisions of Article XV.

D. AUTOMATIC SUSPENSION OR REVOCATION

1. Failure to Complete Medical Records. An automatic suspension of the Medical Staff member's admitting or consulting privileges shall, after appropriate notice of delinquency, be imposed for failure to complete medical records. If the medical records remain incomplete 30 days after receipt of a written notice of suspension, such failure shall constitute a resignation from the Medical Staff effective immediately. For the purpose of enforcement, justified reasons for delay in completing medical records shall include, without limitation:
   a. That the Medical Staff member or any other individual contributing to the record is ill, on vacation, or otherwise unavailable without fault for a period of time not to exceed seven calendar days;
   b. That the Medical Staff member is waiting for the results of a late report and the record is otherwise complete except for the discharge summary and the final diagnosis;
   c. That the Medical Staff member has dictated reports and is waiting for Hospital personnel to transcribe them.

2. Loss of License. If a Medical Staff member's license to practice his profession in the State of Texas is revoked or suspended, such Medical Staff member shall immediately and automatically be suspended from practicing in the Hospital. When the licensing agency has imposed terms of probation or limitation of practice on the Medical Staff member but the license status is maintained, the Executive Committee shall treat the matter as a request for corrective action and the appropriate procedures will be followed. When the action of the licensing agency has been to revoke or suspend the Medical Staff member's license, for any subsequent request for the opportunity to practice at the Hospital after the Practitioner has regained his license, the Executive Committee shall decide whether the individual should be required to submit an application for appointment.

3. Controlled Substance Registrations. A Medical Staff member whose DEA or DPS registration is revoked, suspended, or voluntarily relinquished shall immediately and automatically be divested of all Clinical Privileges, including the right to admit patients to the Hospital.

4. Conviction of a Felony. Upon exhaustion of appeals after a felony conviction of a Medical Staff member in any court of the United States, either federal or state, the Medical Staff member's appointment is automatically revoked.

5. Corrective Action at Another Hospital. A Medical Staff member who is the subject of corrective action at any hospital must make this known to the Executive Committee and Facility Administrator. Any individual who has privileges revoked, suspended or reduced or who has been subjected to any terms of probation, consultation or supervision at such hospital shall

automatically have his Clinical Privileges reduced commensurately at this Hospital unless more severe corrective action is taken against the Practitioner by the Medical Staff.

6. Failure to Maintain Acceptable Limits of Professional Liability Insurance. Failure to maintain insurance required by these Bylaws shall warrant automatic suspension of a Practitioner's Clinical Privileges until he can produce evidence to the Executive Committee and the Governing Body that acceptable professional liability coverage has been secured. If the period is greater than six months, then this is deemed a voluntary resignation of Practitioner's Medical Staff membership.

7. Failure to Satisfy Special Appearance Requirement. A Medical Staff member whose patient's clinical course of treatment is scheduled for discussion at a committee meeting shall be given written notice of the matter and of the time and place of the meeting. Whenever apparent or suspected deviation from standard clinical practice is involved, special notice shall be given at least five days prior to the meeting by the President or his designee and shall include a statement of the issue involved and that the Medical Staff member's appearance is mandatory. Failure of a Medical Staff member to appear at any meeting for which he was given such special notice, shall, unless excused by the Executive Committee upon a showing of good cause, result in an automatic suspension of all or such portion of the Medical Staff member's Clinical Privileges as the Executive Committee may direct. Such suspension shall remain in effect until the matter is resolved by subsequent action of the Executive Committee or of the Governing Body or through corrective action, if necessary.

8. Procedural Rights Based on Categories of Automatic Suspension. A Medical Staff member who has resigned or is under automatic suspension due to medical records delinquency is entitled to procedural rights provided in Article VIII only for the purposes of establishing justification for the delay in completing medical records. A Medical Staff member whose appointment or Clinical Privileges have been automatically suspended or revoked by operation of Section 2, 3, 4, 5, and 6 above, may request an interview by a committee appointed by the Governing Body to present evidence to establish that the automatic suspension or revocation was invoked in error. The interview and any subsequent proceedings shall be conducted in accordance with the provisions of Article VIII.

E. REPORTING OF PROFESSIONAL REVIEW ACTIONS

1. Mandatory Reporting. As required by law, professional review actions taken against a Practitioner will be reported to the National Practitioner Data Bank and the State Licensing Board by the Facility Administrator within 15 days from the date the adverse action is taken. Reportable actions include:
   a. professional review actions that adversely affect a Practitioner's Clinical Privileges for a period of more than 30 days; and
   b. acceptance of a Practitioner's surrender or restriction of Clinical Privileges while under investigation for possible professional incompetence or improper professional conduct or in return for not conducting an investigation or professional review action.
   c. Matters not related to the professional competence or professional conduct of a Practitioner will not be reported.

ARTICLE VIII
INTERVIEWS, HEARINGS, AND APPELLATE REVIEW

A. INTERVIEWS

When the Executive Committee or the Governing Body receives or is considering initiating an adverse

recommendation concerning a Medical Staff member, the Medical Staff member may be afforded an interview. The interview shall not constitute a hearing, shall be preliminary in nature, and need not be conducted according to the procedural rules provided with respect to hearings. The Medical Staff member shall be informed of the general nature of the circumstances and may present information relevant thereto. A record of such interview shall be made.

B. RIGHT TO HEARING AND APPELLATE REVIEW

1. Right to Hearing Generally. When any Practitioner receives notice of an adverse action as defined in Section B, 2 and 3 below, the Practitioner shall be entitled, upon timely and proper request, to the hearing and other procedures provided for in this Article.

2. Triggering Events. The following recommendations or actions, if deemed adverse under Section B, Part 3 below, shall entitle the Practitioner to the rights provided for in this Article VIII:
    a. Denial of initial appointment to the Medical Staff;
    b. Denial of reappointment to the Medical Staff;
    c. Summary suspension of Medical Staff membership;
    d. Revocation of Medical Staff membership;
    e. Denial of requested appointment to or advancement in Medical Staff membership category;
    f. Reduction in category of Medical Staff membership;
    g. Denial of requested Clinical Privileges;
    h. Reduction or revocation of Clinical Privileges; and
    i. Summary suspension of Clinical Privileges.

3. Adverse Action. A recommendation or action listed in Section B, Part 2 above is adverse only when it has been or is:
    a. Recommended by the Executive Committee; or
    b. A suspension continued in effect after review by the Executive Committee and/or the Governing Body; or
    c. Taken by the Governing Body under circumstances where no prior right to request a hearing existed.

4. Actions not Deemed Adverse. None of the following actions shall entitle an affected Practitioner to any hearing, appellate review, or other rights under this Article VIII:
    a. The issuance of a warning, a letter of admonition, or a letter of reprimand;
    b. The imposition of terms of probation, preceptorship, monitoring, or pre or post case consultation requirements;
    c. The termination of any temporary privileges;
    d. Automatic suspensions due to loss of license, failure to complete medical records pursuant to these Bylaws or the Rules and Regulations, or due to suspension or revocation of Medical Staff membership or privileges at another hospital.

C. NOTICE OF ADVERSE ACTION

The Facility Administrator shall be responsible for giving, within seven days, written notice of adverse action taken pursuant to Article VIII, Section A, Part 3 by delivery to the affected Practitioner either in person or by certified mail, return receipt requested. This notice shall state: that an adverse action has been taken or is proposed to be taken against the Practitioner; the reasons for the adverse action; that the Practitioner has no more than 30 days from the date of furnishing the notice to request the hearing; and a

summary of the hearing procedures and rights of the Practitioner, which can consist of furnishing the Practitioner a copy of this Article VIII with the notice.

D. REQUEST FOR HEARING

The Practitioner shall have no more than 30 days after receiving a notice under Article VIII, Section C to file a written request for a hearing. The request must be delivered to the Facility Administrator either in person or by certified mail, return receipt requested.

E. WAIVER BY FAILURE TO REQUEST A HEARING

Failure of a Practitioner to request a hearing within the time and in the manner specified in Article VIII, Section D above shall be deemed to be a waiver of the Practitioner's right to any hearing or appellate review to which the Practitioner might otherwise have been entitled. Such waiver shall apply only to the matters which were the basis for the adverse action triggering the Article VIII, Section B notice. Upon waiver, the adverse action taken against the Practitioner shall remain in effect pending the Governing Body's final action in the matter. The Governing Body is not bound by the previous adverse action that the Practitioner has accepted by virtue of the waiver, but may take any action, whether more or less severe, it deems warranted by the circumstances. The Facility Administrator shall promptly notify the affected Practitioner of the Practitioner's status and the final action of the Governing Body.

F. HEARING PREREQUISITES

1. Notice of Time and Place of Hearing. Within ten days after receipt of a request for a hearing from a Practitioner entitled to it, the Facility Administrator shall schedule and arrange for a hearing and shall notify the Practitioner of the time, place and date of the hearing by written notice delivered to the Practitioner either in person or by certified mail, return receipt requested. Ordinarily, the hearing date shall not be less than 14 days nor more than 31 days from the date of the receipt of the request for hearing by the Facility Administrator; provided, however, that a hearing for a Practitioner who is under suspension which is then in effect shall be held as soon as arrangements may reasonably be made. These time periods are merely guidelines, which are designed to assist the Facility Administrator and members of the Medical Staff in accomplishing their tasks. Consequently, they shall not be deemed to create any right for the applicant to have a hearing within these periods.

2. Statements of Issues. The notice of hearing shall contain a concise statement of the factual basis for the adverse action, a list by number of the specific or representative patient records in question, and/or the other reasons or subject matter forming the basis for the adverse action or recommendation which is to be the subject of the hearing.

3. Hearing Committee.
   a. A hearing occasioned by an adverse action taken by the Executive Committee shall be conducted by an ad hoc hearing committee appointed by the Governing Body comprised of a committee of impartial peers, plus the President, the Facility Administrator, and Medical Director. The hearing committee may name such non-voting, advisory members to assist it as it deems necessary.
   b. A hearing occasioned by an adverse action of the Governing Body under circumstances where the Practitioner had no right to request a hearing shall be conducted by the hearing committee designated in 3.a. The hearing committee may name such non-voting, advisory members to assist as it deems necessary.

4. Service on Hearing Committee.
   Prior involvement of a hearing committee member in formulation of the adverse action which

occasioned the hearing, shall not bar participation as a hearing committee member. To the extent practicable, a hearing committee shall have no members who have actively participated in formulating the adverse action that occasioned the hearing, or in initiating or investigating the underlying matter at issue at any earlier stage of the proceedings. When it is not practicable for the hearing committee to exclude such persons, the President of the Medical Staff or the Chief Executive Officer as the case may be, shall make such determination and shall file a statement with the chairman of the hearing committee stating the reasons. A copy of such statement shall be provided promptly to the Practitioner. Any such determination made without malice shall be final and binding on all parties.

G. HEARING PROCEDURE

1. Personal Presence. The personal presence of the Practitioner who requested the hearing is required. A Practitioner who fails without good cause to appear and proceed at a hearing shall be deemed to waive the Practitioner's rights in the same manner and with the same consequences as provided in Section D of Article VIII hereof.

2. Presiding Officer. Either a hearing officer, if one is appointed, or the chairman of the hearing committee or his designee, shall serve as presiding officer at the hearing. The presiding officer shall maintain decorum and assure that all participants have a reasonable opportunity to present relevant oral and documentary evidence. The presiding officer shall determine the order of procedure during the hearing and make all rulings on matters of law, procedure, and the admissibility of evidence.

3. Representation of the Adverse Recommendation. If the action which prompted the hearing was taken by the Executive Committee, it shall appoint one of its members or some other Medical Staff member to represent it at the hearing. If the action which prompted the hearing was taken by the Governing Body, it shall appoint one of its members, or another person of its choosing, to represent it at the hearing. Such representative shall have the obligation to present the facts in support of the adverse action, to examine witnesses, and to otherwise participate in the hearing.

4. Representation of the Practitioner. The Practitioner who requested the hearing shall be entitled to be accompanied by a member of the Medical Staff in good standing, or by a member of his local professional society, and may utilize this person as an advocate to present evidence, examine witnesses, and otherwise participate in the hearing.

5. Utilization of Attorneys. The affected Practitioner and the representative of the Executive Committee or the Governing Body shall be entitled to utilize an attorney-at-law to make statements, introduce evidence, examine witnesses, or otherwise serve as an advocate at the hearing. Further, if a hearing officer is used, he may be an attorney-at-law.

6. Rights of Parties. During a hearing, each party may:
   a. Call and examine witnesses,
   b. Introduce exhibits and present relevant evidence,
   c. Cross examine any witness on an matter relevant to the issues,
   d. Impeach any witnesses,
   e. Rebut any evidence,
   f. Request that the record of the hearing be made by use of a court reporter or electronic recording unit.
   g. Submit a written statement at the close of the hearing.

If the Practitioner does not testify in his own behalf, the Practitioner may be called and examined as if under cross-examination.

7. Procedure and Evidence. The hearing need not be conducted strictly according to the rules of law relating to the examination of witnesses or the presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs may be considered, regardless of the admissibility of such evidence in a court of law. Each party is entitled, prior to or during the hearing, to submit memoranda concerning any issue of law or fact, and such memoranda become part of the hearing record. The hearing officer may, but is not required to, order that oral evidence be taken only on oath or affirmation administered by any person designated by him and entitled to notarize documents in the State of Texas.

8. Evidentiary Notice. In reaching a decision the hearing committee may take official notice, either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration and of any facts that may be judicially noticed by the courts of Texas. Parties present at the hearing must be informed of the matters to be noticed, and those matters must be noted in the hearing record. Any party shall be given opportunity, on timely request, to request that a matter be officially noticed and to refute any officially noticed matter by evidence or by written or oral presentation of authority, in a manner to be determined by the hearing committee. The committee is also entitled to consider all other information that can be considered under these Bylaws in connection with credentialing matters.

9. Burden of Proof. When a hearing relates to Article VIII, Section B2, (a), (e), or (g), the Practitioner shall have the burden of proving, by clear and convincing evidence, that the adverse action lacks any substantial factual basis or that the action based thereon is either arbitrary, unreasonable or capricious. When a hearing relates to other adverse action, the body whose adverse recommendation or action occasioned the hearing shall have the initial obligation to present evidence in support of the adverse action, but the Practitioner thereafter is responsible for supporting, by clear and convincing evidence, his challenge that the adverse action lacks any substantial factual basis, or that such basis or the action based thereon is either arbitrary, unreasonable, or capricious.

10. Hearing Record. A record of the hearing must be kept that is of sufficient accuracy to permit an informed and valid judgment to be made by any group that may be later called upon to review the record and render a recommendation or decision in the matter. The hearing committee chairman may select a method to be used for making the record, such as court reporter, electronic recording unit, detailed transcription, or minutes of the proceeding. A Practitioner electing an alternate method under Article VIII, Section G (6) shall bear the cost thereof.

11. Postponement. Postponement of a hearing shall be granted only by the hearing committee, at its sole discretion, upon a showing of good cause. The hearing shall be postponed no more than two times at the request of the Practitioner.

12. Presence of Hearing Committee Members and Votes. A majority of the hearing committee members must be present throughout the hearing and deliberations. If a committee member is absent from any part of the hearing, he may not participate in the final hearing committee vote until he certifies that he has reviewed the portion of the hearing record covering the portion of the hearing which took place during his absence. No committee member may vote by proxy.

13. Recesses and Adjournment. The hearing committee may recess and reconvene the hearing

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

H. HEARING COMMITTEE REPORT AND FURTHER ACTION

1. Hearing Committee Report. Within 15 days after final adjournment, the hearing committee shall make a written report of its findings and recommendations in the matter and shall forward the same, together with the hearing record and all other documentation considered by it to the Governing Body.

2. Action on Hearing Committee Report. Within 20 days after receipt of the report of the hearing committee, the Governing Body shall make its decision in the matter. It shall transmit its decision, together with the hearing record, the report of the hearing committee, and all other documentation considered, to the Facility Administrator and the President of the Medical Staff.

3. Notice. The Facility Administrator shall within at most, seven days send a copy of the Governing Body's decision either by certified mail, return receipt requested, or personal delivery, to the affected Practitioner.

4. Effect of Report.

   a. Effect of Favorable Decision Adopted by the Governing Body: If the Governing Body's decision pursuant to Section H 2 is favorable to the Practitioner, such decision shall become the final decision of the Governing Body and the matter shall be considered closed.

   b. Effect of Adverse Decision: If the decision of the Governing Body pursuant to Section H 2 continues to be adverse to the Practitioner in any of the respects listed in Article VIII Section B (2) and (3), the special notice required by Section H (3) shall inform the Practitioner of his right to request an appellate review by the Governing Body as provided in Section I., below.

I. INITIATION AND PREREQUISITES OF APPELLATE REVIEW

1. Request for Appellate Review. The Practitioner shall have ten days after receiving a notice of adverse action under Section H, Part 3 that entitles the Practitioner to appellate review, to file a written request for appellate review. The request must be delivered to the Facility Administrator either in person or by certified mail, return receipt requested, and shall, in the affected Practitioner's discretion, include requests for:
   a. A copy of the hearing committee report and record and all other material, favorable or unfavorable, if not previously forwarded, that was considered in taking the adverse action; and/or
   b. The right to submit a written statement pursuant to Section J, Part 2 of Article VIII;
   c. Consideration of new or additional matters pursuant to Section J, Part 4 of Article VIII.

2. Waiver.
   a. A Practitioner who fails to request an appellate review within the time and manner

specified in Section I, Part 1 shall be deemed to have waived any right to appellate review. Such waiver shall have the same force and affect as provided in Article VIII, Section E.

b. The failure of the Practitioner to include in the request for appellate review a specific request for the right to submit a written statement or a specific request for the right to make an oral statement shall be deemed to be a waiver of any right the Practitioner may otherwise have to request the same.

c. The failure of the Practitioner to include in the request for appellate review a request for consideration of new or additional matters shall be deemed a waiver of any right the Practitioner would otherwise have to request the same.

3. Notice of Time and Place for Appellate Review. Upon receipt of a timely request for appellate review, the Facility Administrator shall deliver such request to the Governing Body. The Governing Body shall promptly schedule and arrange for an appellate review which shall not be less than 15 days nor more than 35 days from the date of receipt of the appellate review request; provided however, that an appellate review for a Practitioner who is under a suspension then in effect shall be held as soon as the arrangements for it may reasonably be made, but not later than 21 days from the date of receipt of the request for appellate review. At least ten days prior to the appellate review, the Facility Administrator shall send the Practitioner notice of the time, place, and date of the review. The time for the appellate review may be extended by the appellate review committee for good cause.

4. Appellate Review Committee . The Governing Body shall determine whether the appellate review shall be conducted by the Governing Body as a whole or by an appellate review committee composed of at least three members of the Governing Body appointed by the chairman. If a committee is appointed, one of its members shall de designated as chairman. All members of the appellate review body shall be required to consider the appeal with good faith and objectivity.

J. APPELLATE REVIEW PROCEDURE

1. Nature of the Proceedings. The proceedings by the appellate review committee shall be in the nature of an appellate review based upon the record of the hearing before the hearing committee, that committee's report, and all subsequent results and actions thereon. The appellate review committee shall also consider the statements submitted pursuant to Section J 2 and 3 below.

2. Written Statements. Unless waived, the Practitioner seeking the review may submit a written statement detailing the findings of fact, conclusions and procedural matters with which he disagrees, and his reasons for such disagreement. This written statement may cover any matters raised at any step in the hearing process, and legal counsel may assist in its preparation. The statement shall be submitted to the appellate review committee through the Facility Administrator at least seven days prior to the scheduled date of the appellate review. A written statement in reply may be submitted by the Executive Committee or by the Governing Body and, if submitted, the Facility Administrator shall provide a copy thereof to the Practitioner at least three days prior to the scheduled date of the appellate review.

3. Oral Statements. The appellate review committee, in its sole discretion, may allow the parties or their representatives to appear personally and make oral statements in favor of their positions. Any party or representative so appearing shall be required to answer questions put to him by any member of the appellate review committee.

4. Consideration of New or Additional Matters. New or additional matters or evidence not raised or presented during the original hearing or in the hearing committee report and not otherwise reflected in the record may, if not previously waived, be introduced at appellate review only under unusual circumstances. The appellate review committee, in its sole discretion, shall determine whether such matters or evidence shall be considered or accepted.

5. Presiding Officer. The chairman of the appellate review body shall serve as the presiding officer and shall determine the order of procedure during the review, make all required rulings and maintain decorum.

6. Presence of Members and Vote. A majority of the appellate review body must be present throughout the review and deliberations.

7. Recesses and Adjournment. The appellate review committee may recess and reconvene the proceedings without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. At the conclusion of the oral statements, if any, the appellate review shall be closed. The appellate review committee shall then, at a time convenient to itself, conduct its deliberations outside the presence of the parties. The appellate review shall be adjourned at the conclusion of those deliberations.

8. Action Taken. The appellate review body may recommend that the Governing Body affirm, modify or reverse the Governing Body's decision made in accordance with Article VIII, Section H (4).

K. COMPLETION OF HEARING AND APPELLATE REVIEW PROCESS

The hearing and appellate review process provided herein shall not be deemed to have been concluded until all of the procedural steps provided in this article have been either completed or waived.

L. FINAL DECISION OF THE GOVERNING BODY

Within 15 days after the conclusion of the appellate review, the Governing Body shall render its decision in the matter in writing. The Governing Body's decision on the matter shall be immediately effective and final, and shall not be subject to further hearing or appellate review. The Facility Administrator shall send notice of the Governing Body's decision, which includes a statement of the basis for the decision, to the Practitioner by personal delivery or by certified mail, return receipt requested, and to the President of the Medical Staff.

M. NUMBER OF HEARINGS AND REVIEWS

Notwithstanding any other provision of these Bylaws, no Practitioner shall be entitled as a right to request more than one evidentiary hearing and appellate review with respect to the subject matter that is the basis of an adverse action taken against the Practitioner.

N. BOARD COMMITTEE ACTION

Where permitted by the Governing Body Bylaws, all action required of the Governing Body may be taken by committee of the Governing Body duly authorized to act.

O. RELEASE

By requesting a hearing or appellate review under this Article, a Practitioner agrees to be bound by the provisions of these Bylaws relating to immunity from liability.

P. PUBLIC LAW 99-660

In relation to Public Law 99-660, members of the appellate and hearing sections are held harmless in

review of practices if acting without malice.

ARTICLE IX
OFFICERS

A. ELECTED OFFICERS OF THE STAFF

The elected officers of the Medical Staff shall be:

1. President
2. Vice President
3. Secretary/Treasurer

B. QUALIFICATIONS OF OFFICERS

Officers must be members of the Active Staff at the time of nomination and election, must remain members in good standing continuously during their term of office, and must be willing and able to faithfully discharge the duties of the office held. Failure to maintain such status shall immediately create a vacancy in the office involved.

C. NOMINATION AND ELECTION OF OFFICERS

1. Nominations. Nominations for officers shall be made in writing at least 30 days prior to the annual meeting and shall be communicated to the Medical Staff at least 15 days prior to the meeting.
2. Election. The officer shall be elected by majority vote of the members of the Medical Staff and subject to approval by the Governing Body. If no candidate for an office receives a majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes.

D. TERM OF OFFICE

The term of office of Medical Staff officers is one Professional Medical Staff Year. Officers assume office on the first day of the first month of the Professional Medical Staff Year, except that an officer elected to fill a vacancy assumes office immediately upon election. Each officer serves until the end of his term or until a successor is elected, unless the officer sooner resigns or is removed from office.

E. VACANCIES IN OFFICE

If a vacancy occurs in the office of the President, the Vice President shall serve out the remaining term. Other vacancies in office shall be filled by vote of the Medical Staff.

F. RESIGNATION AND REMOVAL FROM OFFICE

1. Resignation. Any Medical Staff officer may resign at any time by giving written notice to the Governing Body. Such resignation, which may or may not be made contingent upon formal acceptance, takes effect on the date of receipt or at any later time specified in it.

2. Removal. Removal of a Medical Staff officer may be effected by the Governing Body acting upon its own initiative or by a majority vote by secret ballot of the members of the Medical Staff eligible and qualified to vote for Medical Staff officers, such vote being taken at a special meeting called for that purpose. Permissible basis of removal of a Medical Staff officer include, without limitation:

   a. Failure to perform the duties of the position held in a timely and appropriate manner,
   b. Failure to continuously meet the qualifications for the position.

G. DUTIES OF OFFICERS

1. President. The President shall serve as the chief administrative officer of the Medical Staff to:
   a. Act in coordination and cooperation with the Medical Staff as a whole and with the Medical Director in formulation of reports to be submitted to the Facility Administrator and the Governing Body in all matters of mutual concern within the Hospital;
   b. Serve as chairman of the Executive Committee. Call, preside at, and be responsible for the agenda of all meetings of the Medical Staff; authenticate minutes, resolutions, and other Medical Staff documents;
   c. Be responsible for the enforcement of Medical Staff Bylaws, and the Rules and Regulations, for implementation of sanctions where these are indicated, and for the Medical Staff's compliance with the procedural safeguards in all stages of the Medical Staff's credentialing process and in all instances where corrective action has been requested against a Practitioner;
   d. Review and enforce compliance with standards of ethical conduct and professional demeanor among the members of the Medical Staff in their relations with each other, the Governing Body, Hospital administration, other professional and support staff, and the community the Hospital serves;
   e. Communicate and represent the views, policies, needs and grievances of the Medical Staff to the Medical Director for ultimate submission to the Facility Administrator and the Governing Body;
   f. Receive and interpret the policies of the Governing Body to the Medical Staff and formulation of reports for submission to the Governing Body in all matters concerning the Medical Staff including the maintenance of quality medical care;
   g. Be responsible for the educational activities of the Medical Staff;
   h. Impose sanctions as specified in Article VII of these Bylaws;
   i. Work cooperatively with the Medical Director in all medical administrative affairs affecting the Medical Staff.

2. Vice President. In the temporary absence of the President, the Vice President shall assume all of the duties and have the authority of the President. The Vice President shall be a member of the Active Medical Staff. The Vice President shall automatically succeed the President should the latter fail to serve for any reason.

H. OTHER OFFICIALS OF THE STAFF

1. Medical Director. A Medical Director, under contract with Post Acute Medical, LLC, shall be a member of the Active or Provisional Medical Staff, a board certified physical medicine and rehabilitation physician; or shall be a physician board certified in the area of his specialty who has completed a either formal residency in physical medicine and rehabilitation, or a fellowship in rehabilitation for a minimum of one year, or has a minimum of two years experience as a collaborative team member providing rehabilitation services in a comprehensive inpatient rehabilitation or Long-Term Acute Care Hospital program. Additionally, a Medical Director, under contract with the Post Acute Medical, LLC in the Long Term Acute Care Hospital setting, shall be a member of the Active or Provisional Medical Staff, and may be a board certified internal medicine physician who has completed either a formal residency or fellowship in internal medicine for a minimum of one year, and has a minimum of two years experience providing complex medical care in an Acute Hospital or Long Term Acute Care Hospital program. The Medical Director shall be subject to the Rules and Regulations and shall have all privileges of Medical Staff membership. The administrative duties of the Medical Director shall be defined and evaluated by the Facility Administrator and shall be incorporated into the contract with the Medical Director executed by the Chief Executive Officer on behalf of Post Acute Medical, LLC.

ARTICLE X
CLINICAL SERVICES

A. ORGANIZATION OF SERVICES

The Hospital, being a specialty hospital for long term acute inpatient care, shall not be departmentalized. The duties and functions of the Medical Staff required by these Bylaws shall be handled by the Executive Committee or the Medical Staff as a whole.

ARTICLE XI
COMMITTEES

A. EXECUTIVE COMMITTEE

1. The Executive Committee or Medical Executive Committee means the three elected officers of the Medical Staff, and the Medical Director, if not an elected officer.

2. Authority. The power and authority of the Executive Committee is derived from the Medical Staff and as such is accountable to the Medical Staff for all its actions.

3. Composition. If the Medical Staff consists of less than three members, the Medical Staff as a whole will function as the Executive Committee. No Medical Staff member practicing in the Hospital is ineligible for membership on the Executive Committee solely because of professional discipline or specialty. The President of the Medical Staff shall be Chairman of the Executive Committee. Non-medical members, the Facility Administrator and the Senior Nurse shall be ex officio members of the committee without vote. Resignation and/or removal from membership of the Executive Committee will be handled in the same manner as outlined in Article IX, Section F. Resignation and Removal From Office.

4. Duties. The duties of the Executive Committee shall be:
    a. To represent and to act on behalf of the Medical Staff in the intervals between Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws;
    b. To coordinate the activities of and general policies adopted by the Medical Staff;
    c. To receive and act upon reports and recommendations of any ad hoc committees and officers of the Medical Staff concerning findings from the quality monitoring and improvement programs and other delegated administrative responsibilities;
    d. To provide liaison between the Medical Staff and the Facility Administrator and the Governing Body;
    e. To recommend action to the Facility Administrator on matters of a medical administrative nature;
    f. To make recommendations on Hospital management matters (for example, long range planning) to the Governing Body through the Medical Director;
    g To fulfill the Medical Staff's accountability to the Governing Body for the medical care rendered to patients in the Hospital;
    h. To ensure that the Medical Staff is kept informed about the accreditation program and the accreditation status of the Hospital;
    i. To review the credentials of all applicants and to make recommendations to the Governing Body on all matters relating to appointment, reappointment, staff category, and

Clinical Privileges;

j. To initiate and pursue corrective action, when warranted, in accordance with these Bylaws;

k. To coordinate all performance improvement programs in the Hospital. The Executive Committee, through standing, special, and ad hoc committees of the Medical Staff, will identify issues and problems relating to the quality of patient care and the operation of the Hospital and will oversee the development and implementation of solutions to those problems identified and take steps to improve care throughout the Hospital. The Executive Committee will receive, review, and collate all information regarding performance improvement at prescribed intervals and transmit progress reports to the Governing Body on a regular basis;

l. To create and ensure a mechanism designed for use in the fair hearing procedures; and

m. To implement a process, separate and distinct from the disciplinary progress, that provides education about physician health, addresses prevention of physical, psychiatric, or emotional illness, and facilitates confidential diagnosis, treatment, and rehabilitation of Medical Staff members who suffer from a potentially impairing condition.

5. Functions.

a. Peer Review: The Executive Committee shall be constituted and operate as a medical peer review committee, professional review body, and medical committee, as such terms are defined by law, and is authorized by the Governing Body to: engage in professional review activity; evaluate health care services, including evaluation of the qualifications of Practitioners and allied health professionals and the health care services they provide; and evaluate the merits of complaints relating to Practitioners, Allied Health Professionals or other individuals providing health care services in the Hospital. The Governing Body, acting through the Facility Administrator, may require that additional peer review be conducted by a qualified independent contractor/consultant, who is not a member of the Medical Staff, with respect to deaths, unplanned transfers, questionable Code Blue incidents and other events identified from time to time.

b. Performance Improvement: The Executive Committee shall act as the Medical Staff performance improvement review body, will follow the approved Hospital performance improvement plan, and will select cases for presentation at Medical Staff meetings that will contribute to the continuing education of every Practitioner. Such review shall include a consideration of all deaths, of patients with infections, complications, errors in diagnosis and treatment, the patients currently in the Hospital with unsolved clinical problems, of proper utilization of facilities and services, and of other significant patient care matters. The following will be included in performance improvement review mechanisms:

1. Medical Records Inclusion: The Executive Committee shall be responsible for assuring that all medical records meet the highest standards of patient care, usefulness and historical validity. The Medical Staff representatives shall be specifically responsible for assuring that the medical records reflect realistic documentation of medical events. The committee shall ensure that monthly review of currently maintained records is conducted to assure that they properly describe the condition and progress of the patient, the therapy provided, the results thereof, and the identification of responsibility for all actions taken, and that they are sufficiently complete at all times so as to meet the criteria of medical comprehension of the case in the event of transfer of physician responsibility for

patient care. They shall also ensure that a review of records of discharged patients is conducted to determine the promptness, pertinence, adequacy and completeness thereof.

2. Pharmacy and Therapeutics Inclusion: The Executive Committee shall be responsible for the development and review of all drug utilization policies and practices within the Hospital in order to strive for optimal clinical results and a minimum potential for hazard. The Director of Pharmacy reports to the Executive Committee. The committee shall assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the Hospital. It shall also perform the following specific functions:
   a. Serve as an advisory group to the Hospital for Medical Staff and the pharmacist in matters pertaining to the choice of availability drugs;
   b. Make recommendations concerning drugs to be stocked on the nursing units and by other services;
   c. Develop and review periodically a formulary or drug list for use in the Hospital;
   d. Prevent unnecessary duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients;
   e. Evaluate clinical data concerning new drugs or preparations requested for use in the Hospital; and,
   f. Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs in conjunction with an independent Institutional Review Board.

3. Drug Usage Inclusion: The Executive Committee shall be responsible for the development and oversight of proper and appropriate utilization of drugs used for Hospital patients. The following specific functions will be monitored:
   a. monitoring of therapeutic, empiric and prophylactic use of drugs to assess effectiveness, patient safety and appropriate choice;
   b. assessment of drug adverse reactions whether due to the drug itself or interaction with other drug regimens to decrease health risk;
   c. cooperation in monitoring drug therapies will be in association with the Hospital's licensed pharmacy service, administration, and nursing service; and
   d. drug utilization when appropriate will be considered in the Medical Staff reappointment processes.

4. Blood Usage Inclusion: The Executive Committee shall include a subsection for performance improvement and will review all transfusions of blood and blood products based or retrospective usage. These will consist of components of the following specific functions:
   a. review of all transfusions of whole blood or blood components for appropriateness to patients' needs;
   b. report and review of all transfusion reactions;
   c. development for the Medical Staff in conjunction with local standards and laboratory appropriate approval of policies and procedures for product selection, distribution, handling, use, and administration of blood or blood

components; and

d. review of ordering practices for blood and blood products.

5. Utilization Review Inclusion: The Executive Committee shall conduct utilization review studies designed to evaluate the appropriateness of admissions to the Hospital, lengths of stay, discharge practices, use of medical and hospital services and all related factors which may contribute to the effective utilization of Hospital and physician services. Specifically, it shall analyze how under-utilization and over-utilization of each of the Hospital services affects the quality of patient care provided at the Hospital, shall study patterns of care and obtain criteria relating to average or normal (usual) lengths of stay by specific disease categories, and shall evaluate systems by utilization review employing such criteria. It shall also work toward the assurance of proper continuity of care upon discharge through, among other things, the accumulation of appropriate data on the availability of other suitable health care facilities and services outside the Hospital. The Executive Committee shall communicate the results of its studies and other pertinent data to the entire Medical Staff and shall make recommendations for the optimal utilization of Hospital resources and facilities commensurate with quality of patient care and safety.

The Executive Committee shall also formulate a written utilization review plan for the Hospital. Such plan, as approved by the Medical Staff and the Governing Body, must be in effect at all times and must include all of the following elements:

a. the organization and composition of the committee which will be responsible for the utilization function;
b. the types of records to be kept;
c. the method to be used in selecting cases on a sample or other basis;
d. the relationship of the utilization review plan to claims administered by a third party;
e. arrangements for committee reports and their dissemination; and
f. responsibilities of the Hospital's administrative staff in support of utilization review.

The Executive Committee shall also evaluate the medical necessity for continued Hospital services for particular patients, where appropriate. In making such evaluations, the committee shall be guided by the following criteria:

a. No Practitioner shall have review responsibility for extended stay cases in which he is professionally involved.
b. A decision that further inpatient stay is not medically necessary shall be made by physician members of the committee and only after opportunity for consultation has been given the attending physician by the committee and full consideration has been given to the availability of out of hospital facilities and services.
c. Where there is a significant divergence in opinion following such consultation regarding the medical necessity for continued in-hospital services for the patient, the judgment of the attending physician shall be given great weight.
d. A decision that further inpatient stay is not medically necessary shall be

given by written notice to the Medical Director, to the Facility Administrator, and to the attending physician, for such action, if any, as may be warranted.

6. Infection Control Inclusion. The Executive Committee shall be responsible to monitor inadvertent Hospital infection potentials, the review and analysis of actual infections, the promotion of a preventative and corrective program designed to minimize infection hazards, and the supervision of infection control in all phases of the Hospital's activities including:
   a. special care units, i.e. wound care and hyperbaric unit, dialysis unit, etc.;
   b. sterilization procedures by heat, chemicals or otherwise;
   c. isolation procedures;
   d. prevention of cross-infection by respiratory therapy equipment;
   e. testing of personnel for carrier/contagious status;
   f. disposal of infectious material;
   g. outbreak investigation; and
   h. other situations as requested by the Governing Body.

c. Other Functions of the Executive Committee. The Executive Committee shall also conduct itself as a forum for the discussion of matters of Hospital policy and practice, especially those pertaining to efficient and effective patient care and shall provide medical administrative liaison with the Governing Body through the Medical Director and the Facility Administrator. Recommendations of the Medical Staff will be transmitted by the Executive Committee in the aforementioned manner. The Executive Committee shall also have the following specific duties:

1. Accreditation: It shall be responsible for acquisition and maintenance of accreditations approved by the Governing Body for which purpose it may form a subcommittee that includes key Hospital personnel who are important in implementing the accreditation program(s). From time to time, it shall require that survey forms for accreditations be used as a review method to estimate the accreditation status of the Hospital and it shall supervise trial surveys and shall make recommendations to the Medical Staff for appropriate action.

2. Disaster Planning: It shall be responsible for the development of maintenance methods for the protection and care of Hospital patients and others at the time of internal and external disaster. Specifically, it shall form ad hoc committees to:
   a. Adopt and periodically review a written plan to safeguard patients at the time of an internal disaster, particularly fire, and shall assure that all key personnel rehearse fire drills at least quarterly; and,
   b. Adopt and periodically review a written plan for the care, reception and evacuation of mass casualties, and shall assure that such plan is coordinated with the inpatient and outpatient services of the Hospital, that it adequately reflects developments in the Hospital community and the anticipated role of the Hospital in the event of disaster in nearby communities, that the plan is rehearsed by key personnel at least twice yearly.

3. Risk Management Activities. The Executive Committee will review risk management activities related to the clinical aspects of patient care and safety by providing for:

a. identification of areas of potential risk relating to the clinical aspects of patient care and safety;
b. programmatic design to reduce risk in the clinical aspects of patient care and safety;
c. development of criteria in association with the Hospital designated risk manager for identification of specific cases with potential risk for aspects of patient care and safety; and
d. correction of problems related to identified potential risks relating to patient care and safety.

4. Hospital Safety Activities. In coordination with the Hospital Safety Committee, the Executive Committee will review hospital safety activities, including:
   a. assist in appropriate direction to maintain patient safety and health status; and
   b. coordination of efforts to also maintain safety for Hospital employees in addition to internal and external disaster planning.

5. Professional Library Services. The Executive Committee shall be responsible for an analysis of the changing needs of the library service. These activities shall include deletion of outmoded material as well as the acquisition of new material.

6. Meetings. The Executive Committee shall meet once a month or at least six times annually, and maintain a permanent record of its proceedings and actions.

ARTICLE XII
MEDICAL STAFF MEETINGS

A. ANNUAL MEETINGS

Meetings of the Medical Staff shall be held annually and coincide with the calendar year and a permanent record of its proceedings maintained.

B. SPECIAL MEETINGS

1. Call. The President, the Facility Administrator or the Medical Director may call a special meeting of the Medical Staff at any time. The President shall call a special meeting within 14 days after receipt by him of a written request for same signed by not less than 25% of the Medical Staff and stating the purpose for such a meeting. The President shall designate the time and place for any special meeting.

2. Notice. Written or printed notice stating the place, day and hour of any special meeting of the Medical Staff shall be delivered, either personally or by mail, to each member of the Medical Staff not less than one or more than 14 days before the date of such meeting, by or at the direction of the President. If mailed, then notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail, addressed to each Medical Staff member at the Medical Staff member's address as it appears in the records of the Hospital. Notice may also be sent to members of other Medical Staff groups at the discretion of the Medical Staff. The attendance of a member of the Medical Staff at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting except as stated in the notice calling the meeting.

C. QUORUM

The presence of 50% of the Medical Staff officers shall constitute a quorum at any regular meeting. The presence of 50% of the Medical Staff officers and 50% of the Medical Staff shall constitute a quorum for special called meetings.

D. ATTENDANCE REQUIREMENTS

Members of the Medical Staff are encouraged to attend annual meetings of the Medical Staff. Annual meeting attendance will not be used in evaluating members at the time of reappointment.

E. AGENDA FOR MEETINGS

The order of business at an annual meeting shall be determined by the President. The agenda shall include at least:

1. Acceptance of the minutes of the last annual and of all special meetings held since the last annual meeting;
2. Administrative reports from the Facility Administrator, President, and Medical Director;
3. The election of officers; and
4. Reports on the overall results of quality/utilization management, and other quality maintenance activities of the Medical Staff and fulfillment of other required Medical Staff functions.
5. Recommendations for improving patient care within the Hospital.
6. New Business.

F. MINUTES

Minutes of each regular and special meeting of the Medical Staff acting as a whole or an ad-hoc committee shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be signed by the presiding officer and copies thereof shall be submitted to the Executive Committee. Each committee shall maintain a permanent file of the minutes of each meeting.

ARTICLE XIII
MEDICAL STAFF COMMITTEE MEETINGS

A. REGULAR MEETINGS

Committees shall, by resolution, provide the time for holding regular meetings and no notice other than such resolution shall be required.

B. SPECIAL MEETINGS

A special meeting of any committee may be called by the Executive Committee, or at the request of the chairman of an ad hoc committee, or by the President, or by one-third of the group's then members, but not less than two members.

C. NOTICE OF MEETINGS

Except in an emergency, written or oral notice stating the place, day and hour of any special meeting or of any regular committee meeting not held pursuant to resolution shall be given to each member of the committee, not less than seven days before the time of such meeting, by the person or persons calling the meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited in the United States mail, addressed to the member at address as it appears on the records of the hospital, with postage thereon pre-paid. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

D. QUORUM

Fifty percent of members of a committee who are members of the Medical Staff is considered a quorum for constitution of any committee meeting but this must not be less than two members.

E. MANNER OF ACTION

The action of a majority of the members present at a meeting at which a quorum is present shall be the committee. Action may be taken without a meeting by unanimous consent in writing (setting forth the action so taken) signed by each member entitled to a vote.

F. EXOFFICIO MEMBERS

Persons serving under these Bylaws as ex-officio members of a committee shall have all rights and privileges of regular members without a vote. Exofficio members shall include the Facility Administrator and the Senior Nurse Executive.

G. MINUTES

Minutes of each regular and special meeting of the Medical Staff acting as a whole or an ad-hoc committee shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be signed by the presiding officer, approved by the attendees, and forwarded to the Executive Committee. Each committee shall maintain a permanent file of the minutes of each meeting.

H. ATTENDANCE REQUIREMENTS

1. Meeting Requirements. Each member assigned to a standing or ad hoc committee shall be required to attend not less than 50% of all meetings of committees of which the Practitioner may be a member in each year. Any member of the Medical Staff who is compelled to be absent from a meeting of a committee of which the Practitioner is a member shall submit to the chairman, in writing, the reason for such absence. The failure to meet the foregoing attendance requirements, unless excused by the President for good cause shown, may be grounds for corrective action Committee chairmen shall report any such failure to the Executive Committee for action.

2. Special Attendance Requirements.

   Whenever a Medical Staff educational program is prompted by findings of performance improvement activities, the Practitioner whose performance prompted the program will be notified of the time, date, and place of the program, the subject matter to be covered, and its special applicability to the Practitioner's practice. Except in unusual circumstances, the Practitioner shall be required to be present.

   Whenever a pattern of suspected deviation from standard clinical or professional practice is identified, the President may require the Practitioner to confer with him or with a standing or ad hoc committee considering the matter. The Practitioner will be given special notice of the conference at least five days prior to the conference, including the date, time, and place, a statement of the issue involved, and a statement that the Practitioner's appearance is mandatory. Failure of the Practitioner to appear at any such conference, unless excused by the Executive Committee upon showing good cause, will result in an automatic suspension of all or such portions of the Practitioner's Clinical Privileges as the Executive Committee may direct. A suspension under this Section will remain in effect until the matter is resolved by subsequent action of the Executive Committee and the Governing Body. Such resolution shall be made in a timely manner.

ARTICLE XIV
CONTINUING EDUCATION

A. The Medical Staff will participate in continuing education activities not only on the professional level, but also for Hospital staff or related key diagnostic groups or encountered problems when appropriate Hospital

programs can be sponsored. Other CME credit with respect to AMA, or university-sanctioned events are encouraged.

B. Continuing education will be a criteria for consideration of reappointment to the Medical Staff. The CME requirement for Practitioner members shall be that of the Texas State Board of Medical Examiners. Other Medical Staff members shall complete the same number of CME hours as required for Practitioner members.

ARTICLE XV
CONFIDENTIALITY, IMMUNITY AND RELEASES

A. SPECIAL DEFINITIONS

For purposes of this article, the following definitions shall apply:

1. Information means a record of proceedings, minutes, interviews, records, reports, forms, memoranda, statements, recommendations, findings, evaluations, opinions, conclusions, actions, data and other disclosures or communications whether in written or oral form relating to any of the subject matter specified in Section E of Article XV hereof.

2. Malice means the dissemination of a knowing falsehood or of information with a reckless disregard for whether or not it is true or false, or the absence of a reasonable belief that an action, statement or recommendation is warranted by the facts.

3. Representative means a board of a hospital or any director or committee thereof; a hospital chief executive officer or designee; registered nurses and other employees of a hospital; a medical staff organization and any member, officer, clinical unit or committee thereof; and any individual authorized by any of the foregoing to perform specific information gathering, analysis, use or disseminating functions.

4. Third Parties means both individuals and organizations providing information to any Representative.

B. AUTHORIZATIONS AND CONDITIONS

By applying for or exercising Clinical Privileges or providing specified patient care services in the Hospital, a Practitioner:

1. Authorizes Representatives to solicit, provide and act upon information bearing on the Practitioner's professional ability and qualifications.
2. Agrees to be bound by the provisions of this Article and to waive all legal claims against any Representative who acts in accordance with the provisions of this Article.
3. Acknowledges that the provisions of this Article are express conditions to the Practitioner's application for, or acceptance of, Medical Staff membership and to the Practitioner's exercise of Clinical Privileges or provision of specified patient services at this Hospital.

C. CONFIDENTIALITY OF INFORMATION

Information with respect to any Practitioner submitted, collected or prepared by any Representative of this or any other health care facility or organization or medical staff for the purpose of evaluating and improving the quality and efficiency of patient care, reducing morbidity and mortality, contributing to teaching or clinical research, determining that health care services are professionally indicated or were performed in compliance with the applicable standard of care, or establishing and enforcing guidelines to keep

healthcare costs within reasonable bounds shall, to the fullest extent permitted by law, be confidential and shall not be disseminated to anyone nor be used in any way except as provided herein or except as otherwise, required by law. Such confidentiality shall also extend to information of like kind that may be provided by Third Parties. This Information shall not become part of any particular patient's record or the Hospital records.

D. IMMUNITY FROM LIABILITY

1. For Action Taken. No Representative shall be liable in any judicial proceeding for damages or other relief for any decision, opinion, action, statement or recommendation made within the scope of his duties as a Representative, if such Representative acts in good faith and without Malice after reasonable effort under the circumstances to ascertain the truthfulness of the facts and in the reasonable belief that the decision, opinion, action, statement or recommendation is warranted by such facts. Regardless of any provisions of state law to the contrary, truth shall be an absolute defense for a Representative in all circumstances.

2. For Providing Information. No Representative of the Hospital or Medical Staff and no Third Party shall be liable in any judicial proceeding for damages or other relief by reason or providing information, including otherwise privileged or confidential information, to a Representative of the Hospital or Medical Staff or to any other healthcare facility or organization of health professionals concerning a Practitioner who is or has been an applicant to or member of the Medical Staff or who did or does exercise Clinical Privileges or provide specified services at the Hospital, providing that such Representative or a Third Party acts in good faith and without malice and provided further that such information is related to the performance of the duties and functions or the recipient and is reported in a factual manner.

E. ACTIVITIES AND INFORMATION COVERED

1. Activities. The confidentiality and immunity provided by this article applies to all acts, communications, proceedings, interviews, reports, records, minutes, forms, memoranda, statements, recommendations, findings, evaluations, opinions, conclusions or disclosures performed or made in connection with this or any other healthcare facilities or organization's activities concerning, but not limited to:
   a. Applications for appointment and Clinical Privileges or specified service;
   b. Periodic reappraisals for reappointment and Clinical Privileges, or specified services;
   c. Corrective or disciplinary actions;
   d. Hearings and appellate reviews;
   e. Performance improvement program activities;
   f. Utilization reviews;
   g. Claims review;
   h. Profiles and profile analysis;
   i. Malpractice loss prevention; and
   j. Other Hospital and Medical Staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

2. Information. The information referred to in this Article may relate to a Practitioner's professional qualifications, clinical ability, judgment, character, physical or mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care.

F. RELEASES

Each Practitioner shall, upon request of the Hospital, execute general and specific releases in accordance

with the tenor and import of this Article, subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of this state. Execution of such releases is not a prerequisite to the effectiveness of this Article.

G. CUMULATIVE AFFECT

Provisions in these Bylaws and in application forms relating to authorizations, confidentiality of information and immunities from liable are in addition to other protections provided by law and not in limitation thereof.

ARTICLE XVI
GENERAL PROVISIONS

A. STAFF RULES AND REGULATIONS

Subject to approval by the Governing Body, the Medical Staff shall adopt Rules and Regulations as may be necessary to implement more specifically the general principles found in these Bylaws. These shall relate to the proper conduct of Medical Staff organizational activities, as well as embody the level of practice that is to be required of each Medical Staff member or allied health practitioner in the Hospital and shall be reviewed at least every two years. Such rules and regulations shall be a part of these Bylaws, except that they may be amended at any regular meeting of the Medical Staff or at regularly scheduled Executive Committee meetings at which a quorum is present and without previous notice, or at any special meeting on notice, by a majority vote of those present and eligible to vote. Such changes shall become effective when approved by the Governing Body.

B. CONSTRUCTION OF TERMS AND HEADINGS

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

C. SUBSTANTIAL COMPLIANCE

Minor deviations from the procedures set forth in these Bylaws shall not be grounds for invalidating the action taken.

ARTICLE XVII
REVIEW, REVISION, ADOPTION AND AMENDMENT OF THE BYLAWS

A. MEDICAL STAFF RESPONSIBILITY

The Medical Staff shall have the initial responsibility and delegated authority to formulate, adopt, and recommend to the Governing Body Medical Staff Bylaws and amendments thereto, which shall be effective when approved by the Governing Body. Such responsibility and authority shall be exercised in good faith and in a reasonable and timely manner. This applies as well to the review, adoption, and amendment of the Rules and Regulations developed to implement various sections of these Bylaws. The Medical Staff shall review the Bylaws at least every two years.

B. METHODS OF ADOPTION AND AMENDMENT

All proposed amendments, whether originated by the Executive Committee, another committee, or by a member of the Medical Staff, must be reviewed and discussed by the Executive Committee prior to an Executive Committee vote. Such amendments may be recommended to the Governing Body:

1. By the Executive Committee after a majority vote, provided that the proposed amendment(s) was first distributed to the members of the Medical Staff at least seven days prior to an Executive Committee vote. The Executive Committee's recommendation may not be acted upon by the Governing Body if more than one third of the Medical Staff object. If more than one third (1/3) of the Medical Staff object to a proposed amendment, the President will schedule and hold a special Medical Staff meeting at which the proposed amendment will be presented, discussed, and acted upon. The affirmative vote of a majority of the Medical Staff members who are eligible to vote and who are present and voting is required for passage.

2. The Executive Committee may make nonsubstantive changes and corrections to the Bylaws at any regular or special meeting of the committee by vote of a two thirds majority, which changes shall become effective 30 days after such vote, unless the Governing Body takes action to nullify the changes.

C. BOARD ACTION

Amendments adopted by the Medical Staff pursuant to Section B, Article XVII shall be effective when approved by the Governing Body. Provided, however, that in the event that the Medical Staff shall fail to exercise its responsibility and authority as required by Section A, Article XVII, and after notice from the Governing Body to such effect including a 120 day period of time for response, the Governing Body may resort to its own initiative in formulating or amending Medical Staff Bylaws. In such event, Medical Staff recommendations and views shall be carefully considered by the Governing Body during its deliberations and in its actions.

Adopted by the Medical Staff: ____ (date) ______________

Approved by the Governing Body: ____________________________________ (date) ______________