MEDICAL STAFF BYLAWS

Fort Sanders Regional Medical Center

MEDICAL STAFF BYLAWS

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

The definitions that apply to terms used in the Medical Staff documents are set forth in the Credentials Policy.

In smaller, less complex hospitals where the entire medical staff functions as the Medical Executive Committee, it is often designated as a committee of the whole. If the medical staff serves as the Medical Executive Committee (MEC), references in these bylaws to the MEC means the medical staff. Likewise, if the medical staff is not departmentalized, the responsibilities of a department chair belong to the Chief of Staff. References to the department chair in the bylaws would refer to the Chief of Staff. References to a department would refer to the medical staff.

ARTICLE 2

CATEGORIES OF THE MEDICAL STAFF

Only those individuals who satisfy the qualifications and conditions for appointment to the Medical Staff and APP Staff set forth in the Credentials Policy are eligible to apply for appointment to one of the categories listed below.

2.A. ACTIVE STAFF

2.A.1. Qualifications:

(a) The Active Staff consists of members of the Medical Staff who:

(1) are involved in at least 50 (fifty) patient contacts at the Hospital per year; or

(2) Individuals with fewer than 50 (fifty) patient contacts per year who wish to apply or reapply for Active Staff status may request evaluation on a case-by-case basis. Such request will be evaluated based upon recommendations by the applicable department chairperson.

(b) Unless an Active Staff member can demonstrate to the satisfaction of the Credentials Committee at the time of reappointment that his or her practice patterns have changed and that he or she will satisfy the activity requirements of this category, any member who has fewer than 50 (fifty) patient contacts per year will not be eligible to request Active Staff status at the time of his or her reappointment unless exempted by the MEC. The member must select and be transferred to another staff category that best reflects his or her relationship to the Medical Staff and the Hospital.

2.A.2. Prerogatives:

Active Staff members may:

(a) admit patients if privileged to do so;

(b) vote in general and special meetings of the Medical Staff and applicable department, section, and committee meetings; and

(c) hold office, serve on Medical Staff committees, and serve as a department chair, section chair, and committee chair.

2.A.3. Responsibilities:

(a) Active Staff members must assume all the responsibilities of the Active Staff, including:

(1) serving on committees, as requested;

(2) providing specialty call coverage for the Emergency Department as deemed appropriate by service department, as outlined in the Emergency Call section of these bylaws, and accepting referrals from the Emergency Department for follow-up care of patients;

(3) accepting inpatient consultations, when requested; and

(4) paying application fees, dues, and assessments.

(b) Members of the Active Staff who are 60 years of age or older and have provided 20 years of service at any Covenant Health Hospital may request to be excused from providing specialty coverage for the Emergency Department and accepting referrals from the Emergency Department. Prior to making an official request, the physician must provide the CAO a six (6) month notification of intent to request such exemption. The request for exemption from call will be reviewed by the department, and a recommendation made to the MEC. The MEC will review the recommendation of the department and will make its recommendation on the matter to the Board, which shall have final authority to approve or deny the request. In reviewing a request, consideration should be given to the need and the effect on others who serve on the Emergency Department call roster. A member who is relieved of the obligation of providing coverage may be required to resume on-call duties within the first two (2) years of being granted exemption from call if the MEC or Board determines at a later date that extraordinary circumstances exist. Such situation may be due to a lack of call coverage in the member's specialty area which is likely to have an adverse impact on patient care and for which there is no immediately practical alternative to requiring the member to resume call coverage for the Emergency Department. Such recall will be limited to a maximum one (1) year period. Once these latter determinations have been made, the CAO and Department Chair will advise the affected physician(s) of the requirement to return to call, and will meet with the physician(s) and discuss in good faith the scope of the return to call and other possible options for everyone concerned.

2.B. COURTESY STAFF

2.B.1. Qualifications:

(a) The Courtesy Staff consists of members of the Medical Staff who:

(1) are involved in fewer than 50 (fifty) patient contacts per year; and

(2) are members of the active staff at another hospital, unless their clinical specialty does not support an active inpatient practice and the MEC recommends an exception to this requirement that is approved by the System Credentials and Clinical Standards Committee.

(b) Any member who has more than 50 (fifty) patient contacts per year will be transferred to Active Staff status automatically.

2.B.2. Prerogatives and Responsibilities:

Courtesy Staff members:

(a) may admit patients;

(b) may attend and participate in Medical Staff, and department, or section meetings (without vote);

(c) may not hold office or serve as department chair, section chair, or committee chair, unless the MEC recommends an exception that is approved by the System Credentials and Clinical Standards Committee;

(d) may exercise such clinical privileges as are granted;

(e) may be invited to serve on committees (with vote);

(f) are generally excused from providing specialty coverage for the Emergency Department for unassigned patients, but will be required to provide coverage if the Department and/or MEC finds that there are insufficient Active Staff members in a particular specialty area to perform these responsibilities; and

(g) must pay application fees, dues, and assessments.

2.C. CONSULTING STAFF

2.C.1. Qualifications:

The Consulting Staff consists of members of the Medical Staff who:

(a) are of demonstrated professional ability and expertise and provide a service not otherwise available on the Active Staff;

(b) provide services at the Hospital only at the request of other Members of the Medical Staff; and

(c) are Members of the Active Staff at another Hospital, unless their clinical specialty does not support an active inpatient practice and the MEC recommends an exception to this requirement that is approved by the System Credentials and Clinical Standards Committee.

2.C.2. Prerogatives and Responsibilities:

Consulting Staff members:

(a) may evaluate and treat (but not admit) patients in conjunction with other members of the Medical Staff;

(b) may attend meetings of the Medical Staff and applicable departments, and sections, (without vote) and applicable committee meetings (with vote);

(c) may not hold office or serve as department chair, sections chair, or committee chair, unless the MEC recommends an exception that is approved by the System Credentials and Clinical Standards Committee;

(d) are generally excused from providing specialty coverage for the Emergency Department for unassigned patients, but will be required to provide specialty coverage if the MEC finds that there are insufficient Active and Courtesy Staff members in a particular specialty area to perform these responsibilities; and

(e) must pay application fees, dues, and assessments.

2.D. COMMUNITY AFFILIATE STAFF

2.D.1. Qualifications:

The Community Affiliate Staff consists of members of the Medical Staff who:

(a) desire to be associated with, but who do not intend to establish a practice at, this Hospital;

(b) are interested in pursuing professional and educational opportunities, including continuing medical education, available at the Hospital; and

(c) satisfy the qualifications for appointment set forth in the Credentials Policy, but are exempt from the qualifications pertaining to response times, emergency call, and coverage arrangements.

2.D.2. Prerogatives and Responsibilities:

Community Affiliate Staff members:

(a) may attend meetings of the Medical Staff and applicable department and section, (without vote);

(b) may not hold office or serve as department chair or section chair unless the MEC recommends an exception that is approved by the System Credentials and Clinical Standards Committee (the MEC may only consider waivers of this provision for members of the Community Affiliate Staff who had previously been appointed to the Active Staff for a period of at least four years and who only transitioned to the Community Affiliate Staff in response to changes in that individual's clinical practice patterns);

(c) may serve on committees (with vote), including as committee chair;

(d) may attend educational activities sponsored by the Medical Staff and the Hospital;

(e) may refer patients to members of the Medical Staff for admission and care;

(f) may review the medical records and test results (via paper or electronic access) for any patients who are referred;

(g) are encouraged to visit such patients and communicate directly with Active Staff about the care of their patients;

(h) may perform preoperative history and physical examinations in the office and have those reports entered into the Hospital's medical records;

(i) are not granted inpatient or outpatient clinical privileges and, therefore, may not admit patients, attend patients, write orders for inpatients, perform consultations, assist in surgery, or otherwise participate in the management of clinical care to patients at the Hospital;

(j) may refer patients to the Hospital's diagnostic facilities and order such tests;

(k) are encouraged to accept referrals from the Emergency Department for follow-up care of patients treated in the Emergency Department; and

(l) must pay application fees, dues, and assessments.

The grant of appointment to the Community Affiliate Staff is a courtesy only, which may be terminated by the System Credentials and Clinical Standards Committee upon recommendation of the MEC, with no right to a hearing or appeal.

2.E. COVERAGE STAFF

2.E.1. Qualifications:

The Coverage Staff consists of members of the Medical Staff who:

(a) desire appointment to the Medical Staff solely for the purpose of being able to provide coverage assistance to Active Staff members of a Covenant affiliate who are members of their group practice or their coverage group;

(b) at each reappointment time, provide quality data and other information to assist in an appropriate assessment of current clinical competence as set forth in the Credentials Policy;

(c) are not required to satisfy the response time requirements set forth in the Credentials Policy, except for those times when they are providing coverage;

(d) agree that their Medical Staff appointment and clinical privileges will be automatically relinquished, with no right to a hearing or appeal, if their coverage arrangement with the Active Staff Member(s) terminates for any reason; and

(e) must identify the facility where they hold Active Staff membership.

2.E.2. Prerogatives and Responsibilities:

Coverage Staff members:

(a) when providing coverage assistance for an Active Staff member, will be entitled to admit and/or treat patients who are the responsibility of the Active Staff

member who is being covered (i.e., the Active Staff member's own patients or unassigned patients who present through the Emergency Department when the Active Staff member is on call);

(b) will assume all Medical Staff functions and responsibilities as may be assigned, including, where appropriate, emergency call coverage, consultation, and teaching assignments when covering for a member of their group practice or coverage group;

(c) may attend Medical Staff, department, and section, meetings (without vote);

(d) may not hold office or serve as department chair, section chair, or committee chair;

(e) generally have no staff committee responsibilities, but may serve on committees (with vote); and

(f) will pay applicable fees, dues, and assessments.

2.F. HONORARY STAFF

2.F.1. Qualifications:

(a) The Honorary Staff consists of Members of the Medical Staff who:

(1) have a record of previous long-standing service to the Hospital, have retired from the active practice of medicine and, in the discretion of the MEC, are in good standing at the time of initial application for membership on the Honorary Staff; or

(2) are recognized for outstanding or noteworthy contributions to the medical sciences.

(b) Once an individual is appointed to the Honorary Staff, that status is ongoing. As such, there is no need for the individual to submit a reappointment application.

2.F.2. Prerogatives and Responsibilities:

Honorary Staff members:

(a) may not consult, admit, or attend to patients;

(b) may attend Medical Staff, departments, and sections meetings when invited to do so (without vote);

(c) may not hold office or serve as departments chair, sections chair, or committee chair;

(d) may be appointed to committees (with vote);

(e) may attend educational programs of the Medical Staff and the Hospital; and

(f) are not required to pay application fees, dues, or assessments.

2.G. TELEMEDICINE STAFF

2.G.1. Qualifications:

The Telemedicine Staff consists of members of the Medical Staff who:

(a) satisfy the qualifications for appointment to the Medical Staff, but are exempt from the eligibility criteria set forth in the Credentials Policy pertaining to residence, emergency call, and coverage; and

(b) limit their practice at the Hospital exclusively to providing telemedicine services.

2.G.2. Prerogatives and Responsibilities:

Telemedicine Staff Members:

(a) may admit patients if the physician, as privileged, is virtually present via a Covenant Health approved virtual device with the physician extender present at the bedside at the time of the admission. The physician extender must have demonstrated competence and/or certification specific to their specialty approved by the System Credentials and Clinical Standards Committee;

(b) may not vote at departments or sections meetings;

(c) may not serve on Medical Staff committees; and

(d) must pay staff dues if not on Active or Courtesy staff at another Covenant facility, and any assessments.

2.H. ADVANCED PRACTICE PROFESSIONAL STAFF

2.H.1. Qualifications:

The Advanced Practice Professional Staff is not a category of the Medical Staff, but is included in this Article for convenient reference.

2.H.2. Prerogatives and Responsibilities:

Advanced Practice Professional Staff:

(a) may attend and participate in Medical Staff, departments, and sections meetings (without vote);

(b) may not hold office or serve as departments chair, sections chair, or committee chair;

(c) may be invited to serve on committees (with vote); and

(d) must pay application fees, dues, and assessments.

ARTICLE 3

OFFICERS

3.A. DESIGNATION

The Medical Staff will have the following officers:

Chief of Staff, Chief of Staff Elect, and Immediate Past Chief of Staff.

3.B. ELIGIBILITY CRITERIA

Only those members of the Medical Staff who satisfy the following criteria initially and continuously will be eligible to serve as an officer of the Medical Staff, department and committee chair (unless an exception is recommended by the MEC and approved by the System Credentials and Clinical Standards Committee). They must:

(1) have served on the Active Staff for at least three years;

(2) have no pending adverse recommendations concerning appointment or clinical privileges;

(3) not presently be serving as a Medical Staff officer, board member, or department chair at any other hospital and will not so serve during their terms of office;

(4) be willing to faithfully discharge the duties and responsibilities of the position;

(5) have experience in a leadership position or other involvement in performance improvement functions for at least two years;

(6) participate in Medical Staff Leadership training as determined by the MEC;

(7) have demonstrated an ability to work well with others

(8) not have demonstrated conduct detrimental to the interests of the Medical Staff, Hospital, or Health System.

3.C. DUTIES

3.C.1. Chief of Staff:

The Chief of Staff will:

(a) act in coordination and cooperation with the CAO, the CMO, the System Quality Committee, and the System Credentials and Clinical Standards Committee in matters of mutual concern involving the care of patients in the Hospital;

(b) represent and communicate the views, policies and needs, and report on the activities, of the Medical Staff to the CAO, CMO, System Quality Committee, and System Credentials and Clinical Standards Committee;

(c) call, preside at, and be responsible for the agenda of meetings of the Medical Staff and the MEC;

(d) promote adherence to the Bylaws, policies, rules and regulations of the Medical Staff and to the policies and procedures of the Hospital; and

(e) perform functions authorized in these Bylaws and other applicable policies, including collegial intervention in the Credentials Policy.

3.C.2. Chief of Staff Elect:

The Chief of Staff Elect will:

(a) assume the duties of the Chief of Staff and act with full authority as Chief of Staff in his or her absence;

(b) perform other duties as are assigned by the Chief of Staff or the MEC; and

(c) automatically succeed the Chief of Staff at the beginning of the next Medical Staff year (unless the Chief of Staff is reelected) or sooner should the office become vacated for any reason during the Chief of Staff's term of office.

3.C.3. Immediate Past Chief of Staff:

The Immediate Past Chief of Staff will:

(a) serve as an advisor to other Medical Staff Leaders;

(b) perform other duties as are assigned by the Chief of Staff or the MEC; and

(c) serve on the Credentials Committee.

3.D. NOMINATION AND ELECTION PROCESS

3.D.1. Nominating and Physician Leadership Development Committee:

The MEC will appoint a minimum of three members of the Medical Staff to serve on the Nominating and Physician Leadership Development Committee, including Past Chief(s) of Staff when possible and other experienced members of the Active Staff. The Chief of Staff and CAO will serve as voting members of the committee. Members of the Nominating and Physician Leadership Development Committee must meet the qualifications set forth in Section 3.B of these Bylaws.

3.D.2. Nominating Process:

(a) Not less than 45 days prior to the annual meeting of the Medical Staff, the Nominating and Physician Leadership Development Committee will prepare a slate of nominees for each Medical Staff office that will be vacant. Notice of the nominees will be provided to the Medical Staff at least 30 days prior to the election.

(b) Ballot will include votes by secret ballot at the annual meeting, or by written ballot delivered, mailed, faxed or emailed to the Medical Staff Coordinator prior to the meeting.

(c) Nominations from the floor will not be accepted.

3.D.3. Election:

(a) Except as provided below, the election will take place at a meeting of the Medical Staff. If there are two or more candidates for any office or position, the vote will be by written ballot.

(b) In the alternative, the MEC may determine that the election will be held by written ballot returned to the Medical Staff Office. Ballots may be returned in person or by mail, facsimile, or e-mail. All ballots must be received in the Medical Staff Office by the day of the election.

(c) The candidates receiving a majority of the votes cast will be elected.

(d) If no candidate receives a simple majority vote on the first ballot, a run-off election will be held promptly between the two candidates receiving the highest number of votes.

3.D.4. Physician Leadership Development Process:

On an annual basis, the Nominating Committee will identify future medical staff leaders and their leadership development needs.

A leadership development plan will be recommended which may include serving on committees, attending conferences or other activities to provide content expertise and leadership relationships.

3.E. TERM OF OFFICE, VACANCIES AND REMOVAL

3.E.1. Term of Office:

(a) Officers will assume office on the first day of the Medical Staff year.
(b) Officers will serve an initial two year term; and may be reelected for subsequent two year terms.
(c) At-large members of the MEC will serve up to a two-year term and may be appointed by the MEC (as in Article 5.B.1) to serve additional two-year terms.

3.E.2. Vacancies:

(a) If there is a vacancy in the office of Chief of Staff, the Chief of Staff Elect will serve until the end of the unexpired term of the Chief of Staff.

(b) If there is a vacancy in the office of Chief of Staff Elect, the MEC will appoint an individual, who satisfies the qualifications set forth in Section 3.B of these Bylaws, to the office until a special election can be held.

(c) If there is a vacancy in the position of an at-large member of the MEC, the MEC will appoint an individual who satisfies the qualifications set forth in Section 3.B of these Bylaws.

3.E.3. Removal:

(a) Removal of an elected officer or an at-large member of the MEC may be effectuated by a two-thirds vote of the Medical Staff or a three-fourths vote of the MEC for:

(1) failure to comply with applicable policies, Bylaws, or the Rules and Regulations;

(2) failure to perform the duties of the position held;

(3) conduct detrimental to the interests of the Medical Staff or the Hospital;

(4) an infirmity that renders the individual incapable of fulfilling the duties of that office; or

(5) failure to continue to satisfy any of the criteria in Section 3.B of these Bylaws.

(b) Prior to scheduling a meeting to consider removal, a representative from the MEC along with the CAO will meet with and inform the individual of the reasons for the proposed removal proceedings.

(c) The individual will be given at least ten days' special notice of the date of the meeting at which removal is to be considered. The individual will be afforded an opportunity to address the MEC or the Active Staff, as applicable, prior to a vote on removal.

(d) Removal will be effective when approved by the MEC.

ARTICLE 4

CLINICAL DEPARTMENTS

4.A. ORGANIZATION

4.A.1. Organization of Departments and Sections:

(a) The Medical Staff may be organized into the clinical departments and sections as listed in the Medical Staff Organization Manual.

(b) Subject to the approval of the System Credentials and Clinical Standards Committee, the MEC may create or eliminate departments, create or eliminate sections within departments, or otherwise reorganize the department's structure.

4.A.2. Assignment to Departments:

(a) Upon initial appointment to the Medical Staff, each member will be assigned to a clinical department and may be assigned to a section. Assignment to a particular department or section does not preclude an individual from seeking and being granted clinical privileges typically associated with another department or section.

(b) An individual may request a change in departments or sections assignment to reflect a change in the individual's clinical practice.

4.A.3. Functions of Departments:

The departments are organized for the purpose of implementing processes (i) to monitor and evaluate the quality and appropriateness of the care of patients served by the departments; (ii) to monitor the practice of individuals with clinical privileges in a given departments; and (iii) to provide appropriate specialty call coverage in the Emergency Department, consistent with the provisions in these Bylaws and related documents.

4.B. DEPARTMENT CHAIRS AND VICE CHAIRS

4.B.1. Qualifications:

Each department chair (and vice chair) will:

(a) be an Active Staff member;

(b) be certified by an appropriate specialty board or possess comparable competence, as determined through the credentialing and privileging process; and

(c) satisfy the eligibility criteria in Section 3.B.

4.B.2. Selection and Term of Department Chair or Vice Chair:

(a) Except as otherwise provided by contract, when there is a vacancy in a chair position, or a new department is created, the department will elect a new chair.

(b) Except as may otherwise be provided by contract, a chair will serve a term of two years and may be elected for additional terms.

(c) Each department chair may recommend the appointment of a vice chair. These recommendations will be reviewed by the MEC.

4.B.3. Removal of Chair or Vice Chair of a Department:

(a) Removal of a department chair or vice chair may be effectuated by vote of the MEC for:

(1) failure to comply with the Bylaws or applicable policies, or rules and regulations;

(2) failure to perform the duties of the position held;

(3) conduct detrimental to the interests of the Medical Staff or the Hospital;

(4) an infirmity that renders the individual incapable of fulfilling the duties of that office; or

(5) failure to continue to satisfy any of the criteria in Section 3.B of these Bylaws.

(b) Prior to scheduling a meeting to consider removal, the MEC will meet with and inform the individual of the reasons for the proposed removal proceedings.

(c) The individual will be given at least ten days' special notice of the date of the meeting at which removal is to be considered. The individual will be afforded an opportunity to address the departments, the MEC as applicable, prior to a vote on removal.

(d) Removal of a department chair or vice chair will be effective when approved by the MEC.

4.B.4. Duties of Department Chair:

Each department chair is responsible for the following functions, either individually or in collaboration with Hospital personnel:

(a) all clinically-related activities of the department;

(b) all administratively-related activities of the department, unless otherwise provided for by the Hospital;

(c) continuing surveillance of the professional performance of individuals in the department who have delineated clinical privileges, including performing ongoing and focused professional practice evaluations;

(d) recommending criteria for clinical privileges that are relevant to the care provided in the department;

(e) evaluating requests for clinical privileges for each member of the department;

(f) assessing and recommending off-site sources for needed patient care, treatment, and services not provided by the departments or the Hospital;

(g) the integration of the department into the primary functions of the Hospital;

(h) the coordination and integration of interdepartment and intradepartment services;

(i) the development and implementation of policies and procedures that advance quality and that guide and support the provision of care, treatment, and services;

(j) recommendations for a sufficient number of qualified and competent individuals to provide care, treatment, and services;

(k) determination of the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;

(l) continuous assessment and improvement of the quality of care, treatment, and services provided;

(m) maintenance of quality monitoring programs, as appropriate;

(n) the orientation and continuing education of members in the department;

(o) recommendations for space and other resources needed by the department;

(p) performing functions authorized in the Credentials Policy, including collegial intervention efforts; and

(q) appointing and removing sections chair and one or more departments vice chairs as deemed necessary, subject to approval of the MEC.

ARTICLE 5

MEDICAL STAFF COMMITTEES AND PERFORMANCE IMPROVEMENT FUNCTIONS

5.A. GENERAL

5.A.1. Appointment:

(a) This Article and the Medical Staff Organization Manual outline the committees of the Medical Staff that carry out ongoing and focused professional practice evaluations and other performance improvement functions that are delegated to the Medical Staff by the Board.

(b) Except as otherwise provided by these Bylaws or the Medical Staff Organization Manual, the Chief of Staff will appoint the members and the chair of each Medical Staff committee, in consultation with the CAO and administrative staff. Committee chairs must satisfy the criteria in Section 3.B of these Bylaws. The Chief of Staff will also recommend Medical Staff representatives to Hospital committees.

(c) The CAO or his/her designee will make appointments of administrative staff to Medical Staff committees. Administrative staff will serve on Medical Staff committees without the right to vote.

(d) Chairs and members of standing committees will be appointed for an initial term of one year, but may be reappointed for additional successive terms.

(e) Chairs and physician members of standing committees may be removed and vacancies filled at the discretion of the Chief of Staff.

(f) The Chief of Staff will be an *ex officio* member, with vote, on all Medical Staff committees.

(g) The CAO will be an *ex officio* member, without vote, on all Medical Staff committees.

5.A.2. Meetings, Reports and Recommendations:

Except as otherwise provided, committees will meet, as necessary, to accomplish their functions, and will maintain a permanent record of their findings, proceedings, and actions. Committees will make timely written reports to the MEC.

5.B. Medical Executive Committee (MEC)

5.B.1. Composition:

(a) The MEC will include:

(1) Chief of Staff, Chief of Staff Elect, and Immediate Past Chief of Staff;

(2) the clinical departments chairs;

(3) chair of the Credentials Committee, with vote; and

(4) CAO and other members of the senior leadership team (CNO, CFO, CSO, etc.) *ex officio,* without vote.

(b) The Chief of Staff will serve as chair of the MEC, with vote.

(c) The Chief of Staff and CAO will recommend at-large members, with vote, to the MEC for approval.

(d) Other individuals may be invited to MEC meetings as guests, without vote.

5.B.2. Duties:

The MEC is delegated the primary authority over activities related to the Medical Staff and to performance improvement activities. This authority may be removed or modified by amending these Bylaws. The MEC is responsible for the following:

(a) acting on behalf of the Medical Staff in the intervals between Medical Staff meetings (the officers are empowered to act in urgent situations between MEC meetings);

(b) recommending directly to System Credentials and Clinical Standards Committee on at least the following:

(1) the Medical Staff's structure;

(2) the mechanism used to review credentials and to delineate individual clinical privileges;

(3) applicants for Medical Staff appointment and reappointment;

(4) delineation of clinical privileges for each eligible individual;

(5) participation of the Medical Staff in Hospital performance improvement activities and the quality of professional services being provided by the Medical Staff;

(6) the mechanism by which Medical Staff appointment may be terminated;

(7) hearing procedures; and

(8) reports and recommendations from Medical Staff committees, departments, and other groups, as appropriate;

(c) consulting with Administration on quality-related aspects of contracts for patient care services;

(d) providing oversight and guidance with respect to continuing medical education activities;

(e) reviewing or delegating the review of quality indicators to facilitate uniformity regarding patient care services;

(f) providing leadership in activities related to patient safety;

(g) providing oversight in the process of analyzing and improving patient satisfaction;

(h) reviewing and approving applicable patient care policies that guide and support patient care, treatment and services, coordinating at a system-wide level as applicable;

(i) providing and promoting effective liaison among the Medical Staff, Administration, the System Quality Committee, and the System Credentials and Clinical Standards Committee;

(j) recommending clinical services, if any, to be provided by telemedicine;

(k) reviewing and approving standing orders and protocols for consistency with recognized evidence-based guidelines; and

(l) performing any other functions as are assigned to it by these Bylaws, the Credentials Policy or other applicable policies.

5.B.3 Removal of MEC Members

The MEC, by a two-thirds vote (exclusive of the member who is the subject of the removal action), may remove any member of the MEC for conduct deemed detrimental to the interests of the hospital or Medical Staff, or if the member is suffering from a physical or mental infirmity that renders the individual incapable of fulfilling his or her duties, provided that notice of the meeting at which such action shall be decided is given in writing to such member at least ten (10) days prior to the date of the meeting. The member shall be afforded the opportunity to speak prior to the taking of any vote on such removal.

5.B.4 Removal of Authority of the MEC

The authority delegated to the MEC under these Medical Staff Bylaws may be modified or removed and any act of the MEC overridden in accordance with the following requirements:

(a) A special meeting of the voting members of the Medical Staff shall be held if the greater of ten percent (10%) of all voting members or ten (10) voting members sign, date and deliver to the Medical Staff Coordinator a written demand for a special meeting to consider modification or removal of authority delegated to the MEC under these bylaws and/or overriding any act of the MEC taken pursuant to the authority delegated under these bylaws. Such demand shall include a description of the specific action(s) that the voting members will be asked to approve at such meeting and the reasons for such proposal(s).

(b) The Medical Staff Coordinator shall post such demand on a Medical Staff bulletin board and deliver, either in person, by mail or by electronic means, to each voting member a copy of such demand, together with a notice of special meeting of the voting members to be held no fewer than seven (7) days and no more than fourteen (14) days following the date of the posting of such demand and a form of ballot for voting on each proposed action. Such notice shall state the date, time and place of the meeting. Such posting and delivery shall be deemed to constitute actual notice to all voting members.

(c) An action proposed for consideration at the meeting shall be adopted if approved by the affirmative vote of two-thirds (2/3) of all members entitled to vote at such meeting.

(d) Notwithstanding any other provision of these bylaws to the contrary, votes at this special meeting must be cast by the voting member either (1) in person while present at the meeting or (2) by written ballot delivered to the Medical Staff Coordinator prior to the meeting. Proxy voting shall not be permitted. A voting member who attends the meeting may elect to rescind any ballot delivered to the Medical Staff Coordinator prior to the meeting by casting a ballot at the meeting.

5.B.5. Meetings:

The MEC will meet at least ten times a year and more often if necessary to fulfill its responsibilities and maintain a permanent record of its proceedings and actions.

5.B.6. Leadership Council:

The Chief of Staff, Immediate Past Chief of Staff, Credentials Chair and Professional Quality & Peer Review Committee Chair/Chief of Staff Elect may meet between meetings of the MEC to review and address issues involving concerns regarding Medical Staff and APP Staff clinical practice, health and professionalism. Ad hoc members may be added by the Council when appropriate. The CAO and Quality Manager will also attend the meeting. The Leadership Council may make recommendations to the MEC, and cannot act unilaterally or supersede these Bylaws.

5.C. PERFORMANCE IMPROVEMENT FUNCTIONS

(1) The Medical Staff is actively involved in the measurement, assessment, and improvement of at least the following:

(a) patient safety activities designed to meet patient safety goals, including processes to respond to patient safety alerts and reduce patient safety risks.

(b) the Hospital's and individual practitioners' performance on quality measures;

(c) medical assessment and treatment of patients;

(d) medication usage, minimization of drug errors, including review of significant adverse drug reactions, medication errors and the use of experimental drugs and procedures;

(e) utilization of antibiotics including review of antibiotic sensitivity patterns;

(f) the utilization of blood and blood components, including review of significant transfusion reactions;

(g) operative and other invasive procedures, including tissue review and review of discrepancies between pre-operative and post-operative diagnoses;

(h) appropriateness of clinical practice patterns;

(i) significant departures from established patterns of clinical practice;

(j) use of information about adverse privileging determinations regarding any practitioner;

(k) the use of developed criteria for autopsies;

(l) sentinel events, including root cause analyses and responses to unanticipated adverse events;

(m) healthcare associated infections;

(n) unnecessary procedures or treatment;

(o) appropriate resource utilization;

(p) education of patients and families;

(q) coordination of care, treatment, and services with other practitioners and Hospital personnel;

(r) accurate, timely, and legible completion of patients' medical records;

(s) the required content and quality of history and physical examinations, as well as the time frames required for completion, which are set forth in Article 9 of these Bylaws;

(t) review of findings from the ongoing and focused professional practice evaluation activities that are relevant to an individual's performance; and

(u) communication of findings, conclusions, recommendations, and actions to improve performance to appropriate Medical Staff members, the System Credentials and Clinical Standards Committee, and the System Quality Committee.

(2) A description of the committees that carry out monitoring and performance improvement functions, including their composition, duties, and reporting requirements, is contained in the Medical Staff Organization Manual.

5.D. CREATION OF STANDING COMMITTEES AND AD HOC COMMITTEES

(1) In accordance with the amendment provisions for the Medical Staff Organization Manual, the MEC may, by resolution and upon approval of the System Credentials and Clinical Standards Committee and without amendment of these Bylaws, establish additional committees to perform one or more staff functions. The MEC may also dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions.

(2) Any function required to be performed by these Bylaws which is not assigned to an individual, a standing committee, or an ad hoc committee will be performed by the MEC.

(3) Ad hoc committees may be created and their members and chair appointed by the Chief of Staff and the MEC. Such committees will confine their activities to the purpose for which they were appointed and will report to the MEC.

ARTICLE 6

MEETINGS

6.A. GENERAL

6.A.1. Meetings:

(a) The Medical Staff year is January 1 to December 31.

(b) Except as provided in these Bylaws or the Medical Staff Organization Manual, each department and committee will meet as often as needed to perform their designated functions.

6.A.2. Regular Meetings:

(a) The Chief of Staff, the chair of each department, and the chair of each committee will schedule regular meetings for the year.

(b) The Medical Staff will meet at least twice a year, with elections taking place at one of these meetings.

6.A.3. Special Meetings:

(a) A special meeting of the Medical Staff may be called by the Chief of Staff, a majority of the MEC, the CAO, or by a petition signed by at least 25% of the voting members of the Medical Staff.

(b) A special meeting of any department, or committee may be called by the Chief of Staff, the relevant department chair, or committee chair, or by a petition signed by at least 25% of the voting members of the department, or committee, but in no event fewer than two members.

(c) No business will be transacted at any special meeting except that stated in the meeting notice.

6.B. PROVISIONS COMMON TO ALL MEETINGS

6.B.1. Prerogatives of the Presiding Officer:

(a) The Presiding Officer of each meeting is responsible for setting the agenda for any regular or special meeting of the Medical Staff, department, or committee.

(b) The Presiding Officer has the discretion to conduct any meeting by telephone conference or videoconference.

(c) The Presiding Officer shall have the authority to rule definitively on all matters of procedure. While Robert's Rules of Order may be used for reference, in the discretion of the Presiding Officer, it shall not be binding. Rather, specific provisions of these Bylaws and Medical Staff, department, or committee custom shall prevail at all meetings and elections.

6.B.2. Notice:

(a) Medical Staff members will be provided with notice of regular meetings of the Medical Staff and regular meetings of departments, and committees. Notice will be provided via regular U.S. mail, e-mail, Hospital mail or by posting in a designated location at least 7 days in advance of the meeting.

(b) When a special meeting of the Medical Staff, department, or committee is called, the notice period will be 48 hours. Posting may not be the sole mechanism for providing notice.

(c) Notices will state the date, time, and place of the meetings.

(d) The attendance of any individual at any meeting will constitute a waiver of that individual's notice of the meeting.

6.B.3. Quorum and Voting:

(a) For any regular or special meeting of the Medical Staff, department, section, or committee, those voting members present (but not fewer than two members) will constitute a quorum.

(b) For meetings of the MEC, the Credentials Committee, and the Professional Quality and Peer Review Committee, quorum requirements are as follows:

1. the Chair of the committee (or his/her designee as permitted by the applicable bylaws) shall be required for a quorum;
2. for routine matters, a quorum shall consist of the voting members present at the meeting; and
3. for non-routine matters, a quorum shall consist of at least 50% of the committee members, or 3 of the voting members, whichever is greater. Non-routine matters include, but are not limited to, actions relative to the suspension, restriction, limitation or condition imposed upon an individual.

The Chair of these committees may at their discretion determine if a matter is routine or non-routine.

(c) Once a quorum is established, the business of the meeting may continue and actions taken will be binding.

(d) Recommendations and actions taken by the Medical Staff, department, and committee will be by consensus. In the event it is necessary to vote on an issue, that issue will be determined by a majority of the voting members.

(e) As an alternative to a formal meeting, the voting members of the Medical Staff, a department, or committee may also be presented with a question by mail, facsimile, e-mail, hand-delivery, or telephone, and their votes returned to the committee or department chairman by the method designated in the notice. Except for amendments to these Bylaws and actions by the MEC, the Credentials Committee, and the Peer Review Committee (as noted in (b)), a quorum for purposes of these votes will be the number of responses returned to the committee or department chairman by the date indicated. The question raised will be determined in the affirmative and will be binding if a majority of the responses returned has so indicated.

(f) Any individual who, by virtue of position, attends a meeting in more than one capacity shall be entitled to only one vote.

(g) There shall be no proxy voting.

6.B.4. Minutes:

(a) Minutes of Medical Staff, department and committee meetings will be prepared and signed by the committee or department chairman.

(b) Minutes will include a record of the attendance of members and the recommendations made.

(c) Minutes of meetings of the Medical Staff, department and committees will be forwarded to the MEC.

(e) A permanent file of the minutes of meetings will be maintained by the Hospital.

6.B.5. Confidentiality:

(a) Medical Staff business conducted by departments, sections, and committees is considered confidential and proprietary and should be treated as such.

(b) Members of the Medical Staff who have access to, or are the subject of, credentialing or peer review information must sign an agreement to maintain the confidentiality of the information.

(c) Credentialing and peer review documents, and information contained in these documents, must not be disclosed to any individual not involved in the credentialing or peer review processes, except as authorized by the Credentials Policy or other applicable Medical Staff or Hospital policy.

(d) A breach of confidentiality may result in the imposition of disciplinary action.

ARTICLE 7

BASIC STEPS

The details associated with the following Basic Steps are contained in the Credentials Policy in a more expansive form.

7.A. QUALIFICATIONS FOR APPOINTMENT AND REAPPOINTMENT

To be eligible to apply for initial appointment or reappointment to the Medical Staff or for the granting of clinical privileges, an applicant must demonstrate appropriate education, training, experience, current clinical competence, professional conduct, licensure, and ability to safely and competently perform the clinical privileges requested as set forth in the Credentials Policy.

7.A.1 Professional Conduct

Individuals appointed to the Medical Staff shall be bound by applicable policies on behavior and shall be expected to relate in a positive and professional manner to other health care professionals, to cooperate and work collegially with the Medical Staff leadership and hospital management and personnel, and to interface with the public in such a manner and fashion as will not reflect adversely upon that individual and the health care institution(s) with which he is identified or associated.

7.A.2 Emergency Call Requirements

The Emergency Department responds to emergency care situations in the emergency room itself, as well as to emergency care situations involving inpatients, guests, or staff located elsewhere on hospital premises. Each Practitioner assigned to a category of the Medical Staff having an obligation to participate in the emergency room call schedule shall, when so scheduled, provide coverage appropriate for the department to which he or she is assigned, responding or making adequate arrangements for a response to all Emergency Department calls and/or in-house consults to address care situations requiring skills within the scope of his or her coverage responsibilities.

7.B. PROCESS FOR CREDENTIALING AND PRIVILEGING

(1) Complete applications for appointment and privileges will be transmitted to the applicable department chair, who will review the individual's education, training, and experience and prepare a written report stating whether the individual meets all qualifications. This report will be forwarded to the Credentials Committee.

(2) The Credentials Committee will review the chair's report, the application, and supporting materials and make a recommendation. The recommendation of the Credentials Committee will be forwarded, along with the departments chair's report, to the MEC for review and recommendation.

(3) The MEC may accept the recommendation of the Credentials Committee, refer the application back to the Credentials Committee for further review, or state specific reasons for disagreement with the recommendation of the Credentials Committee. If the recommendation of the MEC is to grant appointment or reappointment and privileges, it will be forwarded to the System Credentials and Clinical Standards Committee for final action. If the recommendation of the MEC is unfavorable, the individual will be notified by the CAO of the right to request a hearing.

(4) When the disaster plan has been implemented, the CAO and Chief of Staff may use a modified credentialing process to grant disaster privileges after verification of the volunteer's identity and licensure.

7.C. INDICATIONS AND PROCESS FOR AUTOMATIC RELINQUISHMENT OF APPOINTMENT AND/OR PRIVILEGES

(1) Appointment and clinical privileges may be automatically relinquished if an individual:

(a) fails to do any of the following:

(i) complete medical records;

(ii) satisfy the specific threshold eligibility criteria as listed in the Credentials Policy, Article 6.F.2;

(iii) provide requested information; or

(iv) attend a required meeting to discuss issues or concerns;

(b) makes a misstatement or omission on an application form;

(c) in the case of an APP, fails, for any reason, to maintain an appropriate supervision/collaborative relationship with a Supervising/Collaborating Physician; or

(d) remains absent on leave for longer than one year, unless an extension is granted by the CAO.

(2) Automatic relinquishment will take effect immediately and will continue until the matter is resolved, as applicable.

7.D. INDICATIONS AND PROCESS FOR PRECAUTIONARY SUSPENSION

(1) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the CAO, the Chief of Staff, the MEC, or the chair of the System Credentials and Clinical Standards Committee is authorized to suspend or restrict all or any portion of an individual's clinical privileges pending an investigation.

(2) A precautionary suspension is effective immediately and will remain in effect unless it is modified by the CAO or the MEC.

(3) The individual will be provided a brief written description of the reason(s) for the precautionary suspension.

(4) The MEC, with the system CMO, will review the reasons for the suspension within a reasonable time under the circumstances, not to exceed 7 business days.

(5) Prior to, or as part of, this review, the individual will be given an opportunity to meet with the MEC.

7.E. INDICATIONS AND PROCESS FOR PROFESSIONAL REVIEW ACTIONS

Following an investigation, the MEC may recommend suspension or revocation of appointment or clinical privileges, based on concerns about (a) clinical competence or practice; (b) the safety or proper care being provided to patients; (c) violation of ethical standards or the Bylaws, policies, rules and regulations of the Hospital or the Medical Staff; or (d) conduct that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff. If there is an adverse recommendation, the Medical Staff Member is entitled to a fair hearing.

7.F. HEARING AND APPEAL PROCESS

(1) The hearing will begin no sooner than 30 days after the notice of the hearing, unless an earlier date is agreed upon by the parties.

(2) The Hearing Panel will consist of at least three members or there will be a Hearing Officer.

(3) The hearing process will be conducted in an informal manner; formal rules of evidence or procedure will not apply.

(4) A stenographic reporter will be present to make a record of the hearing.

(5) Both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer:

a) to call and examine witnesses, to the extent they are available and willing to testify;
b) to introduce exhibits;
c) to cross-examine any witness;
d) to have representation by counsel who may be present but may not call, examine, and cross-examine witnesses or present the case;
e) to submit a written statement at the close of the hearing; and
f) to submit proposed findings, conclusions and recommendations to the Hearing Panel.

(6) If the individual who requested the hearing does not testify, he or she may be called and questioned.

(7) The Hearing Panel (or Hearing Officer) may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

(8) The affected individual and the MEC may request an appeal of the recommendations of the Hearing Panel (or Hearing Officer) to the System Quality Committee.

ARTICLE 8

AMENDMENTS

8.A. MEDICAL STAFF BYLAWS

(1) Amendments to these Bylaws may be proposed by a petition signed by the Bylaws Committee, the MEC or by 25% of the voting Members of the Medical Staff.

(2) Proposed amendments will be reviewed by the MEC prior to a vote by the Medical Staff. The MEC will provide notice of proposed amendments, including amendments proposed by the voting members of the Medical Staff as set forth above, to the voting staff. The MEC may also report on any proposed amendments, either favorably or unfavorably, at the next regular meeting of the Medical Staff or at a special meeting called for such purpose.

(3) The proposed amendments may be voted upon at any meeting if notice has been provided at least 14 days prior to the meeting. To be adopted, the amendment must receive a majority of the votes cast by the voting staff at the meeting.

(4) In the alternative, the MEC may present any proposed amendments to the voting staff by written or electronic ballot, returned to the Medical Staff Office by the date indicated by the MEC. Along with the proposed amendments, the MEC may, in its discretion, provide a written report on them, either favorably or unfavorably. To be adopted, an amendment must receive a majority of the votes cast.

(5) The MEC will have the power to adopt such amendments to these Bylaws which are needed because of reorganization, renumbering, or punctuation, spelling or other errors of grammar or expression.

(6) Amendments to these Bylaws will be effective only after approval by the Board.

(7) If the Board has determined not to accept a recommendation submitted to it by the MEC or the Medical Staff, the MEC may request a conference between the System Quality Committee and the officers of the Medical Staff. Such conference will be for the purpose of further communicating the Board's rationale for its contemplated action and permitting of the Medical Staff to discuss the rationale for the recommendation.

(8) Neither the Medical Staff nor the Board can unilaterally amend these Bylaws.

8.B. RULES AND REGULATIONS

(1) Amendments to the Rules and Regulations may be made by a majority vote of the members of the MEC present and voting at any meeting of that committee where a quorum exists. Notice of any proposed amendments to these documents will be provided to each voting member of the Medical Staff at least 14 days prior to the vote by the MEC. Any voting member may submit written comments on the amendments to the MEC.

(2) Amendments to the Rules and Regulations may be proposed to the MEC by a Medical Staff Committee or a petition signed by 25% of the voting Members of the Medical Staff.

(3) The MEC and the Board will have the power to provisionally adopt urgent amendments to the Rules and Regulations that are needed in order to comply with a law or regulation, without providing prior notice of the proposed amendments to the Medical Staff.

(4) Amendments to the Rules and Regulations that relate to routine or minor matters, including but not limited to routine operational matters related to the medical staff, matters pertaining to provider prescribing behavior, matters pertaining to medical records and documentation, assurance of physician wellness and behavioral expectations, maintenance of physician quality files, medical staff issues surrounding accreditation and matters pertaining to resource utilization, will become effective only when approved by the System Quality Committee. It is anticipated that amendments to the Rules and Regulations will generally be routine and/or minor in nature; provided that if the Chairman of the System Quality Committee or the Covenant Health President and CEO (an ex officio member of the committee) shall consider any proposed amendment not to be routine or minor, then such person can in his/her discretion refer the matter to the Board and in such event the subject amendment will become effective only when approved by the Board.

(5) Amendments to the Rules and Regulations are to be distributed or otherwise made available to Medical Staff members and those otherwise holding clinical privileges, in a timely and effective manner.

8.C. OTHER MEDICAL STAFF DOCUMENTS

(1) In addition to the Medical Staff Bylaws, other Medical Staff documents include the Organization Manual and other Medical Staff policies and procedures that are applicable to members and other individuals who have been granted clinical privileges.

(2) An amendment to the Medical Staff Organization Manual may be made by a majority vote of the members of the MEC present and voting at any meeting of that committee where a quorum exists.

(3) Other policies of the Medical Staff may be adopted and amended by a majority vote of the MEC.

(4) Adoption of and changes to the Medical Staff Organization Manual and other Medical Staff policies will become effective only when approved by the System Quality Committee.

(5) Amendments to the Organization Manual and other Medical Staff policies are to be distributed or otherwise made available to Medical Staff members and those otherwise holding clinical privileges in a timely and effective manner.

8.D. SYSTEM CREDENTIALS POLICY

(1) Amendments to the Credentials Policy may be proposed by a majority vote of the System Credentials and Clinical Standards Committee.

(2) Proposed written amendments will be reviewed by the System Credentials and Clinical Standards Committee prior to a vote.

(3) The proposed amendments may be voted upon at any meeting if notice has been provided at least 14 days prior to the meeting. To be recommended for adoption, the amendment must receive a majority of the votes cast by the voting staff at the meeting.

(4) Amendments to the Credentials Policy will be effective only after approval by the Board.

(5) If the Board has determined not to accept a recommendation submitted to it by the System Credentials and Clinical Standards Committee, the System Credentials and Clinical Standards Committee may request a conference between System Credentials and Clinical Standards Committee and the Board. Such conference will be for the purpose of further communicating the Board's rationale for its contemplated action and permitting the System Credentials and Clinical Standards Committee to discuss the rationale for the recommendation.

8.E. CONFLICT MANAGEMENT PROCESS

(1) When there is a conflict between the Medical Staff and the MEC, supported by a petition signed by 25% of the voting staff, with regard to:

(a) a new Medical Staff Rule and Regulation proposed by the MEC or an amendment to an existing Rule and Regulation; or

(b) a new Medical Staff policy proposed by the MEC or an amendment to an existing policy,

a special meeting of the Medical Staff to discuss the conflict will be called. The agenda for that meeting will be limited to attempting to resolve the differences that exist with respect to the Rules and Regulations or policy at issue.

(2) If the differences cannot be resolved at the meeting, the MEC will forward its recommendations, along with the proposed recommendations pertaining to the Medical Staff Rules and Regulations or policies offered by the voting members of the Medical Staff, to the System Quality Committee for final action.

(3) This conflict management section is limited to the matters noted above. It is not to be used to address any other issue, including, but not limited to, professional review actions concerning individual members of the Medical Staff.

(4) Nothing in this section is intended to prevent individual Medical Staff members from communicating positions or concerns related to the adoption of, or amendments to, the Medical Staff Rules and Regulations or other Medical Staff policies directly to the System Quality Committee. Communication from Medical Staff members to the System Quality Committee will be directed through the CAO, who will forward the request for communication to the chair of the System Quality Committee. The CAO will also provide notification to the MEC by informing the Chief of Staff of such exchanges. The chair of the System Quality Committee will determine the manner and method of the System Quality Committee's response to the Medical Staff member(s).

ARTICLE 9

HISTORY AND PHYSICAL

9.A. ADMITTING PRIVILEGES – HISTORY AND PHYSICAL REQUIREMENT

The member of the Medical Staff admitting a patient must assure that a complete and current medical history and a complete and current physical examination of the patient are carried out by a physician (MD/DO/Podiatrist) or oral-maxillofacial surgeon on the medical staff, or other appropriately credentialed, qualified licensed practitioner in accordance with State law. When the history and physical or admission note is completed by a practitioner other than a physician or oral-maxillofacial surgeon, within the first 24 hours of admission, the supervising physician will see the patient, review the plan of care, and co-sign the H&P making any necessary modifications. To be current, the history and physical must be carried out no more than 30 days before the admission, or within 24 hours after admission, and in any event, prior to any surgery or procedure requiring anesthesia services. If the history and physical were completed before the admission, they must be updated by a physician or oral-maxillofacial surgeon, or other qualified practitioner (as stated above), to include an examination for changes in the patient's condition within 24 hours after admission or prior to any surgery or procedure requiring anesthesia services. Documentation of the history and physical, completed and updated as required herein, must be placed in the patient's chart prior to the procedure requiring anesthesia services.

ARTICLE 10

MEDICAL STAFF DUES

10.A. MEDICAL STAFF DUES

(1) Medical Staff dues will be as recommended by the MEC and may vary by category.

(2) Dues will be payable annually upon request. Failure to pay dues will result in ineligibility for continued appointment and privileges.

(3) Signatories to the Medical Staff account will be the Chief of Staff and Chief-Elect.

ARTICLE 11

ADOPTION

These Bylaws are adopted and made effective upon approval of the Board, superseding and replacing any previous Medical Staff Bylaws, Rules and Regulations, policies, manuals or Hospital policies pertaining to the subject matter contained herein.

Adopted by the Medical Staff on:

Date: September 10, 2018

Approved by the Board:

Date: December 3, 2018