PARKVIEW
LOGANSPORT HOSPITAL

POLICY ON MEDICAL STAFF APPOINTMENT, REAPPOINTMENT, AND CLINICAL PRIVILEGES

Table of Contents

DEFINITION OF TERMS

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

ADVERSELY AFFECTING or **ADVERSE ACTION** - Any action reducing, restricting, suspending, revoking, denying or failing to renew clinical privileges or appointment to the Medical Staff of the Hospital. Letters of reprimand or warning, requirements of proctoring or consultations, investigative suspensions not in excess of fourteen (14) calendar days, requirements of further continuing medical or training, and imposition of terms of probation which do not prevent a Provider from exercising any privileges which have been granted to him shall not constitute "adverse action" and shall not give rise to any rights to a hearing or appeal. Further, automatic suspensions, administrative relinquishments, or terminations, as set forth in Section 2.5, shall not be deemed "Adverse Actions".

BOARD CERTIFICATION - Specialty certification and recertification obtained through appropriate boards of the American Board of Medical Specialties, American Osteopathic Association., American Board of Physician Specialties, American Board of Oral and Maxillofacial Surgery, American Board of Podiatric Medicine or the American Board of Foot and Ankle Surgery.

BOARD OF TRUSTEES or **BOARD** - The governing body of Parkview Logansport Hospital, who has the overall responsibility for the conduct of the hospital.

CHIEF EXECUTIVE OFFICER or President - The individual appointed by the Board to act on its behalf in the overall administrative management of the Hospital.

CHIEF MEDICAL OFFICER - A Provider, employed by or otherwise serving the hospital on a full or part-time basis, whose duties include certain responsibilities, which are both administrative and clinical in nature. Clinical responsibilities are defined as those involving professional capability as a Provider, such as to require the exercise of clinical judgement with respect to patient care and include the supervision of professional activities of Providers and Practitioners under his/her direction.

CLINICAL PRIVILEGES or **PRIVILEGES** - The permission granted by the Board of Trustees to qualified individuals to render specific diagnostic, therapeutic, medical, or surgical services, and includes other circumstances pertaining to the furnishing of medical care under which a Physician or other licensed healthcare practitioner is permitted to furnish such care.

DAYS - As included in this Policy with respect to time allowed for delivery or receipt of any Notice, shall be defined to mean calendar days (i.e., including Saturdays, Sundays, and legal holidays) unless the due date for such Notice or receipt falls on a Saturday, Sunday or legal holiday, in which case the due date shall be the first date immediately following which is not a Saturday, Sunday or legal holiday.

DIRECT ECONOMIC COMPETITION - Any individual who would with reasonable probability have a financial interest in the outcome of any adverse action taken against a provider of medical services.

EX OFFICIO - Service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means with voting rights.

FPPE / FOCUSED PROFESSIONAL PRACTICE EVALUATION – A time–limited evaluation and monitoring of Provider competence for initially privileged Providers, increased privileges or privileged Providers for whom a focused review is indicated.

GOVERNING BODY - The Board of Trustees of the Hospital acting as a hearing body. When the Governing Body is considering appointments or reappointments, delineation of privileges, and/or the proposed corrective action for any Provider, it shall be acting as a Professional Review Body as defined by

the Health Care Quality Improvement Act of 1986 and as a Peer Review Committee as defined by the Indiana Peer Review Act, I.C. §34-30-15 et seq.

HEARING COMMITTEE or **HEARING PANEL** - The Committee appointed under this Policy to conduct an evidentiary hearing properly filed and pursued by an affected Provider.

HOSPITAL - ~~Memorial Hospital~~ Parkview Logansport Hospital of Logansport, Indiana.

INVESTIGATIVE SUSPENSIONS - Suspensions of all or any portion of a Provider's privileges for a period not to exceed fourteen (14) days during which an investigation is being conducted to see if any corrective action is necessary. Investigative suspensions are instituted in the same manner and are reviewable in the same manner as a summary suspension. Investigative suspensions may be imposed to protect either patient safety and/or the orderly operation of the Hospital in a non-disruptive manner. If an investigative suspension is lifted or terminates in fourteen (14) days or less without further corrective action, no right to a hearing or appeal shall arise unless an investigative suspension has been imposed on the same Provider more than twice in any six, (6) month period of time.

MEDICAL EXECUTIVE COMMITTEE or **MEC** - The Executive Committee of the medical staff.

MEDICAL STAFF or **STAFF** - The formal organization of all Providers with an unlimited license to practice medicine in Indiana who are given privileges to attend to patients in the hospital.

OPPE / ONGOING PROFESSIONAL PRACTICE EVALUATION - The routine/ongoing data collection and monitoring for privileged Providers in order to assess a Provider's clinical competence and professional behavior.

ORAL MAXILLOFACIAL SURGEON - An individual with a either a DDS or DMD degree, who then completes further training and is certified by the American Board of Oral and Maxillofacial Surgery, with an unlimited license to practice oral maxillofacial surgery in the state of Indiana.

PEER REVIEW COMMITTEE or **PROFESSIONAL REVIEW BODY** - The governing body of the Hospital, the Medical Staff, the Medical Executive Committee, the Credentials Committee and all other sections and committees of the Medical Staff which evaluate, recommend, or take actions based on the competence or professional conduct of an individual Provider which affects or may affect their clinical privileges or appointment to the Medical Staff, including any recommendation or decision whether the Provider may have clinical privileges with respect to or appointment to the Medical Staff of the Hospital, the scope of conditions of such privileges or appointment, or any changes or modifications in such privileges or appointment. "Peer Review Committees" shall further include any committee of the Medical Staff or board having responsibility of evaluation of patient care which includes the accuracy of diagnosis, appropriateness or necessity of health care rendered by a professional health care provider, and the reasonableness of the utilization of services, procedures and facilities in the treatment of individual patients and such other matters as are within the scope of the Indiana Peer Review Act.

PERSONNEL OF A PEER REVIEW COMMITTEE - Includes not only members of the committee, but also all of the committee's employees, representatives agents, attorneys, investigators, assistants, clerks, staff, and any other person or organization who serves as a Peer Review Committee in any capacity, including any person acting as a member or staff to the committee, any person under a contract or other formal agreement with the committee, and any person who participates with or assists the committee with respect to the action.

PHYSICIAN - An individual with an M.D. or D.O. degree with an unlimited license to practice medicine in Indiana.

PODIATRIST - An individual with a D.P.M. degree, who then completes further training and is certified by the American Board of Podiatric Medicine or the American Board of Foot and Ankle Surgery, with an unlimited license to practice podiatry in the state of Indiana.

PROVIDER - Unless otherwise expressly limited, any Physician, Podiatrist or Oral Maxillofacial Surgeon applying for or exercising clinical privileges in this organization.

PREROGATIVE - A participatory right granted, by virtue of staff category or otherwise, to a staff member and exercisable subject to the conditions imposed in the bylaws and in other hospital and medical staff policies.

PROFESSIONAL REVIEW ACTION - An action or recommendation of a Peer Review Committee which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual Provider (which conduct affects or could affect adversely the health or welfare of a patient or patients or is disruptive or not conducive to the orderly operation of the organization), and which affects (or may affect) adversely the clinical privileges of the Provider. Such term includes a formal decision of a professional review body not to take action or make a recommendation and also includes professional review activities relating to a professional review action and shall further mean any activity of the Hospital with respect to an individual Provider to determine whether the Provider may or may not have clinical privileges with respect to, or appointment to, the Hospital, to determine the scope or condition of such privileges or appointment, or to change or modify such privileges or appointment.

SPECIAL NOTICE - Written notification sent by electronic mail, certified or registered mail, return receipt requested, or by hand delivery.

1 ARTICLE I: APPOINTMENT TO THE MEDICAL STAFF

1.1 QUALIFICATIONS FOR APPOINTMENT:

1.1-1 General Qualifications

A. Appointment to the medical staff is a privilege that shall be extended only to professionally competent individuals who continuously meet the qualifications, standards and requirements set forth in this Policy and in such policies as are adopted from time to time by the board. All individuals practicing medicine at this hospital, unless excepted by specific provisions of this Policy, must first have been appointed to the medical staff. No Provider, including those having a contract with or employment by the Hospital, shall provide any services to patients of the Hospital unless that Provider is a member of the Medical Staff with Clinical Privileges to provide those services or has been granted temporary or emergency privileges in accordance with policy.

B. Those individuals who have been granted medical staff appointment and clinical privileges exclusively for the purpose of providing patient care services at Parkview Logansport Hospital shall be subject to the Medical Staff Bylaws, Rules and Regulations, this Policy, and to those specific policies promulgated by the board which are applicable to the section(s) to which they have been assigned.

C. Appointment shall confer only such prerogative's as have been granted to the member in accordance with these Bylaws and policies.

D. This Policy shall not be deemed a contract of any kind. Applications for, the conditions of, and the duration of appointment to the Medical Staff or the granting of privileges shall not be deemed contractual in nature since the continuance of any such Medical Staff appointment or any such privileges at this hospital is based solely upon an individual's continued ability to justify such appointment and the exercise of such privileges.

E. The timetables for action upon applications, reapplications, clinical privileges and corrective action are set forth in this Policy, but it shall be understood throughout this Policy that the specification of deadlines for action to be taken in the application process or corrective action procedure shall be goals subject to good faith compliance and that failure to comply with any such deadlines after good faith efforts have been made shall not give rise to any rights or causes of action deriving from this Policy.

F. As described in the Medical Staff Bylaws, section 2.8–1, it is the policy of the hospital Medical Staff that certain Hospital facilities shall be used on an exclusive basis in accordance with contracts between the Hospital and qualified providers or groups of providers. Applications for initial appointment or for clinical privileges related to those Hospital facilities and services will not be accepted for processing or considered unless submitted in accordance with an existing or proposed contract with the Hospital.

1.1-2 Specific Qualifications

Only Providers who satisfy the following conditions shall be qualified for appointment to the Medical Staff:

A. are currently licensed to practice in the State of Indiana;

B. document their experience, background and training, current competence, ability to perform the privileges requested, physical health status, and upon request of the Medical Executive Committee or of the Board, mental health status with sufficient adequacy to demonstrate to the Medical Staff and the Board that any patient treated by them will receive care of the generally recognized professional level of quality and efficiency and that they

are qualified to provide a needed service with the hospital (provided, however, that the above evaluation of physical health status and mental health status shall be conducted in a manner consistent with compliance with the Americans with Disability Act);

C. are determined, on the basis of documented references, to adhere strictly to the ethics of their respected professions, to work cooperatively with others, and to be willing to participate in the discharge of staff responsibilities;

D. possess current, valid professional liability insurance coverage in such form and amounts satisfactory to the hospital, to include participation in the Indiana Patient Compensation Fund;

E. are certified by an appropriate specialty board, as described under Board Certification in this Policy's definition of terms, or have fulfilled the training requirements concerning board admissibility for examination for certification, in the area in which privileges are requested, and thereafter certified within five (5) years of initial staff appointment, or within interval designated by the specialty board involved, whichever is longer.

1) An applicant or re-applicant can satisfy the requirement of E above by establishing that his/her qualifications are the equivalent of certification by the most seemingly relevant (in the opinion of the Credentials Committee) board, as described under Board Certification in this Policy's definition of terms. Such equivalency shall usually be dependent upon adequate documentation of formal training and/or experience of specific duration in a residency program eligible for approval by the appropriate American Specialty Board, the Council on Medical Education and Hospitals of the American Medical Association, or the American College of Surgeons. Additional considerations to be used when assessing whether an applicant has demonstrated board certification equivalency include the following, as determined by the Credentials Committee subject to approval by the Board:
   a. Years of practice;
   b. Medical malpractice history;
   c. National Practitioner Data Bank report (privileges, licensure);
   d. Hospital acute vs. outpatient focused practice;
   e. Availability of specialty within the Hospital network;
   f. Patient wait times to see existing same specialty Providers already in community;
   g. Type of membership sought (Active vs. Affiliate);
   h. Applicant role in Hospitals strategic plan.

2) Applicants or re-applicants seeking privileges to perform Emergency Medical Services in the Hospital's Emergency Room as an appointee of the Emergency Medical Staff must be certified in Emergency Medicine, Internal Medicine, Family Medicine, or other acceptable board documented experience subject to the approval of the Credential's Committee. Emergency Medicine Staff who are not Emergency Medicine boarded must obtain and maintain their Advanced Cardiac Life Support certification (ACLS) and Certification in Pediatric Advanced Life Support (PALS), Advanced Trauma Life Support (ATLS) is also encouraged.

3) Extension of or exemption from the Board certification timeline requirement shall be granted rarely and only when such action is deemed by the Board of Trustees to be of extraordinary benefit to the hospital and/or the patient population that it serves.
   a. Extension: A medical staff applicant or re-applicant may request that the Board certification required timeline be extended. When such a request is made, the applicant/member shall bear the burden of demonstrating that their education, training and experience support an extension. The individual's quality record at

the organization must be based upon sufficient volume of activity to permit a valid determination. The applicant/re-applicant must be actively pursuing certification and provide a detailed plan for achieving certification, including a projected examination timeline. The applicant/reapplicant must also meet the yearly CME requirement currently in place under the rules of the most seemingly relevant (in the opinion of the Credentials Committee) Board. The request shall be evaluated based upon_past professional performance as well as any relevant and pertinent factors that might influence the applicant's performance.

b. Exemption: A medical staff applicant or re-applicant may request an exemption from the Board certification requirement when all options to attain certification have been exhausted. The member must actively practice in the organization and be able to demonstrate competency through quality review activities. The Provider will be required to undergo a continued focused professional practice evaluation process to be determined by the Credentials Committee. Approval of the focused review to support competency will be made by the Medical Executive Committee at specified timeframes throughout the Provider's appointment. Only those Providers in good standing will be considered for exemption. Exemption will be in force for the duration of the reappointment cycle only. Exempt Providers must also comply with the designated CME requirements outlined in article 1.1-2E3a and any current and future accreditation standards.

c. In the event the Board of Trustees does not approve the extension or exemption request, the applicant/re-applicant shall not be entitled to a hearing since the determination that an individual is not entitled to an extension or exemption is not a "denial" of appointment or clinical privileges.

1.1-3 No Entitlement to Appointment

No individual shall be entitled to appointment to the Medical Staff or be granted particular clinical privileges in the Hospital merely by virtue of the fact that such individual:

A. is licensed to practice a profession in this or any other state;

B. is a member of any particular professional organization;

C. is certified by any clinical board or;

D. had in the past, or currently has, medical staff appointment or privileges at any hospital.

1.1-4 Non-Discrimination Policy

No aspect of medical staff appointment or particular clinical privileges shall be denied on the basis of sex, gender, race, age, creed, color, national origin, handicap, disability, religion, ancestry, status as a veteran, or other considerations not impacting the applicants ability to discharge the privileges for which he/she has applied, or on the basis of any other criterion unrelated to the delivery of quality patient care in the hospital, to professional qualifications, to the hospital purposes, needs and capabilities, or to community need.

1.2 CONDITIONS OF APPOINTMENT

1.2-1 Duration of Initial Provisional Appointment

A. All initial appointments to the Medical Staff (regardless of the category of staff to which the appointment is made) and all initial clinical privileges shall be provisional for a period of twelve (12) months from the date of the appointment unless otherwise determined by the Board.

B. During the term of the provisional appointment, unless otherwise determined by the Board, all initial appointees to the Medical Staff shall be subject to a period of observation and focused professional practice evaluation "FPPE", (see also #1482 "FPPE/OPPE Policy"). Recommending an initial appointee for, or subjecting an initial appointee to, this period of observation shall not be deemed a professional review action or disciplinary action of any kind, and shall not give rise to any hearing or appeal rights. Each initial appointee shall be assigned to a clinical section where his/her performance shall be observed by the Chief of Section, or such Chief's designee, to determine their eligibility for continued staff appointment in the staff category to which he/she was initially appointed and for exercising the clinical privileges initially granted in that section. Their exercise of clinical privileges in any other section shall also be subject to observation until he/she has furnished to the Credentials Committee, Medical Executive Committee, the President, and the Board:

   1) the required amount of "Individual Case Review Forms (FPPE)" completed by the evaluator to which they are assigned that rate the Provider's skill and competence; and

   2) a "Focused Professional Practice Evaluation Report (FPPE)" signed by the Chiefs of the Sections or their designees in which the appointee exercised clinical privileges that he/she has satisfactorily demonstrated their ability to exercise the clinical privileges initially granted to him/her. Provisional clinical privileges shall be adjusted to reflect clinical competence at the end of the provisional period or sooner if warranted.

C. Continued appointment after the provisional period shall be conditioned on an evaluation of the factors to be considered for reappointment.

1.2-2 Duties of Appointees

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

1.2-3 Time Requirements for Promotion

The period of time and qualification requirements stated in the Medical Staff Bylaws and this Policy may be altered as to specific applicants by the Board on its own motion. If an initial appointee fails within his/her provisional period to furnish the statements required in Section 1.2-1B, his/her staff appointment or particular privileges, as applicable, shall automatically terminate. The initial appointee so affected shall be given special notice of such termination and shall be entitled to the procedural rights provided in this Policy.

1.3 APPLICATION FOR INITIAL APPOINTMENT AND CLINICAL PRIVILEGES

1.3-1 Application Information

Applications for appointment to the Medical Staff shall be in writing, and shall be submitted on forms (electronic or paper) approved by the Board upon recommendation of the Credentials Committee. These forms shall be obtained from the medical staff office or a designee. The application shall contain specific clinical privileges desired by the applicant and shall require detailed information concerning the applicant's professional qualifications including:

A. the names and complete addresses of at least three (3) peers, as appropriate, who have had recent extensive experience in observing and working with the applicant, and who can provide adequate information pertaining to the applicant's present professional competence and character. Said references may not be personally related to the applicant. A minimum of one (1) peer evaluation references must be returned in order for the application to be considered complete.

B. the names and complete addresses of all hospitals or other institutions at which the applicant has worked or trained. If the number of hospitals the applicant has worked in is great or if a number of years have passed since the applicant worked at a particular hospital, the Credentials Committee and the Board may take into consideration such factors (as per Policy #1474, "Medical Staff Services Procedures for Processing Initial Applications for Medical Staff Appointment");

C. information as to whether the applicant's medical staff appointment or clinical privileges have ever been voluntarily or involuntarily relinquished, denied, revoked, suspended, reduced, or not renewed at any other hospital or health care facility;

D. information as to whether the applicant has ever withdrawn his/her application for appointment, reappointment and clinical privileges, or resigned from the Medical Staff before final decision by a Hospital's or Health Care Facility's governing board;

E. information as to whether the applicant's appointment in local, state or national professional organizations, or license to practice any profession in any Jurisdiction or Federal or State Drug Enforcement Administration license is or has ever been suspended, modified, terminated, restricted or is currently being challenged. The submitted application shall include a copy of all the applicant's current licenses to practice, as well as copies of Drug Enforcement Administration license, medical diploma, and certificates from all post graduate training programs completed;

F. information as to whether the applicant has currently in force professional liability insurance coverage, the name of the insurance company and the amount and classification of such coverage, and whether said insurance coverage covers the clinical privileges the applicant or appointee seeks to exercise at the hospital, in addition to proof of participation in the Indiana Patient Compensation Fund (where applicable);

G. information concerning the applicant's malpractice litigation experience, specifically information concerning final judgements or settlements current or pending claims or suits;

H. information concerning any professional misconduct proceedings and any malpractice actions involving the applicant in this state or any other state, whether such proceedings are closed or still pending, including the substance of the allegations of such proceedings or actions, the substance of the findings of such proceedings or actions, the ultimate disposition of any such proceedings or actions as the applicant may deem appropriate;

I. information on the applicant's physical and mental status;

J. information as to whether the applicant has ever been named in any criminal proceedings along with details about any such instance;

K. information on the citizenship and/or visa status of the applicant;

L. the applicant's signature; and

M. such other information as the Board may require.

1.3-2 Undertakings and Requirements

A. The following undertakings shall be applicable to every medical staff applicant and appointee for staff appointment or reappointment as a condition of consideration of such application and as a condition of continued medical staff appointment if granted:

1) an obligation to provide timely and continuous care and supervision to all patients for whom the individual has responsibility and respond in a reasonable time, or arrange a suitable alternative for such care and supervision of their patients;

2) an agreement to abide by all Bylaws and policies of the hospital, including all Bylaws, Rules and Regulations, and other policies of the Medical Staff as shall be in force during the time the individual is appointed to the Medical Staff;

3) an agreement to accept committee assignments and such other reasonable duties and responsibilities as shall be assigned by appointment, election or otherwise;

4) an agreement to provide, with or without request, new or updated information that is pertinent to any question on the application to the organization as it occurs;

5) a statement that the applicant has received and had an opportunity to read the Bylaws, Rules and Regulations of the Medical Staff and the Policy on Appointment, Reappointment and Clinical Privileges as are in force at the time of application, and that the applicant has agreed to be bound by the terms thereof in all matters relating to consideration of the application without regard to whether or not appointment to the medical staff and/or clinical privileges are granted;

6) a statement of the applicant's willingness to appear for personal interviews in regard to the application;

7) a statement that any misrepresentation or misstatement in, or omission from the application, whether intentional or not, shall constitute cause for automatic and immediate rejection of the application resulting in denial of appointment and clinical privileges. In the event that an appointment has been granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery may result in summary dismissal from the medical staff;

8) an agreement that when an adverse ruling is made with respect to a Provider's staff appointment, staff status, and/or clinical privileges, he/she will exhaust the administrative remedies afforded by these bylaws before resorting to formal legal action;

9) authorizes hospital representatives to consult with others who have been associated with them and/or who may have information bearing on his/her competence and qualifications, and to make inquiries to the National Practitioner Data Bank regarding the applicant;

10) consents to hospital representatives inspecting all records and documents that may be material to an evaluation of their professional qualifications and competence to carry out the clinical privileges they request, of their physical and mental health status and of their professional ethical qualifications;

11) releases from any liability all hospital representatives for their acts performed in good faith and without malice in connection with evaluating the applicant and their credentials;

12) releases from liability all individuals and organizations who provide information, including otherwise privileged or confidential information to hospital representatives in good faith and without malice concerning the applicant's competence, professional ethics, character, physical and mental health, emotional stability, and other qualifications for staff appointment and clinical privileges;

13) authorizes and consents to hospital representatives providing other hospitals, medical associations, licensing boards, and other organizations concerned with provider performance and the quality and efficiency of patient care and any information relevant to such matters that the hospital may have concerning them, and releases hospital

representatives from liability for so doing, provided that such furnishings of information is done in good faith and without malice.

For purposes of this Section, the term "hospital representative" includes the Board, its Directors and Committees; the President or their designee; the Medical Staff Organization and all Medical Staff members, Clinical Sections and Committees that have responsibility for collecting or evaluating the applicant's credentials or acting upon their application; and any authorized representatives of any of the foregoing.

B. The following requirements shall be applicable to every medical staff applicant and appointee for staff appointment or reappointment as a condition of consideration of such application and as a condition of continued medical staff appointment if granted:

1) to refrain from any illegal fee splitting or other illegal inducements relating to patient referral;

2) to refrain from delegating responsibility for diagnoses or care of ~~hospitalized~~ patients to any individual who is not qualified to undertake this responsibility or who is not adequately supervised;

3) to refrain from deceiving patients as to the identity of an operating surgeon or any other individual providing treatment or services;

4) to seek consultation whenever necessary;

5) to abide by generally recognized ethical principles applicable to the applicant's profession as per the "Ethics Manual" of the American College of Physicians, the "Code of Ethics" of the American Osteopathic Association, the "Code of Professional Conduct" of the American College of Surgeons, the "Code of Medical Ethics" of the American Medical Association, the "Code of Ethics" of the American Podiatric Medical Association and/or the "Code of Professional Conduct" of the American Association of Oral and Maxillofacial Surgeons, as described in the Medical Staff Bylaws section 2.2–3 C;

6) to abide by the Parkview Logansport Hospital "Code of Conduct" and "Standards of Behavior", as described in the Medical Staff Bylaws section 2.2–3 C;

7) to uphold and promote the provisions of the Confidentiality Policy of Parkview Logansport Hospital (#1421);

8) to provide for continuous care of their patients;

9) to prepare and complete in a timely fashion the medical and other required records for all patients they admit or in any way provide care to in the hospital or ambulatory setting;

10) to become and remain a qualified provider under Indiana's Medical Malpractice Act; and to provide the Chief of Staff and the President (or their designee's) with immediate written notice of any malpractice claim or lawsuit or any disciplinary proceeding instituted against the Provider, as well as periodic written status reports, upon the request of the Chief of Staff or President (or their designee's), of any such malpractice claim, lawsuit or disciplinary proceeding.

C. Each applicant for medical staff appointment shall specifically agree to these undertakings and requirements as part of their appointment to the medical staff.

1.3-3 Burden of Providing Information

A. The applicant shall have the burden of producing information deemed adequate by the hospital for a proper evaluation of competence, character, ethics and other qualifications, and of resolving any doubts about such qualifications.

B. The applicant shall have the burden of providing evidence that all the statements made and information given on the application are true and correct.

C. Until the applicant has provided all information requested by the hospital, the application for appointment or reappointment will be deemed incomplete and will not be further processed.

D. Should information provided in the initial application for appointment change during the course of an appointment year, the appointee has the burden to provide information about such change to the Credentials Committee sufficient for that committee's review and assessment.

1.3-4 Authorization to Obtain Information

The following statements, which shall be included on the application form and which form a part of this Policy, are express conditions applicable to any medical staff applicant, any appointee to the medical staff, and to all others having or seeking clinical privileges at the hospital. By applying for appointment, reappointment or clinical privileges, the applicant expressly accepts these conditions during the processing and consideration of the application, whether or not appointment or clinical privileges are granted. This acceptance also applies during the time of any appointment or reappointment.

A. Immunity: To the fullest extent permitted by law, the applicant or appointee releases from any and all liability, and extends absolute immunity to the hospital, its authorized representatives and any third parties as defined in subsections (D-E) below, with respect to any acts, communications or documents, recommendations or disclosures involving the applicant or appointee, concerning the following:

1) application for appointment or clinical privileges, including temporary privileges;

2) periodic reappraisals undertaken for reappointment or for increase or decrease in clinical privileges;

3) proceedings for suspension or reduction of clinical privileges or for denial or revocation of medical staff appointment, or any other disciplinary action;

4) summary suspensions and/or administrative relinquishments;

5) hearings and appellate reviews;

6) hospital and medical staff performance improvement evaluations and peer reviews;

7) utilization reviews;

8) matters or inquiries concerning the applicant's or appointee's professional qualifications or conduct, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, or behavior; or

9) any other matter that might directly or indirectly relate to the applicant's or appointee's competence, to patient care, or to the orderly operation of this or any other hospital or health care facility.

B. Authorization to Obtain Information: The applicant or appointee specifically authorizes the hospital and its authorized representatives to consult with any third party who may have

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

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

D. Definitions: As used in this Section, the term "hospital and its authorized representatives" means the hospital corporation and any of the following individuals who have any responsibility for obtaining or evaluating the applicant's or appointee's credentials, or for acting upon that individual's application or conduct at the hospital; the members of its Board and their appointed representatives; the President or their designees; other hospital employees; consultants to the hospital; the hospitals' attorney and the attorney's partners, associates or designees; and all appointees to the Medical Staff who have any responsibility for obtaining or evaluating the individual's credentials, or for acting upon that individual's application or conduct at the hospital.

E. As used in this section, the term "third parties" means all individuals from whom information has been requested by the hospital or its authorized representatives, including appointees to the hospital's Medical Staff and appointees of the Medical Staffs of other hospitals, other Physicians or health care practitioners, other organizations, associations, partnerships and corporations, whether hospital, health care facilities or not, government agencies, and police agencies for the purpose of a criminal history check.

1.4 PROCEDURE FOR INITIAL APPOINTMENT

1.4-1 Pre-Application Process

A. An application for appointment to the Medical Staff shall only be sent upon request to those individuals who, according to the Medical Staff Bylaws and this Policy, are eligible for appointment to the Medical Staff; who meet the threshold criteria for privileges as stated in this Policy to provide care and treatment to patients for conditions and diseases for which the organization has facilities and personnel; and who indicate an intention to utilize the organization as required by the staff category to which they desire appointment.

B. An individual requesting an application for appointment shall initially be sent (1) a letter that outlines basic qualifications for appointment consideration and explains the review process, and (2) a pre-application form that requests proof that the individual can meet the basic qualifications for appointment consideration. A completed pre-application form with copies of all required documents must be returned to the President or a designee within thirty (30) days after receipt of same if the individual desires further consideration.

C. Those individuals who meet the basic qualifications for consideration for appointment to the Medical Staff shall be given an application for appointment. Individuals who fail to meet the basic qualifications shall not be given an application and shall be so notified.

1.4-2 Submission of Application

The application for medical staff appointment shall be submitted by the applicant to the President or a designee. It must be accompanied by payment of such processing fees as may be approved by the Board.

1.4-3 Medical Staff Services Procedure

Following receipt of the application processing fee, the application will be processed by Medical Staff Services as per Policy #1474 "Medical Staff Services Procedures for Processing Initial Applications for Medical Staff Appointment".

A. After reviewing the application to determine that all questions have been answered, and all references and information or materials deemed pertinent are present, the information provided in the application will be verified with the primary sources.

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

C. Each Medical Staff appointee may have an opportunity to submit to the Credentials Committee, in writing, information bearing on the applicant's qualifications for staff appointment or clinical privileges. In addition, any current Medical Staff appointee shall have the right to appear in person before the Credentials Committee to discuss in private and in confidence any concerns the appointee may have about the applicant.

D. Following the submission of an application, the applicant, with the prior written consent of the Credentials Committee, may withdraw, modify or amend the application.

E. The President or their designee or Medical Staff Services shall transmit the complete application and all supporting materials to the appropriate clinical Section Chief.

1.4-4 Section Chief Procedure

A. The Chief of each clinical section in which the applicant seeks clinical privileges shall provide the Credentials Committee with an electronic or written report concerning the applicant's qualifications for appointment and specific written findings supporting the proposed delineation of the applicant's clinical privileges. As part of the process of making this report, the clinical Section Chief has the right to meet with the applicant to discuss any aspect of the application, qualifications and requested clinical privileges.

B. The clinical Section Chief, or their designee, shall evaluate the applicant's education, training and experience and may make inquiries with respect to the same to the applicant's past or current department/section chief(s) and/or the residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others.

C. The appropriate clinical Section Chief shall be available to the Credentials Committee to answer any questions that may arise with respect to the report and findings.

1.4-5 Credentials Committee Procedure

A. It shall be the duty of the Credentials Committee to conduct an appropriate investigation of facts and circumstances relevant to the application and make a written report of the results thereof to the Executive Committee. In connection with its investigation, the Credentials Committee shall examine evidence of the applicant's character, professional competence, qualifications, prior behavior and ethical standing through information contained in references given by the applicant and from other sources available to the committee, including the report and findings from the Chief of each clinical section in which privileges are sought, to determine whether the applicant has established and satisfied all of the necessary qualifications for appointment and for the clinical privileges requested.

B. As part of the process of making its investigation and subsequent report to the Medical Executive Committee, the Credentials Committee may require a physical and/or mental examination of the applicant by a Physician or Physicians satisfactory to that committee and shall require that the results be made available for the committee's consideration. Failure of an applicant to procure such an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall constitute a voluntary withdrawal of the application for appointment and clinical privileges, and all processing of the application shall cease. The above shall be performed within the boundaries of strict adherence to the Americans with Disabilities Act.

C. The Credentials Committee shall have the right to require the applicant to meet with the committee to discuss any aspect of the applicant's application, qualifications, or clinical privileges requested.

D. The Credentials Committee may use the expertise of the clinical Section Chief, or any member of the clinical section, or an outside consultant, if additional research is required into the applicant's qualifications.

E. If, after considering the report of the clinical Section Chief concerned, the Credentials Committee's investigation and report on the application are favorable, the Credentials Committee shall recommend provisional service assignment. All recommendations to appoint, including provisional appointment, must specifically recommend clinical privileges to be granted, which may be qualified by any probationary, observational FPPE or other conditions or restrictions.

1.4-6 Medical Executive Committee Procedure

A. The Medical Executive Committee shall review the Credentials Committee's report on the application, and shall then transmit its recommendation to the Board, together with the report of the Credentials Committee. To the extent that any findings or recommendations of the Medical Executive Committee are inconsistent with the conclusions set forth in the Credentials Committee's report, the Medical Executive Committee's recommendations shall be accompanied by a written statement that describes clear and convincing reasons for such discrepancies and is accompanied by supporting evidence or information.

1.4-7 Board Decision on Application

A. The decision on the application shall be made by the Board. In making its decision, the Board may either adopt or reject the findings and recommendations of the Medical Executive Committee, may refer the application to either committee (or a source inside or outside the hospital) for further research and investigation, may meet with the Chairperson

of the Credentials Committee and/or the Medical Executive Committee, or take such other action with regard to the evaluation of the application as it deems appropriate.

B. If the Board, after informal discussion, is inclined to take action that would entitle the applicant to request a hearing pursuant to this Policy, it shall inform the President or their designee who shall promptly so notify the applicant by special notice, as defined in this Policy, and make no decision until the applicant has had an opportunity to exercise the right to a hearing and appeal as provided in this Policy.

C. Except as expressly stated in this Policy, notice of the Board's final decision shall be given, through the President or their designee to the applicant by means of a special notice. This notice shall include:

1) the staff category to which the applicant is appointed;

2) the term of the appointment;

3) the clinical specialty he/she may exercise; and

4) any special conditions attached to the appointment.

1.4-8 Reapplication after Adverse Appointment Decision

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

1.5 CLINICAL PRIVILEGES

1.5-1 General

A. Medical Staff appointment or reappointment as such shall not confer any clinical privileges or right to practice at the hospital. Each individual who has been appointed to the Medical Staff shall be entitled to exercise only those clinical privileges specifically granted by the Board.

B. The grant of clinical privileges shall carry with it acceptance of the obligation of such privileges including emergency service and other rotational obligations, and clinical privileges shall be voluntarily relinquished only in the manner that provides for the orderly transfer of such obligations.

C. The clinical privileges recommended to the Board shall be based upon the following:

1) the applicant's education, training, experience, demonstrated current competence and judgment, references, utilization patterns, health status and physical ability to perform the tasks and essential functions (with or without reasonable accommodations);

2) availability of qualified Providers or other appropriate appointees to provide medical coverage for the applicant in case of the applicant's illness or unavailability;

3) adequate levels of professional liability insurance coverage with respect to the clinical privileges requested;

4) the organization's available resources and personnel;

5) any previously successful or currently pending challenges to any licensure or registration, or the voluntary relinquishment of such licensure or registration, information concerning any voluntary or involuntary termination of Medical Staff

appointment or voluntary or involuntary limitations, reduction, or loss of clinical privileges at another hospital; and

6) other relevant information, including a written report and findings by the Chairperson of each of the clinical service committees in which such privileges are sought.

D. The applicant shall have the burden of establishing qualifications for and competence to exercise the clinical privileges requested.

E. The report of the Chief of the clinical section in which privileges are sought shall be forwarded to the Credentials Committee and processed as a part of the initial application for staff appointment.

1.5-2 Proctoring

Certain privileges may require proctoring and FPPE, as stipulated in the relevant privilege request form. The sole purpose of proctoring and FPPE is to assess the relevant competence of a Provider granted privileges. Proctors are not present to supervise, instruct, or back up the proctored Provider. There is no expectation that they would intervene in patient care, except in case of emergency, as would be expected from any available staff member.

A. Appointment of Proctors:

1) The Credentials Committee shall appoint the proctor(s) for the Provider. If a vacancy in proctor occurs, the Credentials Committee may appoint a replacement. When no one on the staff can feasibly function as a proctor, the Credentials Committee may allow a satisfactory report based on direct observation of the applicant by an outside authority (whose expertise in the field is established to the satisfaction of the Credentials Committee) to suffice as evidence of competence in lieu of further proctoring.

2) Proctors must have appropriate expertise for the type of procedures they are proctoring, and should, when possible be a Provider in the same specialty as the applicant. If an outside proctor is engaged, such a proctor must obtain temporary privileges prior to proctoring.

3) Proctors shall be appointed to minimize potential conflicts of interest (either of partnership or of competition).

B. Proctoring Process:

1) Until the proctor has submitted all of the FPPE report as requested by the Credentials Committee, and the report has been reviewed by the appropriate Medical Staff committee(s), and privileges without conditions have been granted, the Provider shall arrange for the presence of a proctor whenever they exercise privileges requiring proctoring. The Provider's privileges are conditional on a proctor being present.

2) When the proctor agrees that either (1) the Provider has fulfilled the required number of FPPE cases and adequately demonstrated competence in exercising the proctored privileges, or (2) the Provider has demonstrated that he/she is not competent to exercise the proctored privileges without additional training, they shall send a report to the Credentials Committee. This report shall document the extent of their proctoring, and summarize their findings.

3) When there are two proctors, and the proctors disagree on whether to issue a favorable or unfavorable FPPE report, or whether to issue any report, they will both report to the Credentials Committee, who will seek to resolve the matter. No proctor who favors submitting an unfavorable report shall be required to continue proctoring. If with the assistance of the Credentials Committee the proctors are still not able to come to a joint

report, their several reports shall be submitted to the Credentials Committee for resolution.

C. Effect of Proctoring Report:

1) If favorable, the clinical Section Chief or other designee shall forward a copy of the FPPE proctoring report to the Credentials Committee, via the Medical Staff Office. The FPPE report regarding the relevant privileges will be discussed by the Credentials Committee.

2) If unfavorable, the clinical Section Chief or other designee shall forward a copy of the FPPE proctoring report to the Credentials Committee, via the Medical Staff Office. The relevant privileges shall be discussed by the Credentials Committee and further determination will be made whether to extend the FPPE proctoring or immediately expire the clinical privileges. The Provider may not reapply for the same privileges without first submitting documentation of additional training.

D. Appeal of Unfavorable Report: The Provider may appeal an unfavorable FPPE proctoring report to the Credentials Committee only on the grounds that the proctoring report's recommendations lack any substantial factual basis, or that the basis for its conclusions are arbitrary, unreasonable or capricious. The Credentials Committee may ask a subcommittee to investigate and report back to it. The Credentials Committee shall within 60 days either ratify the proctoring report, or grant the Provider the immediate right to a new proctor.

E. Obligations and Protections: The role of proctor is a delegated credentialing function, and as such is subject to the same obligations of confidentiality and legal protections as apply to the Credentials Committee.

1.5-3 Providers under Contract with the Hospital

From time to time, the Board may enter into contractual or employment relationships on behalf of the hospital with Providers, groups of Providers, or other healthcare professionals for the performance of certain services, including but not limited to clinical and/or medico-administrative services. All individuals functioning pursuant to such contracts or employment relationships shall obtain and maintain appropriate Medical Staff appointment and clinical privileges in accordance with the provisions of this Policy. Such individuals shall be fully subject to the Medical Staff Bylaws, Rules and Regulations, this Policy and the Hospital Bylaws and Policies, where applicable. Issues regarding Providers providing contractual professional services, including the effect of Medical Staff appointment termination and the effect of contract expiration or termination are discussed in the Medical Staff Bylaws section 2.8–1.

1.6 VOLUNTARY RELINQUISHMENT OF PRIVILEGES

1.6-1 Request to Relinquish Clinical Privileges

A Medical Staff appointee who desires to voluntarily relinquish any one or more of the clinical privileges granted at any time during the appointment period may submit a written request to the Chairperson of the Credentials Committee specifying the clinical privilege(s) to be relinquished. Said relinquishment of privileges shall not be effective until acknowledged in writing by the Board. The procedure set forth in this Part shall not apply to situations where the appointee has been deemed by the Hospital to have voluntarily relinquished privileges pursuant to this Policy, the Medical Staff Bylaws, Rules and Regulations, or the Hospital Bylaws or Policies.

1.6-2 Procedure for Relinquishment of Clinical Privileges

A. Upon receipt of a request to relinquish one or more clinical privileges, the Credentials Committee shall review the request and forward a recommendation to the Board for final action. The Credentials Committee may request a meeting with the appointee involved if the decrease of clinical privileges would create a deficiency in available hospital services.

B. A report of such meeting shall be submitted with the Credentials Committee's recommendation to the Board.

C. The Board shall act on the request and its decision shall be reported in writing by the President or their designee to the appointee, the Credentials Committee and the Chief of the applicable clinical section. The decision of the Board shall specify a specific date by which relinquishment of clinical privilege(s) shall become effective.

D. Failure to relinquish any clinical privilege pursuant to Sections 1.6-1 and 1.6-2 or to adhere to the effective date specified by the Board for relinquishment of the clinical privileges in question shall constitute grounds for professional review action pursuant to this Policy.

1.7 PROCEDURE FOR TEMPORARY CLINICAL PRIVILEGES

Upon recommendation from the Chief of Staff, the applicable Section Chief, or their designee, the President or their designee, acting on behalf of the Board, may grant temporary privileges. This may occur regarding temporary privileges for applicants whose initial application is complete, for the care of specific patients by non-applicants, locum tenens, and times of emergency and/or disaster. When temporary privileges are granted, the Board will be notified. Special requirements of supervision and reporting may be imposed by the clinical Section Chief concerned on any individual granted temporary privileges. Temporary privileges shall be immediately terminated by the President or a designee upon notice of any failure by the individual to comply with such special conditions.

1.7-1 Temporary Clinical Privileges for Applicants

Temporary privileges shall not routinely be granted to applicants. In the circumstance where an initial application is complete, and contains all the ACHC required elements as outlined in 03.01.15, and the application is awaiting almost assured approval from the Credentials Committee, the MEC and/or the Board, and when the Provider is needed to fill an important patient care need, then temporary clinical privileges may be considered. The applicant must have satisfied the specific qualifications for appointment to the Medical Staff as set forth in section 1.1–2 and Policy #1474. The President or their designee shall consult with and receive written approval from the Section Chief, the Chief of Staff, and the Chairperson of the Credentials Committee, or their designee(s). In that circumstance, the President or their designee may grant, as appropriate, temporary admitting, patient care and/or, clinical privileges to an applicant for a specific time period up to 120 days. In exercising such privileges, the applicant shall act under the supervision of the Chief or appropriate designee of the clinical section in which the applicant has requested primary privileges.

1.7-2 Temporary Clinical Privileges for Non-Applicants

A. Care Of Specific Patient(s)

Temporary admitting, if applicable, and clinical privileges for care of a specific patient or patients may be granted by the President or their designee to a Provider who is not an applicant for appointment in the same manner and upon the same conditions as set forth in Section 1.7-2 B 2) provided that the President or their

designee shall first obtain such individual's signed acknowledgement to be bound by the Hospital Bylaws, this Policy and Medical Staff Bylaws, Rules and Regulations then in force in all matters relating to temporary clinical privileges. Such privileges shall be restricted to the specific patients for which they are granted. Such privileges shall be restricted to the treatment of not more than five, (5) patients in any one year by any Provider, after which such Provider shall be required to apply for appointment on the Medical Staff before being allowed to attend additional patients.

B. Visiting Preceptor

1) This is a form of temporary privileges for specific patient(s), in which those patients are the patients of a Medical Staff member who has a condition for which preceptoring is indicated. Upon receipt of a written request for specific temporary privileges, an appropriately licensed Provider of documented competence who is serving as a preceptor for an appointee of the Medical Staff may, without applying for appointment to the Staff, be granted temporary privileges for a period of sixty (60) days. Preceptor privileges may be renewed for an additional sixty (60) day period. This shall be limited to no more than ten (10) patients. They are limited to preceptoring and otherwise supervising the treatment of the patients of the staff appointee for whom this Provider is serving as a preceptor and do not entitle him/her to admit his/her own patients to the hospital. As a preceptor, the Provider shall assume shared responsibility for clinical care of the patient with the Provider with restricted privileges.

2) Due to the nature of this preceptor request, an abbreviated verification process will take place and will include the following:

a. Primary source verification of current IN licensure and Drug Enforcement Administration Registration

b. Primary source (or acceptable equivalent) verification of education and training

c. Verification of current competency:

1. One (1) Peer Reference
2. Case log showing experience in the respective procedure(s)
3. Hospital Affiliation verification from his/her current primary hospital

d. National Practitioner Databank Query

e. OIG Database Query

f. Malpractice history will be evaluated via the NPDB at minimum but additional information may be required

g. Proof of current malpractice coverage for services provided at Parkview Logansport Hospital.

1.7-3 Locum Tenens

1) The President or their designee may grant a Provider serving as a locum tenens temporary admitting, if applicable, and clinical privileges to attend patients for an initial period of one hundred twenty (120) days without applying for appointment to the Medical Staff. Such privileges may be renewed for one successive period of one hundred twenty (120) days. If a Provider will be providing services in the Hospital for longer than that, they should apply for Medical Staff Appointment and Clinical Privileges through the standard process.

2) The individual serving as a locum tenens must complete a request for clinical privileges form and must have in force and effect a current license to practice in this state, a DEA registration and CSR, if applicable, and professional liability insurance in an amount and terms acceptable to the Hospital.

A. Medical Staff Services Process

1. The requesting service/specialty will provide the following to Medical Staff Services:

a. Applicant's CV

b. Completed Locum Tenens Pre-Application

c. Physician Narrative - Physician or representative of requesting specialty will conduct a phone or personal interview to gather and confirm information:

(1) Validate adequate verbal communication skills and clinical reasoning to be able to provide quality patient care

(2) Current board certification or eligibility status (certified in primary specialty within 5 years of first opportunity)

(3) Current Indiana medical license and CSR – or application in process

(4) Experience that demonstrates current clinical competence in the specialty

(5) Intentions in practicing as a locum tenens

d. Reason for need and dates of coverage

e. Agency/applicant contact name and email address

2. The Medical Staff Services Manager will email a request for approval to the Hospital President or COO, Medical Staff President, and Medical Staff Services Director and include/attach the items listed above (a. through e.).

3. Hospital President or COO and Medical Staff President will send response to Medical Staff Services. If approved, an application will be sent to agency/physician contact the same day approval is received.

4. Applications for temporary privileges for locum tenens coverage are to be received by Enterprise Credentialing no later than three weeks prior to the proposed start date, to ensure timely completion of verifications.

B. Enterprise Credentialing Process

Upon receipt of a completed application and all required documentation and approvals, Enterprise Credentialing will:

1. Document date received and review application for completeness and concerns

2. Review privilege form for Adv privileges. Send to MS for review. May require program director attestation. See 3.c.(3)

3. Perform verification by primary source and in accordance with Medical Staff credentialing policies to include:

a. Enter and verify state licenses from a minimum of 3 states, if applicable, where applicant most recently practiced, and any license applicant reported as having been challenged

b. Current CSR and Federal DEA, if applicable, and any registration reported as having been challenged

c. Relevant training and/or experience will be verified by the AMA Profile

(1) Medical Education (degree)

(2) ECFMG

(3) Internship, Residency, Fellowship, etc. Enter all education into MSOW, including all foreign education and training NOTE: If Adv privileges requested, criteria may require attestation from program director. Training verification will need to be obtained

d. Any information related to involuntary termination of medical staff membership, limitation, reduction, denial, or loss of clinical privileges requested.

e. Hospital affiliations - Current competence and ability to perform privileges requested* *Note: Due to the typically large number of facilities where locum services are provided, the number of facilities entered into the database and queried is limited to 3 recent hospital affiliations offering length of service to support current competency evaluations. Facilities will be selected from different states, as applicable to coincide with state license verifications.

f. Specialty board certification, as applicable

g. National Practitioner Data Bank (NPDB) query

h. OIG query

i. SAM query

j. Medicare Opt Out

4. Obtain current Malpractice Certificate of Insurance

5. Peer References – Send 3 Peer references, 1 from most recent assignment as applicable.

6. Only Gaps that are within the timeframe for current competency will need to be addressed

7. If applicant returns for subsequent locum tenens assignments, and verifications have not been completed for 180 days, Enterprise Credentialing will re-verify those items above that may be subject to change, including current license, CSR, DEA, COI, NPDB, OIG, board certification and current hospital affiliations.

1.7-4 Times of Emergency and/or Disaster

1) As part of emergency preparedness, where the Hospital might be flooded with patients and the need is present for additional Provider help, the hospital shall follow Policy #1476, "Disaster Credentialing" along with ACHC standards 03.01.17 and 09.01.09, in regard to providing temporary privileges for Providers not already on the Hospital Medical Staff.

1.7-5 Termination of Temporary Clinical Privileges

A. The President or their designee may, at any time after receiving a recommendation from the Chief of Staff or the Chief of the Clinical Section responsible for the individual's supervision, terminate temporary admitting privileges. Clinical privileges shall then be terminated when the individual's patients are discharged from the hospital. However,

where it is determined that the care or safety of such patients would be endangered by continued treatment by the individual granted temporary privileges, a summary termination of temporary clinical privileges may be imposed by the President, the clinical Section Chief, or the Chief of Staff, (or their designee's) and such termination shall be immediately effective.

B. The appropriate clinical Section Chief or the Chief of Staff shall assign to a medical staff appointee responsibility for the care of such terminated individual's patients until they are discharged from the hospital, giving consideration wherever possible to the wishes of the patient in the selection of the substitute.

C. The granting of any temporary admitting and clinical privileges is a courtesy on the part of the hospital. Neither the granting, denial nor termination of such privileges shall entitle the individual concerned to any of the procedural rights provided in this Policy with respect to hearings and appeals.

1.8 EMERGENCY CLINICAL PRIVILEGES

1.8-1 This Section of the Policy deals with patient emergencies, and the response of members of the Hospital Medical Staff to those emergencies, both within times of hospital/community emergency and/or disaster, and with specific patient emergencies occurring outside generalized times of disaster. For the purpose of this section, an "emergency" is defined as a condition which could result in serious or permanent harm to a patient(s) and in which any delay in administering treatment would add to that harm or danger.

1.8-2 In the case of an emergency, any Provider, to the degree permitted by his/her license and regardless of service, staff status or clinical privileges, shall be permitted to do, and shall be assisted by Hospital personnel in doing, everything possible to save the life of a patient or to save a patient from serious harm.

1.8-3 Similarly, in an emergency, a Provider currently appointed to the Medical Staff may be permitted by the hospital to act in such emergency by exercising clinical privileges not specifically granted to that appointee. When the emergency situation no longer exists, such Provider must request the temporary privileges necessary to continue to treat the patient. In the event such temporary privileges are denied or not requested, the patient shall be assigned by the Chief of Staff or their designee to an appointee of the Staff with appropriate clinical privileges. The wishes of the patient shall be considered in the selection of a substitute Provider.

2 ARTICLE II: ACTIONS AFFECTING MEDICAL STAFF APPOINTEES

2.1 PROCEDURE FOR REAPPOINTMENT

2.1.1 Application

A. Each current appointee who is eligible to be reappointed to the Medical Staff shall be responsible for completing the reappointment application form approved by the Board. The reappointment application shall be submitted to the President or a designee, via the Medical Staff Office, at least two, (2) months prior to the expiration of the appointee's current appointment period. Failure to submit an application by that time without good cause will be deemed a voluntary resignation from the staff and will result in automatic expiration of the appointee's appointment and clinical privileges at the end of the then current medical staff appointment. An appointee whose appointment is so terminated shall be entitled to the procedural rights provided in this Policy for the sole purpose of determining the issue of good cause. In special circumstances, this may be waived by the Chairman of the Credentials Committee.

B. Reappointment, if granted by the Board, shall be for a period of not more than two, (2) years.

2.1-2 Factors to be Considered

Each recommendation concerning reappointment of an individual currently appointed to the Medical Staff shall be based upon such appointee's qualifications and demonstrated competency within the applicable scope of practice:

A. ethical behavior, clinical competence and clinical judgment in the treatment of patients;

B. attendance at Medical Staff, clinical sections and standing committee meetings, if applicable, and participation in staff duties;

C. compliance with the Hospital Bylaws and policies and with the Medical Staff Bylaws and Rules and Regulations and associated Policies;

D. behavior at the Hospital, including cooperation with Medical Staff and Hospital personnel as it relates to patient care, the orderly operation of this Hospital, and general attitude toward patients, the Hospital and its personnel;

E. use of the organization's facilities for patients, taking into consideration the individual's comparative utilization pattern;

F. physical, mental and emotional health status, within the boundaries of strict adherence to the Americans with Disabilities Act;

G. capacity to satisfactorily treat patients as indicated by the results of the Hospital's quality assessment, performance improvement, Medical Staff Section peer review, and Ongoing Professional Practice Evaluation-OPPE activities or other reasonable indicators of continuing qualifications;

H. Medical Staff appointees must present evidence of continuing medical education at the time of reappointment, or demonstrate that the Provider has been currently re-accredited by an appropriate specialty board. Providers shall satisfactorily complete such continuing education requirements as may be imposed by law, or applicable accreditation agencies;

I. current licensures, including currently pending challenges to any license or registration;

J. voluntary or involuntary termination of Medical Staff appointment or voluntary or involuntary relinquishment, limitation, reduction, or loss of clinical privileges at another hospital;

K. proof of adequate professional liability insurance, (including cancellations, non-renewals and limits), claims, suits and settlements since last appointment;

L. information as to whether the applicant has ever been convicted or is currently under indictment for a felony;

M. other reasonable indicators of continuing qualifications and relevant findings from the hospital's quality assessment activities.

2.1-3 Section Chief Procedure

A. Upon receipt of the completed (assembled and verified) reappointment application, Medical Staff Services shall send to the clinical Section Chief a copy of the appointee's application and clinical privileges requested.

B. No later than fourteen (14) days after receipt of the application, each clinical Section Chief shall provide the Credentials Committee a recommendation concerning each individual

seeking reappointment. The Chief shall include in their recommendation, when applicable, the reasons for any changes in staff category, in clinical privileges, or for non-reappointment for those who applied for changes and for those who did not. The Section Chief concerned shall also be available to the Credentials Committee to answer any questions that may be raised with respect to any such recommendation.

2.1-4 Credentials Committee Procedure

A. It shall be the duty of the Credentials Committee to conduct an appropriate investigation of factors relevant to the application as set forth in section 2.1-2, and to then make a written report of the results thereof to the Medical Executive Committee.

B. As part of the process of making its investigation and subsequent report to the Medical Executive Committee, the Credentials Committee may require that an individual currently seeking reappointment procure a physical and/or mental examination by a Physician or Physicians satisfactory to the Credentials Committee either as part of the reapplication process or during the appointment period to aid it is determining whether clinical privileges shall be granted or continued. The results of such examination shall be available for the Credentials Committee's consideration. Failure of an individual seeking reappointment to procure such an examination within reasonable time after being requested to so in writing by the Credentials Committee shall constitute a voluntary relinquishment of all clinical privileges until such time as that committee has received the examination results and has had a reasonable opportunity to evaluate them and make a recommendation thereon. The above shall be performed within the boundaries of strict adherence to the Americans with Disabilities Act.

C. The Credentials Committee shall have the right to require the appointee to meet with the Committee to discuss any aspect of the individual's reappointment application, qualifications, or clinical privileges requested.

D. The Credentials Committee may use the expertise of the clinical Section Chief, or any member of the Section, or an outside consultant, if additional research is required into the appointee's qualifications for reappointment.

E. If, after considering the report of the clinical Section Chief concerned, the Credentials Committee's investigation and report on the application are favorable, it shall recommend reappointment and the specific clinical privileges to be granted, which may be qualified by any probationary or other conditions or restrictions, as appropriate.

2.1-5 Medical Executive Committee Procedure

A. The Executive Committee shall review the Credential's Committee's report on the application, and shall then transmit its recommendation to the Board, together with the report of the Credentials Committee. To the extent that any findings or recommendations of the Medical Executive Committee are inconsistent with the conclusions set forth in the Credentials Committee's report, the Medical Executive Committee's recommendations shall be accompanied by a written statement that describes clear and convincing reasons for such discrepancies and is accompanied by supporting evidence or information.

2.1-6 Board Decision on Application

A. The decision on the application shall be made by the Board. In making its decision, the Board may either adopt or reject the findings and recommendations of the Medical Executive Committee, may refer the application to either committee (or a source inside or outside the hospital) for further research and investigation, may meet with the Chairpersons

of the Credentials Committee and Medical Executive Committee, or take such other action with regard to the evaluation of the application as it deems appropriate.

B. If the Board (or its committee), after informal discussion, is inclined to take action that would entitle the applicant to request a hearing pursuant to this Policy, it shall inform the President or their designee who shall promptly so notify the applicant in writing, and make no decision until the applicant has had an opportunity to exercise the right to a hearing and appeal as provided in this Policy.

C. Except as expressly stated in this Policy, notice of the Board's final decision shall be given, through the President or their designee to the applicant by means of a special notice. This notice shall include:

1) the staff category to which the applicant is appointed;

2) the term of the appointment;

3) the clinical specialty he/she may exercise; and

4) any special conditions attached to the reappointment.

2.2 PROCEDURE FOR REQUESTING INCREASE IN CLINICAL PRIVILEGES

2.2-1 Application for Increased Clinical Privileges

Whenever, during the term of appointment to the Medical Staff, increased clinical privileges are desired, the appointee requesting increased privileges shall apply in writing to the President (or their designee) on a form approved by the Board. The application shall state in detail the specific additional clinical privileges desired and the appointee's relevant recent training and experience that justify increased privileges as noted on a CME Learning Assessment Form ("CLAF"). This application shall be transmitted by the President (or their designee) to the appropriate clinical Section Chief. Thereafter, it will be processed in the same manner as an application for initial clinical privileges if the request is made during the term of appointment, or as part of the reappointment application if the request is made at that time.

2.2-2 Factors to be Considered

Recommendation for an increase in clinical privileges made to the Board shall be based upon:

A. recent relevant training;

B. observation of patient care provided;

C. review of the records of patients treated in this or other hospitals;

D. similarity of the requested privilege to other procedures the provider is already performing;

E. results of the hospital's quality assessment activities; and

F. other reasonable indicator of the individual's qualifications for the privileges in question.

The recommendation for such increased privileges may carry with it such requirements for supervision, consultation, Focused Professional Practice Evaluation (FPPE) or other conditions, for such periods as are thought necessary.

2.3 PROCEDURE FOR INITIATING CORRECTIVE ACTION

2.3-1 Standard of Professional Conduct

Whenever the activities or professional conduct of any Provider with clinical privileges are considered to be lower than the standards or aims of the Medical Staff, or to be disruptive to the delivery of quality medical care in the organization, or to make inefficient use of the

organization's resources as determined by standards established by the Medical Staff, or to be in violation of Board, Hospital or Medical Staff Policies, then corrective action against such Provider may be requested by any member of the Medical Staff, by the Hospital's President or their designee, or by any member of the Governing Body (Board). All such requests for corrective action shall be in writing as defined under Special Notice and directed to the Hospital's President or their designee with a copy to the Chief of the Medical Staff, the appropriate Section Chief, and the Chairman of the Credentials Committee. Such request shall be supported by reference to the specific activities or conduct that constitutes the grounds for the request. If the request for corrective action is made by the President or their designee, then the request designated to be sent to the President or their designee as described above, shall instead be sent to the most appropriate member of the Executive Team.

2.3-2 Grounds for Requesting Corrective Action

The following conduct, without limitation, may constitute grounds to request corrective action:

A. the clinical competence of a Provider;

B. the care of a particular patient or patients by a Provider;

C. the violation of the Bylaws of the Medical Staff, Governing Body, or other Policies and Rules and Regulations of the Hospital;

D. a violation of ethics as outlined per section 1.3–2 B5;

E. the mental, emotional, impaired or physical competency of any Provider, (see also Policy #1471 "Impaired Provider Policy – Physician Assistance Committee");

F. conduct disruptive to the delivery of quality medical care or detrimental to the operation of the Hospital and/or patient care (see also Policy #1470 "Medical Staff Code of Conduct/Disruptive Provider Conduct" and Policy #1472 "Procedure to Investigate a Complaint of Workplace Harassment by a Provider"); or

G. unauthorized release of peer review information.

2.3-3 Investigation

Any issue which falls under the categories of Policy #1470 "Medical Staff Code of Conduct/Disruptive Provider Conduct", Policy #1471 "Impaired Provider Policy-Physician Assistance Committee", or Policy #1472 "Procedure to Investigate a Complaint of Workplace Harassment by a Provider" shall be dealt with as defined in those policies. As explained in those policies, such matters may be referred to the MEC, and, if so referred, shall be handled as described below.

If none of those Policies apply, and if, in the opinion of the Chief of the Medical Staff (or the Chief of the Medical Staff-Elect if the Chief is unavailable or unable to make such a determination), the result of such corrective action could potentially adversely affect the clinical privileges of a Provider, the Chief (or Chief-Elect, if appropriate) of the staff shall promptly request the Medical Executive Committee (or an Ad Hoc Investigating Committee appointed by it) to conduct an investigation and prepare a report on the matter.

2.3-4 MEC Report

The Medical Executive Committee shall, within thirty, (30) days after receipt of the request, make a report of its investigation to the Chief of the Medical Staff or their designee, the President or their designee, and the affected Provider. Prior to making any such report, the Provider against whom corrective action has been requested shall have the opportunity for an interview with the Medical Executive Committee or Ad Hoc Investigating Committee at which

time the Provider shall be informed of the general nature of the questions directed to them and shall be invited to discuss, explain, or refute said questions. This interview shall not constitute a hearing, and the procedural rules provided herein with respect to hearings shall not apply. A record of such interview and the deliberations of the Medical Executive Committee or Ad Hoc Investigating Committee shall be made.

2.3-5 MEC Authority

The Medical Executive Committee, in its report to the Governing Body, shall have the authority to make the following recommendations not constituting adverse action and to propose recommendations constituting adverse action and including the following:

A. to reduce, suspend, or revoke clinical privileges;

B. to terminate, modify, or extend an already imposed summary suspension of clinical privileges;

C. to suspend or revoke the Provider's staff privileges; or

D. to propose such other action as is reasonable and warranted under the circumstances.

2.3-6 Rights of Affected Provider

Any proposed recommendation made by the Medical Executive Committee to the Governing Body that would adversely affect the clinical privileges of an appointee or an applicant to the Medical Staff shall entitle the affected Provider to the hearing and appeal rights as provided in this plan.

2.3-7 Reports of Actions

The Chief of the Medical Staff and the President or their designee shall continue to keep each other fully informed of all actions taken in connection herewith, and shall advise and provide copies to each other of any communications made between the Medical Executive Committee and the affected Provider.

2.3-8 Final Decision by Governing Body

If the affected Provider exercises the hearing and appeal rights afforded under Article III of this Policy, then the final decision on the request for corrective action shall be made by the Governing Body in accordance with the provisions of Article III. If the affected Provider fails to exercise the hearing and appeal rights afforded under Article III or otherwise waives such rights, the Governing Body, within thirty, (30) days after any waiver or other expiration of the hearing and appeal rights granted under Article III, shall make its final decision in the matter and shall send written notice thereof to the affected Provider, by certified mail, return receipt requested. Such notice shall include a statement of the basis upon which the decision was made.

2.4 SUMMARY SUSPENSION OF CLINICAL PRIVILEGES

2.4-1 Imposition of Summary Suspension

Any two, (2) of the following acting together as a peer review committee: the Chief of the Medical Staff (or in his/her absence, the Chief of the Medical Staff-Elect), the Chairman of the Credentials Committee, or the Hospital's President or designee, shall have the authority to suspend summarily all or any portion of the clinical privileges of a Provider where the failure to take such action may result in an imminent danger to the health of any individual, or for purposes of conducting an investigation to determine the need for a professional review action, in which event such suspension or restriction of clinical privileges shall not exceed fourteen, (14) days.

A summary suspension under this paragraph shall become effective immediately upon imposition, and the reasons for suspension shall promptly thereafter be stated in writing and given to the Provider in the same manner as other notices as provided herein.

2.4-2 Hearing on Summary Suspension

A Provider whose clinical privileges have been summarily suspended shall be entitled to request that the Medical Executive Committee hold a meeting on the suspension within a reasonable time period (but not more than fourteen, (14) days thereafter in order that the affected Provider might respond to the action and make any requests the Provider deems appropriate under the circumstances. At such meeting, the Medical Executive Committee shall consider any comments or evidence presented by the affected Provider and may thereafter recommend modification, continuance, or termination of the terms of the summary suspension. Unless the Medical Executive Committee determines to exonerate the Provider at this meeting or to lift the suspension and impose any warnings, probation, or other measures not constituting adverse action, the matter shall thereafter be treated as a request for corrective action, and the procedures thereunder shall be followed. Should the Governing Body disagree with the decision of the Medical Executive Committee to exonerate the Provider or to modify the terms of suspension, it shall have the right to unilaterally constitute a hearing committee, as provided for hereinafter to evaluate and review the evidence pursuant to this Policy and to take final action on any recommendation arising from such hearing procedures.

2.4-3 Medical Coverage for Affected Provider's Patients

Immediately after the imposition of a summary suspension, the Chief of the Medical Staff or his/her designee shall have the authority to provide for alternative medical coverage for the patients of the suspended Provider still in the hospital at the time of such suspension. The wishes of the patient shall be considered and followed, if possible, in the selection of any such alternative practitioner.

2.5 AUTOMATIC ADMINISTRATIVE RELINQUISHMENT OF PRIVILEGES

2.5-1 Deficient/Delinquent Medical Records

Incomplete records over fourteen, (14) days old, (from the date of service) shall be considered deficient. Providers with deficient records shall be notified via a reminder letter from Health Information Management along with a copy of their weekly deficiency printout.

Incomplete records over thirty, (30) days old, (from the date of service) shall be considered delinquent. Providers with delinquent records will lose the privilege of admitting patients and use of hospital facilities. Emergency admissions and those patients already admitted prior to the effective date of the suspension under the direct care of that Provider may be treated. The Chief of Staff or President (or their designee's) must grant the Provider approval for all emergency admissions. A Provider whose privileges are relinquished pursuant to this provision may not admit patients under the name of another Provider.

Automatic relinquishment for delinquent medical records is imposed via phone and written notice to the Provider by the Chief of Staff or the President (or their designee's).

If the Provider has not completed all delinquent records within ten, (10) days, all privileges will be suspended, meaning no emergency admissions and those patients currently in the hospital will have to be given care by another Provider. The Provider may still perform his/her Medical Staff Section and Committee duties.

A grace period will be allowed for Providers absent because of vacation or illness. Any exceptions must be approved by the President after consultation with the Chief of Staff (or their

designee's). Providers are responsible for notifying the President or their designee who in turn will notify Medical Records of such instances.

Providers shall be required to complete any such delinquent charts within ten, (10) days after the Provider's return, or face the automatic relinquishment provisions of this section.

Upon completion of all delinquent records, the Provider will be reinstated to full privileges effective the date of notice of substantial completion.

2.5-2 Suspension of License to Practice or DEA

Any suspension of the Provider's license to practice his/her profession by his/her licensing board and any suspension of a Provider's license to prescribe narcotic drugs shall automatically create administrative relinquishment of the Provider's Hospital privileges for the same period of time. Any such administrative relinquishment shall be submitted to the Medical Executive Committee and shall not be lifted until the Medical Executive Committee votes on whether or not to initiate its own corrective action.

2.5-3 Failure to Have Medical Malpractice Insurance

Any notification of cancellation or failure to renew professional liability insurance, and of the failure to carry sufficient malpractice insurance and to pay the surcharge necessary to qualify as a Provider for the State's Patient's Compensation Fund (PCF) under the Indiana Medical Malpractice Act shall automatically create administrative relinquishment of any Provider's privileges in the organization until such coverage is re-established.

2.5-4 Failure to Attend Meetings or to Satisfy Continuing Medical Education Requirements

Automatic administrative relinquishment may also be imposed for failure to complete any required number of hours of continuing medical education or for failure to attend regular required meetings of the Medical Staff and Committees as the Medical Staff may provide in its Bylaws and/or Rules and Regulations.

2.5-5 Rights of Affected Provider

Automatic administrative relinquishments do not give rise to a hearing or appeal, are imposed by notice to the affected Provider by the Health Information Management Department, Medical Executive Committee, or President or designee as appropriate, and are terminated by the Provider fulfilling or correcting the appropriate requirement.

2.6 PROCEDURE FOR LEAVE OF ABSENCE

2.6-1 Leave Status

Individuals appointed to the Medical Staff may, for good cause, be granted voluntary leaves of absence for a period of time not to exceed one, (1) year. Absence for longer than one, (1) year shall constitute voluntary resignation of Medical Staff appointment and clinical privileges unless an exception is made by the Board. Failure, without good cause, to request reinstatement or to provide a requested summary of professional activities as above provided shall be deemed a voluntary resignation from the Staff and shall result in automatic termination of Staff appointment, privileges, and prerogatives. An individual whose appointment is so terminated shall be entitled to the procedural rights provided in this Policy for the sole purpose of determining the issue of good cause. A request for Staff appointment subsequently received from a Staff member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

Requests for leaves of absence shall be made in writing to the President or their designee for transmittal to the Medical Executive Committee and shall state the beginning and ending dates

of the requested leave. The Medical Executive Committee shall transmit the request together with a recommendation to the Board for final action.

2.6-2 Termination of Leave

At the conclusion of the leave of absence, the individual may be reinstated, upon filing a written statement with the President or their designee for transmittal to the Medical Executive Committee, summarizing the professional activities undertaken during the leave of absence. The individual shall also provide such other information as may be requested by the Hospital that time.

The Medical Executive Committee shall make a recommendation to the Board and in acting upon the request for reinstatement, the Board may approve reinstatement either to the same or different staff category, and may limit or modify the clinical privileges to be extended to the individual upon reinstatement.

2.7 CONFIDENTIALITY AND REPORTING

Actions taken and recommendations made pursuant to this Article shall be treated as confidential in accordance with such policies regarding confidentiality as may be adopted by the Board. In addition, reports of any final, substantive, and adverse actions taken by the Board pursuant to this Policy shall be made by the President or their designee to such governmental agencies as may be required by law.

2.8 PEER REVIEW PROTECTION

All minutes, reports, recommendations, communications, and actions made or taken pursuant to this Policy are deemed to be covered by the provision of Indiana Peer Review Act, I.C.34-30-15 et seq. or the corresponding provisions of any subsequent Federal or State statute providing protection to peer review or related activities. Furthermore, the Committees and/or panels charged with making reports, findings, recommendations or investigations pursuant to this Policy shall be considered to be acting on behalf of the Hospital and its Board when engaged in such professional review activities and thus shall be deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986.

3 ARTICLE III: FAIR HEARING PROCESS

3.1 INITIATION OF HEARING

3.1-1 Intent of Plan

When any Provider who is either an appointee of the Medical Staff or an applicant to the Medical Staff receives notice of a proposed recommendation of the Medical Executive Committee, the Governing Body, (or any Committee of either) that could adversely affect the Provider's appointment to, application for, or status as an appointee of the Medical Staff or the Provider's right to exercise clinical privileges as an appointee of the Medical Staff, the Provider shall be entitled to a hearing and an appellate review as hereinafter set forth. The intent of this plan is to ensure that the applicable immunities and protections of the Indiana Peer Review Act and the Federal Health Care Quality Improvement Act of 1986 are afforded to the participants in any such hearing and/or appellate review, and the provisions of this Article shall be construed accordingly.

3.1-2 Grounds for Hearing

A. Except as otherwise specified in this plan or in the Medical Staff Bylaws, any one or more of the following actions or recommended actions shall be deemed an actual or potential adverse action and constitute grounds for a hearing:

   1) Denial of initial Medical Staff appointment;

2) Denial of requested advancement in medical Staff status or category;

3) Denial of medical Staff reappointment;

4) Involuntary change of Medical Staff category;

5) Suspension of Medical Staff appointment status;

6) Revocation of Medical Staff appointment;

7) Denial of requested initial clinical privileges excluding temporary privileges (unless such denial of temporary privileges acts as a denial of an application for appointment);

8) Denial of requested increased clinical privileges;

9) Involuntary reduction of current clinical privileges;

10) Suspension of clinical privileges for a period of longer than fourteen, (14) days;

11) Termination of all clinical privileges for a period of longer than fourteen, (14) days;

12) Involuntary imposition of significant consultation or monitoring requirements (excluding monitoring incidental to provisional staff status);

13) Any other action that the Hospital would have a duty to report pursuant to IC 16-21-2-6.

The above listing is duplicated from the Medical Staff Bylaws Article 4 Section 4.1. Should any conflict between this Policy and the Bylaws be judged to be present, such conflict shall be resolved in favor of the Bylaws, unless there exists a regulatory or legal reason for resolving otherwise, or unless the MEC chooses to resolve such conflict otherwise.

B. No other recommendations except those enumerated in (A) of this section shall entitle the individual to request a hearing.

C. The affected individual shall also be entitled to request a hearing before the Board enters a final decision, in the event the Board should determine, without a similar recommendation from the Credentials Committee, to take any action set forth above.

D. The hearing shall be conducted in as an informal manner as possible, subject to the rules and procedures set forth in this Policy.

E. Neither voluntary relinquishment of clinical privileges, as provided for elsewhere in this Policy, nor the imposition of any general consultation requirement, nor the imposition of a requirement for retraining, additional training or continuing education, constitute grounds for a hearing, but shall take effect without hearing or appeal.

3.2 NOTICE OF PROPOSED ADVERSE ACTION

3.2-1 Notice of Adverse Action

In any potential adverse action, the Hospital's President or their designee shall be responsible for giving prompt written notice to the affected Provider of the proposed adverse action and of the Provider's rights to a hearing by registered or certified mail, return receipt requested, or by hand delivery or delivery by courier service designed for overnight or same day delivery. Such notice shall contain, at a minimum, the following information:

A. That a professional review action has been proposed which could adversely affect the clinical privileges of the Provider;

B. The reasons for the proposed action;

C. Any time limit (but not less than thirty, (30) days from the date of the notice) within which Provider must request a hearing; and

D. A summary of the Provider's rights in the hearing as hereinafter set forth in Section 3.3-6.

3.2-2 Notice of Hearing

If a hearing is requested by the affected Provider on a timely basis as set forth in Section 3.2-1C, the affected Provider shall be provided by the Hospital President or their designee with a notice of hearing providing the following information:

A. The time, place, and date of the hearing, which date shall not be less than thirty, (30) days after the date of notice of hearing; and

B. A list of witnesses known at the time of notice that are expected to testify at the hearing on behalf of the Committee bringing the proposed adverse action.

3.2-3 Failure to Request a Hearing

The failure of an affected Provider to request a hearing on a timely basis shall be deemed a waiver of the affected Provider's right to a hearing and to any appellate review to which the affected Provider might otherwise have been entitled on the matter.

3.3 CONDUCT OF HEARING

3.3-1 Hearing Committee

If a hearing is requested on a timely basis pursuant to Section 3.2-1C, the hearing shall be held before an impartial Committee of at least three, (3) but not more than eight, (8) individuals, appointed by the Hospital acting through the Chairman of the Governing Body or the Hospital President (or their designee's). Each individual selected shall be a member of the Medical Staff and shall not be in direct economic competition with the affected Provider, unless the Provider approves in writing of such individual.

3.3-2 Hearing Committee Chairman

The Hearing Committee, prior to the formal hearing, shall meet and elect a Chairman. The Hearing Committee Chairman shall:

A. serve as the Presiding Officer / Hearing Officer, and shall be entitled to one vote;

B. act to ensure that all participants in the hearing have a reasonable opportunity to be heard and to present all oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process.

C. maintain decorum throughout the hearing;

D. determine the order of the procedure throughout the hearing;

E. have the authority and the discretion, in accordance with this Policy, to make rulings on all questions which pertain to matters of procedure and to the admissibility of evidence;

F. act in such a way that all information reasonably relevant to the continued appointment or clinical privileges of the individual requesting the hearing is considered by the Hearing Committee in formulating its recommendations;

G. act at all times to see that all relevant information is made available to the Hearing Committee for its deliberations and recommendations to the Board.

3.3-3 Failure of a Provider to Appear

The right to any hearing pursuant to this provision will be forfeited if the affected Provider fails, without good cause in the opinion of the Hearing Committee, to appear at the place, time and date of the scheduled hearing.

3.3-4 Exchange of Witness Lists and Exhibits

The hearing officer or presiding member of the Hearing Committee shall appoint a date, time, and place for the exchange of exhibits and witness list, which date shall not be less than five, (5) days prior to the scheduled date of the hearing. Any witnesses not then listed and any exhibits not provided may, in the discretion of the Hearing Committee, be excluded from the hearing.

3.3-5 Access of Affected Provider to File

All material contained in a Provider's credentials and/or personal file shall be part of the hearing record and the Provider shall have the right to have a copy of all such material in advance of the hearing.

3.3-6 Right of Participants

In the hearing, the affected Provider and the medical staff or Governing Body Committee bringing the charges, will each have the following rights:

A. To representation by an Attorney or any other person of the party's choice;

B. to have a record made of the proceedings, copies of which may be obtained by the Provider upon payment of any reasonable charges associated with the preparation thereof;

C. to call, examine and cross-examine witnesses;

D. to present any evidence determined to be relevant by the Hearing Officer/Committee, regardless of its admissibility or inadmissibility in a court of law;

E. to submit a written statement at the close of the hearing; and

F. upon completion of the hearing, the affected Provider shall have the right to receive the written recommendation of the Hearing Officer or Committee, including a statement of the basis for the recommendation.

3.3-7 Record of Hearing

An accurate record of the hearing must be kept. The mechanism shall be established by the Hearing Committee and may be accomplished by the use of an electronic recording unit or detailed transcription.

3.3-8 Postponement or Recess

The Hearing Committee shall have the right to postpone the hearing or to recess the hearing if, in its judgement, such action will be in the best interest of obtaining the facts at issue.

3.3-9 Burden of Proof

When a hearing concerns charges that a Provider is not providing acceptable medical care, or is impaired by physical, mental, or emotional defect, the Provider shall be required to show that his/her care is appropriate and that he/she continues to be competent to exercise privileges on the Medical Staff. When the charges concern disruptive or unethical behavior, the party bringing such charges shall be required to present evidence in support thereof.

3.3-10 Presence of Hearing Committee Members

A majority of the Hearing Committee must be present throughout the hearing and deliberations. If a Committee Member is absent from any part of the hearing of evidence, he/she may not participate in the deliberations or the decision unless such a Committee Member shall be to hear a recording or read the transcript of the deliberations that were missed or with the consent of both parties.

3.4 HEARING COMMITTEE CONCLUSION AND REPORT

3.4-1 Adjournment and Conclusions

The Presiding Officer may adjourn the hearing and reconvene the same at the convenience and with the agreement of the participants without special notice. Upon conclusions of the presentation of oral and written evidence, the hearing shall be closed.

3.4-2 Report of Committee

Within ten, (10) days after the end of the formal hearing and any succeeding deliberations by the Hearing Committee thereafter, the Hearing Committee shall issue its written report and recommendation to the Governing Body. This time period may be extended if the Hearing Committee had not received a copy of the transcript or other materials in sufficient time to allow the committee adequate ability to thoroughly review the facts and testimony in the hearing. The committee's written report shall be provided to the affected Provider along with a statement of the committee regarding the basis for any recommendation made. Such report and recommendation shall be mailed by certified mail, return receipt requested, to the affected Provider, and copies shall be delivered to the Chief of Staff and to the Governing Body through the President (or their designee's) of the hospital. The Governing Body shall thereafter make its final decision in the matter in accordance with the provisions of Section 3.6.

3.5 APPEAL PROCEDURE

3.5-1 Time for Appeal

Within ten, (10) days after the Provider's receipt of the Hearing Committee's recommendation, the affected Provider may, by written notice to the Governing Body delivered through the President or their designee by registered or certified mail, return receipt requested, or by hand delivery or delivery by courier service designed for overnight or same day delivery, request an appellate review by the Governing Body. Such appellate review may be held only on the record on which the adverse recommendation or decision has been based, which record shall include any supporting documents that were admitted by the Hearing Officer or Hearing Committee during the course of the hearing. At the discretion of the Governing Body, oral argument may be permitted.

3.5-2 Grounds for Appeal

The grounds for appeal shall be that:

A. the written recommendation of the Hearing Committee is adverse to the Provider;

B. there was substantial failure to comply with this Policy and/or the Hospital or Medical Staff Bylaws in the matter which was the subject of the hearing so as to deny due process or a fair hearing;

C. the recommendations were made arbitrarily, capriciously or with prejudice; or

D. the recommendations were not supported by substantial evidence.

3.5-3 Waiver of Right to Appellate Review

If such appellate review is not requested within ten, (10) days, the affected Provider shall be deemed to have waived his/her right to the same and to have accepted such adverse recommendations or decision, and the same shall be submitted to the Governing Body for final action.

3.5-4 Schedule and Notice of Appellate Review

If the Provider provides timely notice to the Governing Body of the Provider's request for an appellate review, within fifteen, (15) days after receipt of such notice, the Governing Body shall schedule a date for such review, including a time and place for oral argument if such has been requested and approved by the Governing Body and shall, through the President or their designee, by written notice sent by certified mail, return receipt requested, notify the affected Provider of the same. The date of the appellate review shall not be less than twenty, (20) days, nor more than sixty, (60) days from the date of the receipt of notice of the request for appellate review, except that when the affected Provider requesting the review is under suspension which is then in effect, such review shall be scheduled as soon as the arrangements for it may be reasonably made, but not more than thirty, (30) days from the date of receipt of such notice from the affected Provider.

3.5-5 Conduct for Appellate Review

The appellate review may be conducted by the Governing Body as a whole or, if approved by the Governing Body, by an appellate review committee of the Governing Body appointed by the Chairman of the Board. Such an appellate review committee shall not have less than three, (3) members.

3.5-6 Provider's Access to Records

The affected Provider shall have access to the report, record, exhibits and transcripts, if any, of the Hearing Committee and all other material, favorable or unfavorable, that was considered in making the adverse recommendation or decision. The affected Provider shall have the right to submit a written statement in his/her own behalf, in which those factual and procedural matters with which the Provider disagrees and his/her reasons for such disagreement, shall be specified. This written statement may cover any matters raised in any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the Governing Body through the President or their designee by certified mail, return receipt requested, at least five, (5) days prior to the scheduled date for the appellate review. A similar statement may be submitted by the Medical Staff or Governing Body Committee bringing the initial adverse recommendation.

3.5.7 Determination of Appellate Review Body

The Governing Body, or its appointed review committee, shall act as an appellate body. It shall review the record created in the proceedings and shall consider the written statement(s) submitted pursuant to this Section for the purpose of determining whether the adverse recommendation or decision against the affected Provider was supported by the evidence and whether the Provider was granted a hearing pursuant to the plan.

If the oral argument is requested and approved as a part of the appellate review procedure, the affected Provider may be present at such appellate review, shall be permitted to speak against the adverse recommendation or decision, and shall answer questions put to him/her by any member of the appellate review body. The Medical Staff or Governing Body Committee that presented the original charges at the Hearing Committee shall also be represented by an individual, if desired, who shall be permitted to speak in support of the adverse

recommendation or decision, and who shall answer questions put to him/her by any member of the appellate review body. Both parties may be represented by counsel if they so choose.

3.5-8 Scope of Appellate Review

New or additional matters not raised during the original hearing or in the original report, not otherwise reflected in the record, shall only be introduced at the appellate review if the appellate body decides that the Provider has carried the burden of showing that in the exercise of due diligence the Provider could not have discovered the information during the pendency of the hearing. The appellate body shall, in its sole discretion, determine whether such new matter may be accepted.

3.5-9 Decision of the Governing Body

If the appellate review is conducted by the Governing Body, it may affirm, modify or reverse the recommendation, or in its discretion, refer the matter back to the Hearing Committee/Officer for further review and recommendations. Such review and recommendation to be provided to the Governing Body within fourteen, (14) days. Such referral may include a request that the Hearing Committee/Officer arrange for further hearing to resolve specified disputed issues.

3.5-10 Report of Appellate Review Committee

If the appellate review is conducted by a Committee of the Governing Body, such Committee shall, within fourteen (14) days after the scheduled or adjourned date, whichever is later, of the appellate review, either make a written report recommending that the Governing Body affirm, modify or reverse the prior decision, or refer the matter back to the Hearing Committee/Officer for further review and recommendation. Such referral may include a request that the Hearing Committee/Officer arrange for a further hearing to resolve disputed issues. Within fourteen, (14) days after receipt of such recommendation after referral, the committee shall make its recommendation to the Governing Body as above provided.

3.5-11 Conclusion of Proceedings

The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Section have been completed or waived. Where permitted by law and/or the Hospital Bylaws, all action required of the Governing Body may be taken by a committee of the Governing Body duly authorized to act.

3.6 FINAL DECISION BY THE GOVERNING BODY

3.6-1 Time for Making Final Decision

With the exception of the provisions relating to summary suspension, as described in Section 2, no adverse professional review action otherwise shall be taken or shall become final until after the exhaustion or waiver, as the case may be, of the affected Provider's hearing and appeal rights herein provided. Within thirty, (30) days after the earlier of (1) the conclusion of an appellate review, if taken, or the expiration of the time for exercising the right of appeal, if not taken; or (2) the exhaustion or waiver, as the case may be, of the affected Provider's hearing and appeal rights as herein provided; the Governing Body shall make its final decision in the matter.

3.6-2 Notice of Final Decision

Immediately upon making its final decision in the matter, the Governing Body shall provide written notice thereof to the Chief of the Medical Staff, the President and the affected Provider, via certified mail, return receipt requested. The notice shall recite the decision of the Governing Body and state the basis upon which it was made.

3.6-3 Affected Provider's Rights

Notwithstanding any other provisions herein, no Provider shall be entitled, as a right, to more than one hearing and one appellate review on any matter that shall have been the subject of an action by the Medical Executive Committee or by the Governing Body, or by a duly authorized committee of the Governing Body, or by both. In the event that the Board ultimately determines to deny initial Medical Staff appointment or reappointment to an applicant, or to revoke or terminate the Medical Staff appointment and/or clinical privileges of a current appointee, that individual may not re-apply within one, (1) year for Medical Staff appointment or for those clinical privileges at this Hospital unless the Board provides otherwise.

3.7 COMPULSORY REPORTING OF ADVERSE ACTIONS

In compliance with the Health Care Quality Improvement Act of 1986 and Indiana Code 16-21-2-6 , the Hospital's Governing Board shall report, in writing, to the Indiana Medical Licensing Board the results and circumstances of a final, a substantive, or an adverse disciplinary action taken by the Governing Board regarding a Provider on the Medical Staff, or an applicant for the Medical Staff, if the action results in voluntary or involuntary resignation, termination, non-appointment, revocation or significant reduction of clinical privileges or Staff membership. Such a report shall not be made for non-disciplinary resignations or for minor disciplinary action.

In compliance with the Health Care Quality Improvement Act of 1986 (Public Law 99-660) and the regulations promulgated thereunder at 45 CFR (Part 60) (National Practitioner Databank) the Hospital shall report to the NPBD and provide a copy of the report to the Indiana Board of Medical Examiners:

3.7-1 Any professional review action that adversely affects the clinical privileges of a Physician or Dentist for a period longer than thirty, (30) days;

3.7-2 Acceptance of the surrender of clinical privileges or any restriction of such privileges by a Physician or Dentist;

A. while the Physician or Allied Health Practitioner is under investigation by the Hospital relating to possible incompetence or improper professional conduct; or

B. in return for not conducting such an investigation or proceeding.

Any matter that does not relate to the competence or professional conduct of a Physician or Allied Health Practitioner as defined under the Health Care Quality Improvement Act and the regulations promulgated thereunder, shall not be deemed to be a reportable event pursuant to the Health Care Quality Improvement Act. Any adverse action taken by the Hospital under this Section shall be reported to the Board of Medical Examiners within thirty (30) days from the date the adverse action was taken. For purposes of this Section, a "professional review action" shall mean an action or recommendation of a Peer Review Committee, which is based on the competence or conduct of an individual Physician, (which conduct affects or could affect adversely the clinical privileges of a Physician. A professional review action shall also include a formal decision of a Peer Review Committee not to take an action or make a recommendation described in the previous sentence and also includes professional review activities related to a professional review action. In compliance with the Health Care Improvement Act of 1986 and Indiana Code 16-21-2-6, the Hospital Governing Board shall report to the Indiana Medical Licensing Board and to the designated federal agency (a.k.a. the National Practitioner Data Bank) any final, substantiate, and adverse disciplinary action taken by the Governing Body. Such report shall also be made if the Provider voluntarily resigns while under investigation by the Hospital relating to incompetence or improper professional conduct.

3.8 OTHER PROCEDURAL CONSIDERATIONS

3.8-1 Additional Evidence Discovered

A. **After Waiver:** If an affected Provider discovers facts that the Provider was not aware of or with the exercise of due diligence would not have been aware of, after the Provider had either waived his/her right to a hearing and/or to appellate review, the Provider may petition to the Governing Body to allow withdrawal of the waiver. The affected Provider shall be required to prove that the additional information could reasonably be expected to be material in any corrective action which might be taken against the Provider, and that he/she was not aware of this information at the time the Provider waived his/her rights and would not have become aware of it in the exercise of due diligence.

The Governing Body may grant the affected Provider a hearing which he/she had otherwise waived, remand the matter to a special Hearing Committee for an additional hearing, or rule that the affected Provider had not carried his/her burden of proof on materiality or due diligence.

B. **After Hearing but Before Final Action:** If a Provider discovers additional facts after a hearing has concluded of which he/she was not aware during the hearing and could not reasonably have discovered with the exercise of due diligence, he/she may petition the Governing Body to have the matter remanded to the Hearing Committee to hear additional evidence on the new information. The affected Provider shall have the burden of proof proving both that the new information is material and that due diligence would not have discovered it prior to the conclusion of the hearing. The Governing Body may grant the petition and remand or find that the Provider failed to carry his/her burden of proof as to materiality or due diligence.

4 ARTICLE IV: AMENDMENTS

This Policy may be amended by majority vote of the members of the Executive Committee present and voting at any meeting of that Committee where a quorum exists, provided that the written recommendations of the Credentials Committee concerning the proposed amendments shall have first been received and reviewed by the Executive Committee. No such amendment shall be effective unless and until it has been approved by the Board.

This Policy may also be amended by the Board on its own motion provided that any such amendment is first submitted to the Credentials and Medical Executive Committees of the Medical Staff for review and comment at least thirty, (30) days prior to any final action by the Board on such amendment. Instances where such action by the Board may be warranted shall include:

A. action to comply with changes in Federal and State laws that affect this Hospital and the Hospital Corporation, including any of its entities; and

B. action to comply with State licensure requirements, ACHC Accreditation Standards, and Medicare/Medicaid Conditions of Participation for Hospitals.

Should any conflict between this Policy and any other Hospital or Medical Staff Policies be judged to be present by the Medical Executive Committee or other authority, such conflict shall be resolved by the Medical Executive Committee.

5 ARTICLE V: ADOPTION

This Policy is adopted and made effective upon approval of the Board, superseding and replacing any previous Policy on Medical Staff Appointment, Reappointment, and Clinical Privileges, or related Medical Staff Policies, or Hospital Policies pertaining to the subject matter thereof, and henceforth all activities and

actions of the Medical Staff and of each individual exercising clinical privileges at the Hospital shall be taken under and pursuant to the requirements of this Policy.

Amended by the Medical Executive Committee on 02/12/2026

Timothy Hall, MD
Chief of Staff

Approved by the Board of Trustees on 02/23/2026

Jessica McClintock Glover, MD
Chair of the Board

Approved by Board of Trustees 5/15/06; 3/16/09; 3/26/12, 5/21/15; 6/27/16, 6/24/19, 3/30/20, 5/22/23, 8/25/2025, 02/23/2026