Medical Staff Credentials Policy

Mercy Health - Cincinnati LLC

A Medical Staff Document

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ARTICLE I

DEFINITIONS & APPLICABILITY

1.1 DEFINITIONS & DESIGNEES

1.1-1 Definitions. The definitions set forth in the Medical Staff Bylaws shall apply to this Medical Staff Credentials Policy unless otherwise provided herein.

1.1-2 Designees. Whenever an individual is authorized in the Medical Staff governing documents to perform a duty by virtue of his/her position, then reference to the individual shall also include the individual's authorized designee.

1.2 APPLICABILITY

1.2-1 This Medical Staff Credentials Policy shall individually and separately apply to each of the following Medical Staffs:

(a) Mercy Health – Anderson Hospital LLC (Anderson)

(b) Mercy Health – Clermont Hospital LLC (Clermont)

(c) Mercy Health – Fairfield Hospital LLC (Fairfield)

(d) Jewish Hospital, LLC d/b/a The Jewish Hospital – Mercy Health (Jewish)

(e) Mercy Health – Kings Mills LLC (Kings Mills)

(f) Mercy Health – West Hospital LLC (West)

ARTICLE II PROCEDURE FOR INITIAL GRANT OF MEDICAL STAFF APPOINTMENT AND PRIVILEGES

2.1 NON-DISCRIMINATION

No Practitioner shall be denied appointment and/or Privileges on the basis of: race; color; sex (including pregnancy); sexual orientation; gender identity; gender expression; transgender status; age (40 and older); religion; marital, familial, or health status; national origin; ancestry; disability (provided that the applicant can competently exercise the Privileges requested with or without a reasonable accommodation); genetic information; veteran or military status; or any other characteristic(s) or class protected by applicable law.

2.2 NO ENTITLEMENT

No Practitioner shall be entitled to appointment to the Medical Staff or to the exercise of Privileges at the Hospital merely by virtue of the fact that he or she holds a certain degree; is duly licensed to practice in this or any other state; is certified by any clinical board; is a member of any professional organization; had in the past, or presently has, an appointment and/or similar privileges at another hospital or healthcare entity; or is employed by or contracts with the Hospital.

2.3 DURATION OF MEDICAL STAFF APPOINTMENT AND PRIVILEGES

2.3-1 Granting of appointment, reappointment, and Privileges/regrant of Privileges shall be for a period of not more than three (3) years.

2.3-2 An appointment, reappointment, or grant/regrant of Privileges of less than three (3) years shall not be deemed Adverse for purposes of the Medical Staff governing documents.

2.4 RESOURCES

Requests for Medical Staff appointment and/or Privileges must be compatible with the policies, plans, and objectives formulated by the Board concerning: the Hospital's patient care needs (including current and projected needs) and the care, treatment, and/or services provided by the Hospital; the Hospital's facilities, equipment, personnel, and financial resources; and the Hospital's decision to contract exclusively for the provision of certain medical/professional services with a Practitioner or group of Practitioners other than the applicant.

2.5 APPLICATION FOR MEDICAL STAFF APPOINTMENT AND/OR PRIVILEGES

2.5-1 A request by a Practitioner for an application for Medical Staff appointment and/or Privileges at the Hospital shall be directed to the Credentials Verification Organization (CVO). A Practitioner who receives an application for Medical Staff appointment and/or Privileges will be provided with access to the Medical Staff governing documents.

2.5-2 Unless otherwise provided in the Medical Staff governing documents, an application for Medical Staff appointment and/or Privileges shall include, but not be limited to:

(a) Documentation of professional school/postgraduate education including the name(s) of the institution(s) and the dates attended, the course of study or program completed, and any degree(s) granted.

(b) Documentation of such training (*e.g.,* residency, fellowship, *etc.*) as required for the Privileges requested.

(c) Documentation of a current valid Ohio license to practice his/her profession including the date of issuance, expiration date, and license number.

(d) Attestation of participation in continuing education activities at the level required by the applicant's licensing board. The Hospital, in its discretion, has the right to audit and verify the applicant's satisfaction of continuing education requirements at any time.

(e) Documentation of a current valid Drug Enforcement Administration (DEA) registration (if required for the Privileges requested) including the date of issuance, expiration date, registration number, and schedules.

(f) Documentation of specialty or subspecialty board certification and recertification in accordance with the requirements set forth in Article VII of this Credentials Policy.

(g) Documentation of current valid Professional Liability Insurance.

(1) At the time of request for initial appointment/privileging: Information on professional liability claims history and experience (suits filed, pending, or settled and the names/addresses of present and past insurance carriers) for the past five (5) years.

(2) At the time of request for reappointment/regrant of Privileges: Information on professional liability suits filed, pending, or settled during the last reappointment/regrant cycle.

(h) Documentation of hospital affiliations as required by the application.

(i) Documentation of chronological work history as required by the application.

(j) The nature and specifics of any proposed, pending, or completed action involving voluntary (while under investigation or to avoid investigation for conduct or clinical competency concerns) or involuntary denial, revocation, termination, suspension, probation, reduction, limitation, withdrawal, non-renewal, or relinquishment (by resignation or expiration) of:

(1) any professional license or certificate to practice in Ohio or in any other state or country;

(2) any controlled substance registration;

(3) membership or fellowship in local, state, or national organizations;

(4) specialty or sub-specialty board certification or eligibility;

(5) faculty appointment at any professional school;

(6) medical staff appointment, prerogatives, or privileges at any other health care entity including, but not limited to, any hospital, clinic, skilled nursing facility, or managed care organization in this or any other state;

(7) Professional Liability Insurance;

(8) participation in any Federal Health Program;

or, as may be otherwise specified in the application.

(k) Medical Staff appointment category and/or Privileges requested.

(l) Any past or current criminal charges of which the applicant was convicted or to which the applicant plead guilty or no contest (other than minor traffic/motor vehicle violations).

(m) The names of three (3) Practitioners in the applicant's same professional discipline (*e.g.,* MD/DO for MD/DO, Podiatrist for Podiatrist, *etc.)* with personal knowledge of the applicant's ability to practice.

(1) Only one (1) such reference may be from a current practice associate of the applicant.

(2) At least one (1) such reference shall be from a Practitioner who practices in the same specialty or subspecialty as the applicant.

(3) If the applicant has been out of training for less than two (2) years, one (1) such reference shall be from the director of the program or a preceptor where the applicant completed his/her training.

(4) A reference from the Chief of Staff or Department Chair at the hospital at which the applicant currently practices is preferable, as applicable.

(5) Peer recommendations shall include information regarding the applicant's: medical/clinical knowledge; technical/clinical skills; clinical judgment; interpersonal skills; communication skills; professionalism; patient care; practice-based learning and improvement; and system-based practice.

(6) Peer recommendations may be in the form of written documentation reflecting informed opinions on the applicant's scope and level of performance or a written peer evaluation of Practitioner-specific data collected from various sources for the purpose of validating current competence.

(n) Documentation with respect to military service/status, as applicable.

(o) Documentation of the applicant's ability to fully and competently exercise the Privileges requested, with or without a reasonable accommodation.

(p) Information as to whether the applicant has been sanctioned by, excluded/precluded from, or the subject of investigation by a Federal Health Program and, if so, the outcome of such investigation.

(q) Information required by applicable conflict of interest policies.

(r) A signed release form authorizing a criminal background check and such other information as is necessary to complete same.

(s) Documentation of compliance with state and/or federal vaccination requirements and implementing System/Hospital policies or an approved exemption.

(t) A current valid hospital identification card with photo, name, and professional designation; or a current, valid picture identification issued by a state or federal agency (*e.g.,* a driver's license or passport). An authorized Hospital representative verifies that the Practitioner requesting Medical Staff appointment and/or Privileges is the same individual as identified in the credentialing documents.

(u) The applicant's signature with date.

(v) Such additional information as may be required by the application.

2.5-3 An application for initial appointment to the active or associate Medical Staff category, without Privileges, shall include the information necessary to satisfy the qualifications set forth in Section 2.2.1 (a), (e), and (h) of the Medical Staff Bylaws and in Section 2.2.2 (a), (d), (f), (g), and (h) of the Medical Staff Bylaws as applicable to a Practitioner requesting Medical Staff appointment without Privileges.

2.5-4 A Practitioner with current Medical Staff appointment and/or Privileges at the Hospital who satisfies the qualifications set forth in Section 3.5-1 of the Medical Staff Bylaws and who desires to transfer to the honorary Medical Staff category must submit a written transfer request to the Medical Staff Office. Such request will be processed in accordance with Section 3.3 of this Policy.

2.6 EFFECT OF APPLICATION

2.6-1 By signing and submitting an application for Medical Staff appointment and/or Privileges, the applicant:

(a) Attests that the application is correct and complete and acknowledges that any material misrepresentation, misstatement, or omission may be grounds for denial of the application or termination of Medical Staff appointment and Privileges.

(b) Agrees to appear for interviews in support of his/her application.

(c) Agrees to the applicable provisions set forth in the Medical Staff Bylaws regarding confidentiality, immunity, and release of liability.

(1) Authorizes the Board, the Hospital, its Medical Staff, and their authorized representatives to consult with others who have been associated with the applicant and who may have information bearing on his/her qualifications for Medical Staff appointment and/or Privileges and releases the Board, the Hospital, its Medical Staff, and their representatives from liability for so doing.

(2) Authorizes the Board, the Hospital, its Medical Staff, and their authorized representatives to review all records and documents that may be material to an evaluation of the applicant's qualifications for Medical Staff appointment and/or Privileges and releases the Board, the Hospital, its Medical Staff, and their representatives from liability for so doing.

(3) Authorizes the Board, the Hospital, its Medical Staff, and their authorized representatives to provide to other hospitals, licensing boards, and other organizations concerned with provider performance and the quality and safety of patient care with information relevant to such matters that the Hospital may have concerning the Practitioner and releases the Board, the Hospital, its Medical Staff, and their representatives from liability for so doing.

(d) Agrees to fulfill his/her Medical Staff responsibilities including, but not limited to, practicing in an ethical manner and providing (or arranging for the provision of) continuous care of his/her patients.

(e) Acknowledges receiving access to the Medical Staff governing documents.

(1) Agrees to be bound by the terms of and to comply in all respects with the Medical Staff governing documents in all matters related to consideration of the applicant's application whether or not appointment and/or Privileges are granted.

(2) Agrees to be bound by the terms of and to comply in all respects with the Medical Staff governing documents as well as applicable System/Hospital policies (*e.g.,* corporate compliance plan, notice of privacy practices, conflict of interest policies, *etc.*) if granted Medical Staff appointment and/or Privileges at the Hospital.

(f) Agrees that if an Adverse recommendation or action is made/taken with respect to his/her Medical Staff appointment and/or Privileges, the applicant will exhaust the administrative remedies afforded by the Bylaws and Fair Hearing Policy before resorting to formal legal action.

(g) Understands and agrees that if Medical Staff appointment and/or Privileges are denied based upon the applicant's competence or conduct, the applicant may be subject to reporting to the National Practitioner Data Bank and/or state authorities.

(h) Agrees to promptly notify the Medical Staff Office, in writing, within ten (10) days following any changes to the information set forth in the applicant's Medical Staff application. The Medical Staff Office shall notify the CVO as appropriate. The foregoing obligation shall be a continuing obligation of the applicant so long as he/she has an application pending for Medical Staff appointment and/or Privileges or holds Medical Staff appointment and/or Privileges at the Hospital.

(i) Acknowledges that the Hospital and Affiliate Hospitals are part of a healthcare system and that information is shared among the Hospital and Affiliate Hospitals. As a condition of appointment and/or grant of Privileges, the applicant recognizes and understands that any and all information (including peer review information) relative to his/her appointment and/or Privileges that is maintained, received, and/or generated by the Hospital or Affiliate Hospitals may be shared among the Hospital and Affiliate Hospitals. The applicant further understands that this information may be used as part of the respective Hospital's/Affiliate Hospital's quality assessment and improvement activities and can form the basis for corrective action.

2.7 APPLICANT'S BURDEN; CREDENTIALING COLLECTION & VERIFICATION PROCESS

2.7-1 APPLICANT'S BURDEN

(a) A completed application for Medical Staff appointment and/or Privileges must be submitted to the CVO by the applicant electronically on the Hospital-approved form, signed by the applicant, and accompanied by the full amount of the non-refundable application fee.

(b) Upon receipt of the application and required non-refundable application fee, a credentials file will be created and maintained for each applicant by the Hospital.

(c) The applicant shall have the burden of producing adequate information for a proper evaluation of his/her qualifications for Medical Staff appointment and/or Privileges and for resolving any doubts about such qualifications.

(d) If an application is not submitted to the CVO by the requesting applicant within thirty (30) days after the application was made available to such applicant, the application may be deemed to have been voluntarily withdrawn by the CVO after consultation with the Medical Staff Office.

(e) The applicant shall be responsible for providing a complete application. An application shall be considered incomplete if the need arises at any time for new, additional, or clarifying information.

(f) Until the applicant has provided all information requested, the application for appointment and/or Privileges will be deemed incomplete and will not be processed.

(g) Failure, without good cause, by an applicant to respond to a request for additional information regarding his/her pending application, within thirty (30) days after written request for such additional information, may be deemed a voluntary withdrawal of the application (by the CVO or Medical Staff Office, as applicable, after consultation with each other) and the applicant's file will be closed.

(h) The applicant shall be notified, in writing, when his/her application is deemed to have been voluntarily withdrawn and that such withdrawal does not give rise to any procedural due process rights pursuant to the Medical Staff Bylaws or Fair Hearing Policy.

(i) For any future consideration for Medical Staff appointment and/or Privileges, the applicant must request and submit a new initial application including application fee.

2.7-2 CREDENTIALING COLLECTION AND VERIFICATION PROCESS

(a) The CVO is responsible for collection and verification of applications, and accompanying materials, for Medical Staff appointment and/or Privileges. The CVO shall:

(1) Review the application to determine that all questions have been answered and that all requested information and documentation has been provided.

(2) Verify the information provided in the application with the primary sources, as applicable.

(3) Conduct a National Practitioner Data Bank query on all applicants at the time of initial request for Privileges, upon regrant of Privileges, and when a Practitioner requests additional Privileges during a current appointment/Privilege period. The CVO shall also conduct an NPDB query each time a Practitioner applies for temporary Privileges. The requirements set forth in this subsection may be satisfied by use of the NPDB's continuous query process.

(4) Query the appropriate sources (*e.g.,* Office of Inspector General's Cumulative Sanction report, General Services Administration List of Parties Excluded from Federal Procurement and Non-Procurement Programs, *etc.*) to determine whether the applicant has been convicted of a health care related offense, or debarred, precluded, excluded, or otherwise made ineligible for participation in a Federal Health Program.

(5) When the CVO collection and verification process is finished, the CVO shall notify the Medical Staff Office.

(b) The Medical Staff Office shall gather Privilege related data (*e.g.,* case logs, *etc.*) specific to the Privileges requested by each applicant.

(c) When the application is complete, the Medical Staff Office shall notify the applicable Department Chair/Section Chair that the completed application packet is available for review.

(d) The application shall thereafter be processed in accordance with the:

(1) Routine appointment/privileging process set forth in Section 2.8;

OR

(2) The expedited appointment/privileging process set forth in Section 2.10.

2.8 ROUTINE APPOINTMENT & PRIVILEGING PROCESS

2.8-1 REVIEW BY DEPARTMENT CHAIR/SECTION CHAIR

(a) The chair of the Medical Staff Department (and, as applicable, the chair of the Section) in which the applicant seeks Privileges will review the application and accompanying materials to assess the applicant's qualifications for Medical Staff appointment and/or Privileges.

(b) The Department Chair (and Section Chair, as applicable) may, at his/her discretion, interview the applicant.

(c) Following such review and interview, if any, the Department Chair (and Section Chair, as applicable) will provide his/her written recommendation as to approval or denial of the applicant's request for Medical Staff appointment and/or Privileges to the Credentials Committee.

2.8-2 REVIEW BY SITE CREDENTIALS COMMITTEE

(a) Section 2.8-2 is only applicable to Anderson, Clermont, Jewish, and Kings Mills.

(b) At its next regular meeting after receipt of the Department Chair's (and, as applicable, Section Chair's) recommendation(s), the site Credentials Committee may consider such recommendation(s) and review the application and accompanying materials to determine whether the applicant meets the qualifications for Medical Staff appointment and/or Privileges. Alternatively, the site Credentials Committee chair may determine that the application should be forwarded to the Regional Credentials Committee without review of such application by the site Credentials Committee.

(c) If the site Credentials Committee requires clarification or additional information, it may table transmitting its recommendation to the Regional Credentials Committee and note in the site Credentials Committee minutes the deferral and the reason(s) therefore. The site Credentials Committee shall act on the deferred application at its next regular meeting unless otherwise unable to do so for good cause.

(d) The site Credentials Committee may, at its discretion, interview the applicant.

(e) If, during the processing of an application, it becomes apparent to the site Credentials Committee that the committee is considering a recommendation that would deny Medical Staff appointment/reappointment and/or grant/regrant of Privileges, the chair of the site Credentials Committee may notify the applicant of the general tenor of the possible recommendation and ask if the applicant desires to meet with the committee prior to a recommendation by the committee. At such meeting, if any, the applicant may be informed of the general nature of the evidence supporting the action contemplated and invited to discuss, explain, or refute it. This meeting shall not constitute a hearing and none of the procedural due process rights provided in the Fair Hearing Policy with respect to hearings and appeals shall apply. The site Credentials

Committee shall indicate as part of its report to the Regional Credentials Committee whether such a meeting occurred; and, if so, will include a summary of such meeting.

(f) Following such review and interview, if any, the site Credentials Committee shall provide its written recommendation (which may be set forth in the Credentials Committee minutes) as to approval or denial of the applicant's request for Medical Staff appointment and/or Privileges to the Regional Credentials Committee.

2.8-3 REVIEW BY REGIONAL CREDENTIALS COMMITTEE

(a) At its next regular meeting after receipt of the Department Chair's (and, as applicable, the Section Chair's and site Credentials Committee's) recommendations), the Regional Credentials Committee shall consider such recommendation(s) and review the application and accompanying materials to determine whether the applicant meets the qualifications for Medical Staff appointment and/or Privileges.

(b) If the Regional Credentials Committee requires clarification or additional information, it may table transmitting its recommendation to the MEC and note in the Regional Credentials Committee minutes the deferral and the reason(s) therefore. The Regional Credentials Committee shall act on the deferred application at its next regular meeting unless otherwise unable to do so for good cause.

(c) The Regional Credentials Committee may, at its discretion, interview the applicant.

(d) If, during the processing of an application, it becomes apparent to the Regional Credentials Committee that the committee is considering a recommendation that would deny Medical Staff appointment/reappointment and/or grant/regrant of Privileges, the chair of the Regional Credentials Committee may notify the applicant of the general tenor of the possible recommendation and ask if the applicant desires to meet with the committee prior to a recommendation by the committee. At such meeting, if any, the applicant may be informed of the general nature of the evidence supporting the action contemplated and invited to discuss, explain, or refute it. This meeting shall not constitute a hearing and none of the procedural due process rights provided in the Fair Hearing Policy with respect to hearings and appeals shall apply. The Regional Credentials Committee shall indicate as part of its report to the Medical Executive Committee whether such a meeting occurred; and, if so, will include a summary of such meeting.

(e) When a perceived material omission, misstatement, or misrepresentation is identified, review and discussion will occur at the Regional Credentials

Committee. Legal assistance may be requested. If determined by the Regional Credentials Committee to be a material omission, misstatement, or misrepresentation, a decision will be made as to whether to continue processing the application.

(f) Following such review and interview, if any, the Regional Credentials Committee shall provide its written recommendation (which may be set forth in the Credentials Committee minutes) as to approval or denial of the applicant's request for Medical Staff appointment and/or Privileges to the MEC.

2.8-4 RECOMMENDATION BY MEDICAL EXECUTIVE COMMITTEE

(a) At its next regular meeting after receipt of recommendations from the Department Chair, the Section Chair (as applicable), the site Credentials Committee (as applicable), and the Regional Credentials Committee, the MEC shall consider any such recommendations, review the application and accompanying materials, as necessary, and may take any of the following actions (which may be set forth in the MEC's meeting minutes):

(1) Deferral: The MEC may table a recommendation on the application and note in the MEC minutes the deferral and the reason(s) therefore. A decision by the MEC to defer the application for further consideration must be revisited at the next regularly scheduled meeting, except for good cause, at which point the MEC shall issue its recommendation as to approval or denial of Medical Staff appointment and/or Privileges.

(2) Favorable Recommendation: If the recommendation of the MEC is favorable to the applicant, the MEC shall forward its recommendation to the Board for action.

(3) Adverse Recommendation. If the recommendation of the MEC is Adverse to the applicant, the Chief of Staff shall notify the applicant of the Adverse recommendation, by Special Notice, and of the applicant's right, as applicable, to request a hearing. No such Adverse recommendation shall be forwarded to the Board until after the applicant has exercised or has been deemed to have waived his or her right, as applicable, to a hearing as provided for in the Fair Hearing Policy.

2.8-5 BOARD ACTION

At its next regular meeting after receipt of a recommendation from the MEC, the Board may take any of the following actions:

(a) Deferral: The Board may table a decision on the application and note in the Board minutes the deferral and the reason(s) therefore.

(b) Favorable MEC Recommendation: At its next regular meeting following receipt and consideration of a favorable MEC recommendation, the Board may:

(1) Refer the matter back to the MEC for additional consideration. The Board must state the reason(s) for the requested reconsideration and set a time limit within which a subsequent MEC recommendation to the Board must be made.

(2) Grant Medical Staff appointment and/or Privileges as recommended by the MEC. If the Board's decision is favorable to the applicant, the action shall be effective as the Board's final decision.

(3) Reject or modify the MEC's favorable recommendation in whole or in part. If the Board's proposed decision is contrary to the MEC's favorable recommendation, the matter shall be referred to the Joint Conference Committee pursuant to subsection 2.8-6 below.

(i) If the Board's determination is Adverse to the applicant following such referral, the Hospital President shall notify the applicant, by Special Notice, and the applicant shall be entitled, if applicable, to the procedural due process rights provided for in the Fair Hearing Policy upon proper and timely request therefore.

(ii) Such Adverse decision shall be held in abeyance until the applicant has exercised or been deemed to have waived his/her procedural due process rights, if any, under the Fair Hearing Policy.

(iii) The fact that the Adverse decision is held in abeyance shall not be deemed to confer Medical Staff appointment and/or Privileges where none existed before.

(c) Without Recommendation from MEC

(1) If the Board, in its determination, does not receive a recommendation from the MEC within an appropriate time frame, the Board may, after informing the MEC of the Board's intent and allowing a reasonable period of time for response by the MEC, make its own determination using the same type of criteria considered by the MEC.

(2) If the Board's decision is favorable to the applicant, the Board action shall be effective as its final decision.

(3) If the Board's decision is Adverse to the applicant, the Hospital President shall inform the applicant, by Special Notice, and the applicant shall be entitled, if applicable, to the procedural due process rights provided for in the Fair Hearing Policy.

(i) Such Adverse decision shall be held in abeyance until the applicant has exercised or been deemed to have waived his/her procedural due process rights, if any, under the Fair Hearing Policy.

(ii) The fact that the Adverse decision is held in abeyance shall not be deemed to confer Medical Staff appointment and/or Privileges where none existed before.

(d) <u>Adverse MEC Recommendation</u>

(1) If the Board is to receive an Adverse MEC recommendation, the Chief of Staff shall withhold the recommendation and not forward it to the Board until after the applicant either exercises or waives his/her right, if any, to the procedural due process rights set forth in the Fair Hearing Policy.

(2) The Board shall thereafter take final action in the matter as provided for in the Fair Hearing Policy.

2.8-6 REFERRAL TO JOINT CONFERENCE COMMITTEE

(a) Whenever the Board's proposed decision is contrary to the recommendation of the MEC, there shall be a further review of the recommendation by the Joint Conference Committee.

(b) The Joint Conference Committee shall, after due consideration, make its written recommendation to the Board within seven (7) days after referral to the committee. Thereafter, the Board may act. Such action by the Board may include accepting, rejecting, or modifying, in whole or in part, the recommendation of the Joint Conference Committee.

2.8-7 FINAL DECISION

(a) The Board, through the Hospital President, shall give notice of the Board's final decision to the applicant. The Medical Staff and Hospital personnel shall be notified, as appropriate.

(b) A notice of Medical Staff appointment and/or Privileges shall include, as applicable: the Medical Staff category to which the applicant is appointed; the Department/Section to which he/she is assigned; the Privileges he/she may exercise; and any special conditions attached to the appointment and/or Privileges.

2.9 TIME PERIOD GUIDELINES FOR APPLICATION PROCESSING

2.9-1 All individuals and groups required to act on an application for Medical Staff appointment and/or Privileges must do so in a timely and good faith manner.

2.9-2 The following time periods will be used as a guideline:

(a) Department Chair/Section Chair: Within 30 days following notification from the Medical Staff Office that the complete application is available for review.

(b) Site/Regional Credentials Committee: Next regular meeting after receipt of a recommendation from the Department Chair (and Section Chair, as applicable).

(c) Medical Executive Committee: Next regular meeting after receipt of a recommendation from the Credentials Committee

(d) Board: Next regular meeting after receipt of a recommendation from the MEC.

2.9-3 This timeline is a guideline and shall not create any rights for the applicant to have an application processed within these time periods.

2.9-4 If additional information is needed from the applicant, the time awaiting a response from the applicant shall not count towards the applicable time period guideline.

2.9-5 If the provisions of the Fair Hearing Policy are activated, the time requirements provided therein govern the continued processing of the application.

2.10 EXPEDITED APPOINTMENT & PRIVILEGING PROCESS

2.10-1 The decision to use the expedited appointment and/or privileging process is totally discretionary on the part of the Hospital. No applicant has any entitlement to have his/her application reviewed through the expedited appointment and/or privileging process.

2.10-2 Applications eligible for expedited appointment and/or privileging reflect all of the following:

(a) Timely receipt of a complete application.

(b) All requested information has been returned promptly.

(c) There are no negative or questionable recommendations.

(d) There are no discrepancies in information received from the applicant and/or references.

(e) The applicant completed a normal education/training sequence.

(f) There have been no disciplinary actions or legal sanctions.

(g) The applicant has an unremarkable medical staff/employment history.

(h) For applicant's requesting Privileges: The applicant has submitted a reasonable request for Privileges consistent with his/her specialty and based upon his/her education, experience, training, and current competence.

(i) For applicant's requesting Privileges: The applicant has submitted documentation of his/her ability to competently perform the Privileges requested, with or without reasonable accommodation.

(j) The applicant has never been sanctioned by a Federal Healthcare Program or other third-party payer.

(k) The applicant has never been convicted of a crime with the exception of a minor traffic/motor vehicle violation.

(l) The Applicant's history shows an ability to relate to others in a harmonious, collegial manner.

2.10-3 The following situations are evaluated on a case-by-case basis by the Department Chair and the Credentials Committee chair and usually result in ineligibility for the expedited appointment and/or privileging process:

(a) Current challenge or previously successful challenge to licensure or registration.

(b) Involuntary termination of medical staff appointment at another hospital.

(c) Involuntary limitation, reduction, denial, or loss of privileges.

(d) Unusual pattern of, or an excessive number of, professional liability actions resulting in final judgment against the applicant.

2.10-4 DEPARTMENT CHAIR/SECTION CHAIR REVIEW

(a) The Department Chair (and Section Chair, as applicable) reviews the application and accompanying materials upon receipt of notice from the Medical Staff Office.

(b) If the Department Chair (and Section Chair, as applicable) determines that the application satisfies the criteria set forth in Section 2.10-2, and the recommendation of the Department Chair (and Section Chair, as applicable) is:

(1) Favorable to the applicant: The Department Chair (and Section Chair, as applicable) may forward such recommendation regarding the application to the Regional Credentials Committee chair (rather than the full Credentials Committee) for expedited appointment and/or privileging.

(2) Unfavorable to the applicant: The application will be forwarded to the Regional Credentials Committee chair, held for presentation at the next Regional Credentials Committee meeting, and processed in accordance with the routine appointment and/or privileging procedure set forth in Section 2.8.

(c) If the Department Chair (and Section Chair, as applicable) determines that the application does not satisfy the criteria set forth in Section 2.10-2, the application shall be processed in accordance with the routine appointment and/or privileging procedure set forth in Section 2.8.

2.10-5 REGIONAL CREDENTIALS COMMITTEE CHAIR REVIEW

(a) Upon receipt of a favorable recommendation from the Department Chair (and Section Chair, as applicable), the Regional Credentials Committee chair reviews the application and accompanying materials.

(b) If the Regional Credentials Committee chair agrees that the application satisfies the criteria set forth in Section 2.10-2 and the recommendation of the Regional Credentials Committee chair is:

(1) Favorable to the applicant: The Regional Credentials Committee chair may forward such recommendation regarding the application to the Medical Executive Committee for expedited appointment and/or privileging.

(2) Unfavorable to the applicant: The application will be held for presentation at the next Regional Credentials Committee meeting and processed in accordance with the routine appointment and/or privileging procedure set forth in Section 2.8.

(c) If the Regional Credentials Committee chair determines that the application does not satisfy the criteria set forth in Section 2.10-2, the application shall be held for presentation at the next Regional Credentials Committee meeting and processed in accordance with the routine appointment and/or privileging procedure set forth in Section 2.8.

2.10-6 MEDICAL EXECUTIVE COMMITTEE RECOMMENDATION

(a) Upon receipt of a favorable recommendation from the Department Chair (and Section Chair, as applicable) and the Regional Credentials

Committee chair, the Medical Executive Committee reviews the application and accompanying materials, as necessary.

(b) If the Medical Executive Committee agrees that the application satisfies the criteria set forth in Section 2.10-2 and the MEC's recommendation is:

(1) Favorable to the applicant: The MEC may forward such recommendation regarding the application to the designated Board committee for expedited appointment and/or privileging

(2) Unfavorable to the applicant: The application will be returned to the Regional Credentials Committee chair, held for presentation at the next Regional Credentials Committee meeting, and processed in accordance with the routine appointment and/or privileging procedure set forth in Section 2.8.

(c) If the MEC determines that the application does not satisfy the criteria set forth in Section 2.10-2, the application shall be returned to the Regional Credentials Committee chair, held for presentation at the next Regional Credentials Committee meeting, and processed in accordance with the routine appointment and/or privileging procedure set forth in Section 2.8.

2.10-7 BOARD COMMITTEE ACTION

(a) A designated committee of the Board (comprised of at least two (2) voting Board members (*i.e.,* voting members of the full Board who also serve on the Physicians Council) expedites final action on each application for expedited appointment and/or Privileges presented with a favorable recommendation from the applicable Department Chair/Section Chair, Regional Credentials Committee chair, and the MEC.

(b) The designated Board committee shall perform a final review of the expedited application and accompanying materials, as necessary, on behalf of the Board.

(c) If the Board committee agrees that the application satisfies the criteria set forth in Section 2.10-2 and the recommendation of the Board committee is:

(1) Favorable to the applicant: The applicant shall be granted the Medical Staff appointment/reappointment and/or Privileges/regrant of Privileges for which he/she applied effective as of the date the Board committee takes action.

(2) Unfavorable to the applicant: The application will be returned to the Regional Credentials Committee chair, held for presentation at the next Regional Credentials Committee meeting, and processed

in accordance with the routine appointment and/or privileging procedure set forth in Section 2.8.

(d) If the Board committee determines that the application does not satisfy the criteria set forth in Section 2.10-2, the application shall be returned to the Regional Credentials Committee chair, held for presentation at the next Regional Credentials Committee meeting, and processed in accordance with the routine appointment and/or privileging procedure set forth in Section 2.8.

(e) Full Board action is not required for expedited applications since the expedited process allows the Board's designated committee to act on the Board's behalf to grant Medical Staff appointment/reappointment and/or Privileges/regrant of Privileges to applicants regarding which the applicable Department Chair/Section Chair, Regional Credentials Committee chair, and the Medical Executive Committee are all in agreement.

(f) All other applications shall be processed in accordance with the routine appointment and/or privileging process set forth in Section 2.8.

2.11 RESIGNATIONS

2.11-1 A Practitioner who desires to voluntarily resign his/her Medical Staff appointment and/or Privileges shall submit a written resignation (which may be provided by e-mail) to the Medical Staff Office. Such resignation shall take effect on the date specified in the resignation notice.

2.11-2 Notification of the resignation will be communicated by the Medical Staff Office as appropriate.

2.11-3 A resignation should be submitted sufficiently in advance to assure that there is continuity of patient care and no disruption in services. A Practitioner who resigns his/her Medical Staff appointment and/or Privileges is obligated to complete all medical records for which he/she is responsible prior to the effective date of the resignation. In the event a Practitioner fails to do so, consideration may be given by the Hospital/Medical Staff to contacting the applicable state licensing board regarding the Practitioner's actions.

2.12 REAPPLICATION

2.12-1 Except as otherwise provided in the Medical Staff governing documents, or as otherwise determined by the Board upon recommendation of the Medical Executive Committee in light of exceptional circumstances:

(a) A Practitioner whose Medical Staff appointment and Privileges are automatically terminated pursuant to Section 7.5-1 (a), (b), (d), or (e) of the Medical Staff Bylaws shall not be eligible to reapply for Medical Staff appointment and/or Privileges for a period of at least two (2) years following the effective date of the automatic termination.

(b) A Practitioner who has received a final Adverse decision regarding appointment/reappointment and/or Privileges/regrant of Privileges shall not be eligible to reapply for Medical Staff appointment and/or Privileges for a period of at least two (2) years following the latter of the date of the notice of the final Adverse decision or final court decision.

(c) A Practitioner who has resigned his/her Medical Staff appointment and/or Privileges or who fails to seek reappointment/regrant of Privileges while under investigation or to avoid an investigation for professional conduct or clinical competency concerns shall not be eligible to reapply for Medical Staff appointment and/or Privileges for a period of at least two (2) years following the effective date of the resignation.

(d) A Practitioner who has withdrawn an initial application for appointment and/or Privileges for professional conduct or clinical competency concerns shall not be eligible to reapply for Medical Staff appointment and/or Privileges for a period of at least two (2) years following the date of the withdrawal.

(e) A Practitioner found, pursuant to Section 2.8.3 (e), to have made a material omission, misstatement, or misrepresentation in his/her application for Medical Staff appointment/reappointment and/or grant/regrant of Privileges, may not reapply for Medical Staff appointment and/or Privileges for a period of at least two (2) years following the date of such determination.

2.12-2 Any such reapplication shall be processed as an initial application, in accordance with the routine appointment/privileging process set forth Section 2.8, and the Practitioner must submit such additional information as may be reasonably required to demonstrate that the basis for the automatic termination, Adverse decision, resignation, or withdrawal has been resolved or no longer exists. If such information is not provided, the reapplication will be considered incomplete and voluntarily withdrawn and will not be further processed.

ARTICLE III PROCEDURE FOR REAPPOINTMENT/REGRANT OF PRIVILEGES

3.1 APPLICATION FOR REAPPOINTMENT/REGRANT OF PRIVILEGES

3.1-1 Prior to the expiration date of a Practitioner's current appointment/Privilege period, the Practitioner will be provided with a Hospital-approved application for Medical Staff reappointment and/or regrant of Privileges.

3.1-2 Each current Practitioner who is eligible to be reappointed to the Medical Staff and/or regranted Privileges shall be responsible for returning a completed reappointment/regrant application form to the CVO within the time period specified. The Practitioner must sign the application for Medical Staff reappointment/regrant of Privileges and in so doing accepts the same conditions as set forth in Section 2.6.

3.1-3 The Practitioner has the burden of producing adequate information for a proper evaluation of his/her qualifications for Medical Staff reappointment and/or regrant of Privileges, of resolving any doubts about such qualifications, and of satisfying requests for additional information or clarification made by authorized Medical Staff or Hospital representatives as set forth in Section 2-7-1.

3.1-4 Failure to return an application for reappointment and/or regrant of Privileges results in termination of the Practitioner's Medical Staff appointment and Privileges at the expiration of his/her current appointment/Privilege term. For any future consideration for Medical Staff appointment and/or Privileges, the Practitioner will need to submit a new initial application, including application fees.

3.1-5 Each recommendation concerning reappointment and/or regrant of Privileges shall be based upon review and consideration of a Practitioner's:

(a) Continued satisfaction of the qualifications for Medical Staff appointment and/or Privileges as set forth in Section 2.2 of the Medical Staff Bylaws and the applicable Medical Staff category and/or Delineation of Privileges.

(b) Updated information provided by the Practitioner with respect to Section 2.5 as necessary to bring the Practitioner's credentials file current.

(c) Satisfaction of the Medical Staff responsibilities set forth in the Section 2.3 of the Medical Staff Bylaws and the applicable Medical Staff category.

(d) Attestation of completion of continuing education requirements, as applicable. The Hospital/Medical Staff, through the CVO or the Medical Staff Office, reserve(s) the right to request proof of completion of continuing medical/other professional education requirements.

(e) Results of the Medical Staff's peer review and Focused and Ongoing Professional Practice Evaluations (FPPE and OPPE) and relevant findings from other quality assessment/performance improvement activities.

(f) Request for changes, if any, in Medical Staff appointment category and/or Privileges.

(g) Such other information as the MEC and Board deem applicable to a request for Medical Staff reappointment and/or regrant of Privileges.

3.1-6 To be eligible to apply for a regrant of Privileges, a Practitioner must have had a sufficient number of Patient Encounters in the previous appointment/Privilege period to enable assessment of the Practitioner's current clinical competence for the Privileges requested. A Practitioner seeking reappointment/regrant of Privileges who has had minimal activity at the Hospital must submit such professional practice evaluation data (*e.g.,* FPPE/OPPE)/quality assessment information from the Practitioner's primary hospital, if applicable, and/or such other supplemental information (*e.g.,* additional peer references, *etc.*) as may be requested, before the Practitioner's application for reappointment and/or regrant of Privileges shall be considered complete and processed further.

3.1-7 Practitioners appointed to the honorary Medical Staff category are not required to complete a reappointment application but shall confirm their desire to maintain their Medical Staff appointment in such manner as requested by the CVO/Medical Staff Office.

3.2 PROCESSING APPLICATIONS FOR MEDICAL STAFF REAPPOINTMENT AND/OR REGRANT OF PRIVILEGES

3.2-1 Practitioners appointed to the honorary Medical Staff category shall be reappointed to the honorary Medical Staff category upon recommendation of the MEC and approval of the Board.

3.2-2 With the exception set forth in Section 3.2-1, an application for Medical Staff reappointment and/or regrant of Privileges shall be processed as follows:

(a) The CVO verifies the information provided on the application for reappointment/regrant of Privileges working with the same authorities and generally in the same manner, to the extent applicable, as provided for in the initial application process set forth in Section 2.7-2.

(b) Applications for Medical Staff reappointment and/or regrant of Privileges shall be reviewed and acted upon in accordance with the procedure set forth in Section 2.8 or Section 2.10, as applicable.

(c) For purposes of reappointment and/or regrant of Privileges, the terms "applicant" and "appointment" and "Privileges" as used in Article II shall be read, as "Practitioner" and "reappointment" and "regrant of Privileges," respectively.

(d) All individuals and groups required to act on an application for Medical Staff reappointment and/or regrant of Privileges must do so in a timely and good faith manner.

3.2-3 If an application for reappointment/regrant of Privileges has not been fully processed by the expiration date of the Practitioner's current appointment and/or Privilege period, the Practitioner's appointment and Privileges shall terminate at the end of the last day of his/her current appointment/Privilege period. A Practitioner whose appointment and Privileges are so terminated shall not be entitled to the procedural due process rights provided in the Fair Hearing Policy. If the Practitioner qualifies, he/she may be granted temporary Privileges pursuant to Section 5.1-4.

3.3 MODIFICATION OF APPOINTMENT AND/OR PRIVILEGES

3.3-1 A Practitioner may, either in connection with reappointment and/or regrant of Privileges or at any other time, request modification of his/her Medical Staff appointment category (*i.e.,* a transfer from one Medical Staff category to another) and/or Privileges by submitting a written request to the Medical Staff Office.

3.3-2 A request for transfer from one Medical Staff category to another by a Practitioner with current Medical Staff appointment at the Hospital shall be acted upon by the Site Credentials Committee, as applicable, the Regional Credentials Committee, the MEC, and the Board.

3.3-3 A request for new/additional Privileges during a current appointment/Privilege period by a Practitioner with Medical Staff appointment and/or Privileges at the Hospital requires completion of the applicable Delineation of Privileges, documentation supportive of the request (*e.g.,* appropriate education, training, experience, *etc.*), and will be subject to a period of FPPE if granted. Following collection and verification of required information, such request will be acted upon by the Department/Section Chair, the Site Credentials Committee, as applicable, the Regional Credentials Committee, the MEC, and the Board.

3.4 REQUEST TO PRACTICE AT A NEW SITE WITHIN THE MARKET

3.4-1 If a Practitioner holds Medical Staff appointment and/or Privileges at an Affiliate Hospital and subsequently wishes to apply for Medical Staff appointment and/or Privileges at the Hospital, the application process set forth in the applicable CVO/Medical Staff Office procedure will be followed.

ARTICLE IV LEAVE OF ABSENCE

4.1 NOTICE OF LEAVE

4.1-1 A Practitioner may, for good cause (which may include, but is not limited to, illness, injury, military duty, or educational sabbatical), take a voluntary leave of absence by giving written notice to the Medical Staff Office who shall communicate receipt of such notification as appropriate. The notice must state the reason for the leave and the approximate period of time of the leave which may not exceed one (1) year.

4.1-2 A Practitioner may not take a leave of absence to avoid fulfilling any Medical Staff obligation, such as taking call.

4.1-3 The MEC may decline a leave of absence in the event that such leave does not satisfy the criteria set forth in Section 4.1-1. The decision of the MEC is final without right to appeal.

4.1-4 In the event that a leave of absence extends beyond the final date of the Practitioner's current appointment and Privilege period:

(a) The Practitioner may apply, during the leave, for reappointment to a Medical Staff category without Privileges.

(b) The Practitioner's Privileges will terminate at the end of his/her current appointment/Privilege period. The Practitioner may not apply for a regrant of Privileges during the leave.

(c) The Practitioner may apply for a new grant of Privileges at such time as the Practitioner applies for reinstatement following the leave and requests to transfer back to a Medical Staff category with Privileges.

4.1-5 A Practitioner on a leave of absence shall not be entitled to exercise his/her Privileges or Prerogatives of appointment at the Hospital.

4.1-6 Prior to taking a leave of absence, the Practitioner shall have made arrangements for the care of his/her patients during the leave of absence.

4.2 TERMINATION OF LEAVE OF ABSENCE, REINSTATEMENT OF MEDICAL STAFF APPOINTMENT & REINSTATEMENT OR NEW GRANT OF PRIVILEGES

4.2-1 In order to qualify for reinstatement of Medical Staff appointment and, as applicable, reinstatement or a new grant of Privileges following a leave of absence, the Practitioner must maintain Professional Liability Insurance coverage during the leave or purchase tail coverage for all periods during which the Practitioner held Privileges at the Hospital. The Practitioner shall provide information to demonstrate satisfaction of continuing Professional Liability

Insurance coverage or tail coverage as required by this provision upon request for reinstatement of Medical Staff appointment and, as applicable, reinstatement or a new grant of Privileges upon termination of the leave.

4.2-2 A Practitioner may request reinstatement of his/her Medical Staff appointment and, as applicable, reinstatement or a new grant of Privileges by sending a written request to the Medical Staff Office.

4.2-3 The Practitioner must submit a written summary of relevant activities during the leave as well as such additional information as is reasonably necessary to reflect that the Practitioner is qualified for reinstatement of Medical Staff appointment and, as applicable, reinstatement or a new grant of Privileges.

(a) If a Practitioner is returning from a medical leave of absence, the Practitioner may also be asked to obtain a physical examination and/or mental evaluation addressing the Practitioner's capability to resume clinical practice.

(b) The MEC may, as applicable, recommend reinstatement or a new grant of Privileges subject to an FPPE period to assess current clinical competency upon return from a leave of absence.

4.2-4 When the Practitioner’s request for reinstatement of Medical Staff appointment and, as applicable, reinstatement or a new grant of Privileges is deemed complete, the applicable procedure set forth in Article II or Article III will be followed in evaluating and acting on such request.

4.3 FAILURE TO RETURN FROM LEAVE

4.3-1 If a Practitioner fails to request reinstatement of Medical Staff appointment and, as applicable, reinstatement or a new grant of Privileges upon termination of the leave of absence, the MEC shall make a recommendation to the Board as to how such failure should be construed.

4.3-2 If such failure is deemed by the Board to be a voluntary resignation, it shall not give rise to any procedural due process rights pursuant to the Fair Hearing Policy.

ARTICLE V

TEMPORARY, EMERGENCY, DISASTER, AND TELEMEDICINE PRIVILEGES

5.1 TEMPORARY PRIVILEGES

5.1-1 CONDITIONS

(a) Temporary Privileges may be granted only in the circumstances and under the conditions described in this Section 5.1. Special requirements of consultation and reporting may be imposed by the applicable Department Chair or Section Chair.

(b) Under all circumstances, the Practitioner requesting temporary Privileges shall agree to abide by the Medical Staff governing documents and applicable System/Hospital policies in all matters relating to his/her activities at the Hospital.

5.1-2 GROUNDS FOR & PROCESS TO GRANT TEMPORARY PRIVILEGES

(a) The Hospital President (or authorized designee) may grant temporary Privileges on a case-by-case basis, upon the grounds (and satisfaction of the corresponding requirements) set forth in Section 5.1-3 or Section 5.1-4 following receipt of a written recommendation from the:

(1) Applicable Department Chair (or Section Chair); and,

(2) Chair of the Site or Regional Credentials Committee (or other designated Site representative to the Regional Credentials Committee); and,

(3) Chief of Staff (or authorized designee).

5.1-3 TEMPORARY PRIVILEGES FOR PENDENCY OF REVIEW OF A COMPLETE APPLICATION

(a) Temporary Privileges are not to be automatically granted to all applicants. Temporary Privileges may be granted to applicants for new Privileges awaiting application review and action by the Medical Executive Committee and Board upon written request by the applicant for such temporary Privileges and satisfaction of the following:

(1) Receipt of a complete application that raises no concerns.

(2) Review and verification of:

(i) Current licensure

(ii) Relevant training /experience

(iii) Current competence

(iv) Ability to perform the Privileges requested with or without a reasonable accommodation

(v) Such other information as set forth in Section 2.2 of the Medical Staff Bylaws and Section 2.5 of this Policy.

(3) Completion of a query and evaluation of the National Practitioner Data Bank information and such other queries as required by Section 2.7-2.

(4) Confirmation that the applicant has no current or previously successful challenges to his/her licensure or registration.

(5) Confirmation that the applicant has not been subject to the involuntary termination of his/her medical staff appointment at another organization.

(6) Confirmation that the applicant has not been subject to the involuntary limitation, reduction, denial, or loss of his/her privileges.

(b) Applicants for new Privileges include a Practitioner applying for Privileges at the Hospital for the first time; a Practitioner currently holding Privileges who is requesting one or more additional Privileges during his/her current appointment/Privilege period; and a Practitioner who is in the reappointment/regrant process and is requesting one or more additional Privileges.

(c) Temporary Privileges may be granted in this circumstance for a period not to exceed the pendency of the application (*i.e.,* completion of review and action on the application by the Medical Executive Committee and Board) or one hundred twenty (120) days, whichever is less. Under no circumstances may temporary Privileges be granted if the application is pending because the applicant has not responded in a satisfactory manner to a request for clarification of a matter or for additional information.

5.1-4 TEMPORARY PRIVILEGES FOR AN IMPORTANT/URGENT PATIENT CARE, TREATMENT, OR SERVICE NEED

(a) Temporary Privileges for an important/urgent patient care, treatment, or service need may be granted upon:

(1) Receipt of a written request by the applicant for the specific temporary Privileges desired and verification of the Practitioner's:

(i) Current licensure

(ii) Current competence relative to the temporary Privileges being requested

(iii) DEA registration, if required for the Privileges requested

(iv) Professional Liability Insurance

(2) Query of the National Practitioner Data Bank and such other queries as required by Section 2.7-2.

(b) The important/urgent patient care, treatment, or service need that supports the request for temporary Privileges pursuant to this ground shall be documented at the time temporary Privileges are requested and retained in the Practitioner's credentials file.

(c) Temporary Privileges may be granted for an important/urgent patient care, treatment, or service need for a period of up to 120 days after which the Practitioner must submit an initial application for Medical Staff appointment and Privileges in order to continue to practice at the Hospital.

5.2 EMERGENCY PRIVILEGES

5.2-1 In the case of an emergency, any Practitioner is authorized and shall be assisted to render care, treatment, and/or services to attempt to save a patient's life, or to save a patient from serious harm, as permitted within the Practitioner's scope of practice and notwithstanding the Practitioner's Medical Staff category or Privileges.

5.2-2 A Practitioner exercising emergency Privileges must obtain all consultative assistance deemed necessary and arrange for appropriate post-emergency care.

5.2-3 For purposes of this section, "emergency" is defined as a situation where serious permanent harm is imminent or in which the life of a patient is in immediate danger.

5.2-4 Emergency Privileges automatically terminate upon alleviation of the emergency situation. A Practitioner who exercises emergency Privileges shall not be entitled to the procedural due process rights set forth in the Fair Hearing Policy.

5.3 DISASTER PRIVILEGES

5.3-1 In circumstances of disaster when the Emergency Operations Plan ("EOP") has been activated and the Hospital is unable to meet immediate patient needs, the Hospital may choose to rely on volunteer Practitioners to help meet these needs subject to applicable state licensure laws, rules, and regulations.

5.3-2 Under such circumstances, if the usual credentialing and privileging process cannot be followed, the Hospital President, VPMA, or Chief of Staff may grant such disaster Privileges on a case-by-case basis after the Hospital obtains from the volunteer Practitioner a valid government-issued photo identification (*e.g.,* a driver's license or passport) and at least one of the following:

(a) A current picture identification card from a health care organization that clearly identifies the volunteer Practitioner's professional designation.

(b) A current license to practice.

(c) Primary source verification of licensure.

(d) Identification indicating the individual is a member of a Disaster Medical Assistance Team ("DMAT"), the Medical Reserve Corp ("MRC"), the Emergency System for Advance Registration of Volunteer Health Professionals ("ESAR-VHP"), or other recognized state or federal response organization or group.

(e) Identification indicating the individual has been granted authority to render patient care, treatment, or services in disaster circumstances by a government entity.

(f) Confirmation by current Hospital employees or Medical Staff Members with Privileges at the Hospital who have personal knowledge regarding the volunteer Practitioner's clinical ability to act during a disaster.

5.3-3 If not initially verified pursuant to Section 5.3-2, primary source verification of licensure occurs as soon as the disaster is under control or within seventy-two (72) hours from the time the volunteer Practitioner presents to the Hospital, whichever comes first. In extraordinary circumstances where primary source verification of a volunteer Practitioner's licensure cannot be completed within 72 hours after the Practitioner's arrival, and provided the individual has been exercising disaster Privileges, the CVO/Medical Staff Office must document:

(a) Reason(s) primary source verification could not be performed in the required time frame.

(b) Evidence of a demonstrated ability by each volunteer Practitioner granted disaster Privileges to continue to provide adequate care, treatment, and services.

(c) Evidence of the Hospital's attempt to perform primary source verification as soon as possible.

5.3-4 Primary source verification of licensure is not required if the volunteer Practitioner has not provided care, treatment, or services at the Hospital under the disaster Privileges.

5.3-5 The activities of volunteer Practitioners who receive disaster Privileges shall be managed by and under the supervision of the applicable Department Chair or Section Chair or an appropriate designee.

5.3-6 Within seventy-two (72) hours after a volunteer Practitioner's arrival at the Hospital, the Hospital President, VPMA, or Chief of Staff must make a decision, based upon the information obtained during that time, related to the continuation of the disaster Privileges initially granted.

5.3-7 All volunteer Practitioners who receive disaster Privileges must, at all times while at the Hospital, wear a photo identification badge from the facility at which they otherwise hold Privileges. If a Practitioner does not have such identification, he/she will be issued a badge identifying him/her and designating the Practitioner as a volunteer disaster privileged provider.

5.3-8 Disaster Privileges shall cease upon alleviation of the circumstances of disaster as determined by the Hospital President.

5.4 TELEMEDICINE PRIVILEGES

5.4-1 Section 5.4 applies to distant-site telemedicine Practitioners who do not practice on-site at the Hospital.

5.4-2 Distant-site Practitioners who are responsible for the patient's care, treatment, and/or services via a telemedicine link shall be credentialed (which may be by proxy) and privileged to do so by the Hospital in accordance with the Medical Staff Bylaws and this Credentials Policy, accreditation standards, and applicable laws, rules, and regulations.

5.4-3 Prior to a distant-site Practitioner providing telemedicine services to patients at the Hospital, the Practitioner must be appropriately credentialed (which may be by proxy) and granted Privileges by the Hospital. A distant-site Practitioner providing services via a telemedicine link shall be credentialed and privileged in one of the following ways:

(a) The Hospital may fully credential and grant Privileges to each distant-site Practitioner using the routine credentialing and privileging process set forth in Article II of this Policy; **OR,**

(b) The credentialing information and privileging decision from the distant-site may be relied upon by the Hospital Medical Staff and Board in making its telemedicine privileging recommendations/decisions regarding each distant-site Practitioner provided that the Hospital has entered into a written agreement with the distant-site and all of the following requirements are met:

(1) The distant-site is a Medicare-participating hospital; **OR**, a facility that qualifies as a distant-site telemedicine entity. A "distant-site

telemedicine entity" is defined as an entity that (1) provides telemedicine services, (2) is not a Medicare-participating hospital, and (3) provides contracted services in a manner that enables hospitals using its services to meet all applicable conditions of participation, particularly those requirements related to the credentialing and privileging of practitioners providing telemedicine services to the patients of the hospital.

(i) When the distant-site is a Medicare-participating hospital the written agreement shall specify that it is the responsibility of the distant-site hospital to meet the credentialing requirements of 42 C.F.R. 482.12 (a)(1)-(a)(7), as such provisions may be amended from time to time, with regard to the distant-site hospital Practitioners providing telemedicine services.

(ii) When the distant-site is a distant-site telemedicine entity the written agreement shall specify that the distant-site telemedicine entity is a contractor of services to the Hospital and, as such, furnishes the contracted services in a manner that permits the Hospital to comply with all applicable conditions of participation for the contracted services including, but not limited to, 42 C.F.R. 482.12 (a)(1)-(a)(7) with regard to the distant-site telemedicine entity Practitioners providing telemedicine services. The written agreement shall further specify that the distant-site telemedicine entity's medical staff credentialing and privileging process and standards will, at minimum, meet the standards at 42 C.F.R. 482.12 (a)(1)-(a)(7) and at 42 C.F.R. 482.22 (a)(1)-(a)(2) as those provisions may be amended from time to time.

(2) The distant-site is TJC accredited or a Medicare-participating organization.

(3) Each distant-site Practitioner is privileged at the distant-site for those services to be provided at the Hospital and the distant-site provides the Hospital with a current list of each distant-site Practitioner's privileges at the distant-site.

(4) Each distant-site Practitioner holds an appropriate license issued by the appropriate licensing entity in the state in which the Hospital whose patients are receiving the telemedicine services is located in addition to meeting the licensing standards, as applicable, in the state in which the Practitioner is located.

(5) The Hospital maintains documentation of its internal review of the performance of each distant-site Practitioner and sends the distant-site such performance information for use in the distant-site's periodic appraisal of the distant-site Practitioner. At a minimum, this information must include:

(i) All adverse events that result from the telemedicine services provided by the distant-site Practitioner to Hospital patients.

(ii) All complaints the Hospital receives about the distant-site Practitioner.

5.5 MOONLIGHTING PRIVILEGES

5.5-1 QUALIFICATIONS

Moonlighting Privileges may be granted to Physician residents and fellows who:

(a) Obtain prior written approval from the director of the applicable fellowship or residency program.

(b) Are in good standing in his/her residency or fellowship program as confirmed by the program director.

(c) Are requesting Privileges to provide clinical care, treatment, and/or services to patients at the Hospital (or a provider-based location thereof) outside of the time periods that the resident or fellow is participating in their residency or fellowship training education/program.

(d) Have and maintain a current valid license (not a training certificate) to practice medicine in Ohio and meet the continuing education requirements necessary to maintain such medical license as determined by the State Medical Board of Ohio.

(e) Have and maintain, if required for the Privileges requested, a current valid Drug Enforcement Administration (DEA) registration.

(f) Document successful completion of professional education.

(g) Possess current, valid Professional Liability Insurance coverage in such form and amount as determined by the Board.

(h) Are able to participate in Federal Health Programs.

(i) Are able to read and understand the English language, to write and communicate verbally in the English language in an intelligible manner, and to prepare medical record entries and other required documentation in a legible and professional manner.

(j) Document and demonstrate an ability to work with others in a positive, professional, cooperative, and collegial manner.

(k) Document and demonstrate current ability to competently perform the Privileges requested with or without a reasonable accommodation.

(l) Are able to provide patient care, treatment, and/or services at an acceptable level of quality and efficiency and consistent with available resources and applicable standards of care.

(m) Document and demonstrate adherence to the applicable code of professional ethics and good character/judgment.

(n) Comply with Board or Hospital conflict of interest policies, if any, as applicable.

(o) Comply with Medical Staff requirements regarding criminal background checks.

(p) Satisfy such other qualifications as are set forth in the applicable Delineation of Privileges and as may be otherwise recommended by the Medical Executive Committee and approved by the Board.

5.5-2 CONDITIONS

(a) Fellows and residents on a J-1/J-2 visa, on military support, or as otherwise prohibited by law are not permitted to moonlight. Fellows employed under an H1-B visa may be able to moonlight in limited situations provided certain conditions are met.

(b) PGY-1 residents are not permitted to moonlight.

(c) A moonlighting resident or fellow must request and be granted Privileges prior to providing any clinical care, treatment, and/or services to patients at the Hospital (or a provider-based location thereof) outside of the time periods that the resident or fellow is participating in their residency or fellowship training education/program.

(1) A moonlighting resident or fellow will be subject to FPPE and OPPE with respect to the moonlighting Privileges granted.

(d) Special requirements of consultation and reporting may be imposed at such time as moonlighting Privileges are granted.

(e) A moonlighting resident or fellow must agree, in writing, to abide by the Medical Staff governing documents and the policies of the System/Hospital in all matters relating to his/her moonlighting activities at the Hospital.

(f) Moonlighting is not required and must not interfere with the resident's or fellow's residency or fellowship clinical training/education.

(g) All moonlighting hours must be reported and counted towards work duty hour requirements.

(h) Permission to moonlight may be withdrawn if the residency or fellowship program director determines that the resident's or fellow's education/training is adversely impacted by such moonlighting activities.

5.5-3 PROCESSING A REQUEST FOR MOONLIGHTING PRIVILEGES

(a) A request for moonlighting Privileges shall be processed in accordance with the routine credentialing and privileging process (as applicable) set forth in this Policy.

(b) Moonlighting Privileges may be granted/regranted for a period of up to three (3) years as recommended by the MEC and approved by the Board.

5.6 TERMINATION OF TEMPORARY, DISASTER, TELEMEDICINE, OR MOONLIGHTING PRIVILEGES

5.6-1 The Hospital President, VPMA, or Chief of Staff may terminate a Practitioner's temporary, disaster, or telemedicine Privileges (or a resident's/fellow's moonlighting Privileges) at any time.

5.6-2 Where the life or well-being of a patient is determined to be endangered, the Practitioner's temporary, disaster, or telemedicine Privileges (or a resident's/fellow's moonlighting Privileges) may be terminated by any person entitled to impose a summary suspension pursuant to the Medical Staff Bylaws.

5.6-3 In the event a Practitioner's temporary, disaster, or telemedicine Privileges (or a resident's/fellow's moonlighting Privileges) are revoked, the Practitioner's patients shall be assigned to another Practitioner by the Chief of Staff or applicable Department Chair/Section Chair. The wishes of the patient will be considered, where feasible, in choosing a substitute Practitioner.

5.7 EFFECT OF TERMINATION OF TEMPORARY, DISASTER, TELEMEDICINE, OR MOONLIGHTING PRIVILEGES

5.7-1 A Practitioner who has been granted temporary, disaster, or telemedicine Privileges (or a resident or fellow who has been granted moonlighting Privileges) is not a Medical Staff Member and is not entitled to the procedural due process rights afforded to Medical Staff Members.

5.7-2 A Practitioner (or resident/fellow) shall not be entitled to the procedural due process rights set forth in the Medical Staff Bylaws or Fair Hearing Policy because the Practitioner's request for temporary, disaster, or telemedicine Privileges (or the resident's or fellow's request for moonlighting Privileges) is refused, in whole or in part, or because all or any portion of such Privileges are terminated, not renewed, restricted, suspended, or otherwise limited, modified, or monitored in any way.

5.8 RECOGNITION OF NEW SERVICE OR PROCEDURE; AMENDMENT OF EXISTING DELINEATIONS OF PRIVILEGES

5.8-1 The Board shall determine the Hospital's scope of patient care services based upon recommendations from the Medical Executive Committee. Overall considerations for establishing new services and procedures include, but are not limited to:

(a) The Hospital's available resources and staff.

(b) The Hospital's ability to appropriately monitor and review the competence of the performing Practitioner(s).

(c) The availability of other qualified Practitioners with Privileges at the Hospital to provide coverage for the new service or procedure when needed.

(d) The quality and availability of training programs.

(e) Whether such service or procedure currently, or in the future, would be more appropriately provided through a contractual arrangement with the Hospital.

(f) Whether there is a community need for the service or procedure.

(g) The *Ethical and Religious Directives for Catholic Health Care Facilities.*

5.8-2 Requests for Privileges for a new service or procedure that has not yet been recognized by the Board at the Hospital shall be processed as follows:

(a) The Practitioner must submit a written Privilege request for a new service or procedure to the Medical Staff Office who shall notify the applicable Department Chair. If such request is initially received by the CVO, the CVO shall communicate such request to the Medical Staff Office. The request should include a description of the Privileges being requested, the reason why the Practitioner believes the Hospital should recognize such

Privileges, and any additional information that the Practitioner believes may be of assistance in evaluating the request.

(1) If the Department Chair (who may consult with the applicable Section Chair, if any, as necessary) determines that the service or procedure should not be recognized at the Hospital, the Department Chair will provide his/her recommendation to the Regional Credentials Oversight Committee for consideration.

(2) If the Department Chair (who may consult with the applicable Section Chair, if any, as necessary) determines that the new service or procedure should be included in an existing Delineation of Privileges, the Department Chair will provide the basis for his/her recommendation to the Regional Credentials Oversight Committee.

(3) If the Department Chair (who may consult with the applicable Section Chair, if any, as necessary) determines that the new service or procedure should be recognized at the Hospital and that a new Delineation of Privileges is required, the Department Chair (who may consult with the applicable Section Chair, if any, as necessary) shall develop and submit to the Regional Credentials Oversight Committee a new Delineation of Privileges based upon:

(i) A determination as to what specialties are likely to request the Privileges.

(ii) The positions of specialty societies, certifying boards, *etc.*

(iii) The available training programs.

(iv) Recommended standards to be met with respect to the following: education; training; board certification; experience; and, FPPE/OPPE requirements to confirm and monitor current clinical competency.

(v) Criteria required by other hospitals with similar resources.

(b) Upon receipt of a recommendation from the Department Chair (who may consult with the applicable Section Chair, if any, as necessary), the Regional Credentials Oversight Committee shall review the matter and forward its recommendation to the Medical Executive Committee.

(c) Upon receipt of a recommendation from the Regional Credentials Oversight Committee, the Medical Executive Committee shall review the matter and forward its recommendation to the Board:

(1) If the Board approves the new or amended Delineation of Privileges, the requesting Practitioner(s) may apply for such Privilege(s) consistent with the credentialing and privileging process set forth in Article II.

(2) If the Board does not approve the new or amended Delineation of Privileges, the requesting Practitioner(s) shall be so notified. A decision by the Board not to recognize a new service or procedure does not give rise to the procedural due process rights provided in the Fair Hearing Policy.

5.8-3 Adoption and amendment of Delineations of Privileges (*i.e.,* Privilege sets) for care, treatment, and/or services provided at the Hospital requires review by the Department Chair (the Section Chair, as applicable) and the Regional Credentials Oversight Committee, a recommendation from the MEC, and approval of the Board.

5.9 FOCUSED & ONGOING PROFESSIONAL PRACTICE EVALUATION

5.9-1 The Hospital's FPPE process is set forth, in detail, in the Medical Staff Peer Review Program/Professional Practice Evaluation Policies and shall be implemented for all: (i) Practitioners requesting initial Privileges; (ii) existing Practitioners requesting new Privileges during the course of an appointment/Privilege period; and (iii) in response to concerns regarding a Practitioner's ability to provide safe, high quality patient care. The FPPE period shall be used to determine the Practitioner's current clinical competence and ability to perform the requested Privileges.

5.9-2 Upon conclusion of the FPPE period, OPPE shall be conducted on all Practitioners with Privileges. The Hospital's OPPE process is set forth, in detail, in the Medical Staff Peer Review Program/Professional Practice Evaluation Policies and requires the Hospital to gather, maintain, and review data on the performance of all Practitioners with Privileges on an ongoing basis.

ARTICLE VI

CONFLICTS OF INTEREST & CONTRACTED PROVIDERS

6.1 CONFLICTS OF INTEREST

6.1-1 In any instance where a Practitioner has or reasonably could be perceived to have a conflict of interest in any matter that comes before the Medical Staff, a Department or Section (as applicable), or a Medical Staff committee, the Practitioner is expected to disclose the conflict to, as applicable, the Chief of Staff, the Department Chair or Section Chair (as applicable), or committee chair. The Practitioner may be asked and is expected to answer any questions concerning the conflict. The Chief of Staff, Department Chair or Section Chair (as applicable), or committee chair is responsible for determining whether a conflict exists and, if so, whether the conflict rises to the level of precluding the Practitioner from participating in the pending matter.

6.1-2 For purposes of this Section 6.1, the fact that Practitioners are competitors, partners, or employed in the same group shall not, in and of itself, automatically disqualify such Practitioners from participating in the review of applications or other Medical Staff matters with respect to their colleagues.

6.1-3 All Practitioner nominees for election or appointment: to a position on the Board or a Board committee; as a Medical Staff officer, Department Chair, or Section Chair; as a member or chair of the Medical Executive Committee, a site or Regional Credentials Committee, or such other Medical Staff committee as may be set forth in the applicable conflict of interest policy shall disclose, in writing, any conflicts of interest with the Hospital in accordance with the applicable conflict of interest policy.

6.2 EXCLUSIVE CONTRACTS

6.2-1 The Board, after consultation with the MEC, may:

(a) Establish exclusive contractual relationships with any individual or group of individuals for the provision of clinical services, or the management of specific clinical Departments;

(b) Close a Department or specialty or limit the number of Practitioners; or

(c) Define or limit the patient care services to be provided at the Hospital.

6.2-2 Such Board action should take into consideration the efficient management of the Hospital; the availability, adequacy and extent of Hospital facilities, adequately trained support and monitoring personnel; standards of quality patient care;

patient needs; community needs; and such other criteria as the Board, in consultation with the MEC, may develop.

6.2-3 Nothing in this section limits the Board's power to deny Medical Staff appointments or Clinical Privileges in specific cases if the Hospital would be unable to provide adequate facilities, properly trained support personnel, or monitoring of the applicant's Clinical Privileges or patients.

6.2-4 Exclusive Contracts. Exclusive contracts shall only be authorized by specific action of the Board. The duration, terms, and extent of these contracts shall be governed by Board policy.

(a) A Member under an exclusive contract (or who is affiliated with a group under an exclusive contract) with the Hospital must meet and hold continuously all the necessary qualifications of Medical Staff membership and Clinical Privileges applicable to the facilities he or she uses or the services he or she provides.

(b) When the Hospital enters into an exclusive contract, Members must honor the exclusivity policy and, except in emergencies, arrange for the care of their patients in accordance with the Hospital policy and the terms of the applicable agreements.

(c) Applications for Clinical Privileges covered by a Hospital exclusivity policy will not be accepted or processed, except in accordance with the Board policy and/or any existing written agreements.

(d) Termination of an exclusive contract between the Hospital and:

(1) A Member (for reasons other than competence or professional conduct) is deemed a voluntary resignation of the Member's Medical Staff membership and Clinical Privileges.

(2) A group is deemed a voluntary resignation of the Medical Staff membership and Clinical Privileges of each Member in the group unless an individual Member continues to provide services with another group contracted with Mercy Health.

6.2-5 Termination of any relationship between a group holding an exclusive contract and one or more of its members is deemed a voluntary resignation of the Medical Staff membership and Clinical Privileges of the departing Member.

6.2-6 Termination of a relationship does not result in the resignation of Medical Staff membership or Clinical Privileges of a Practitioner to the extent he or she holds other Clinical Privileges that are not the subject of an exclusive contract at the Hospital. If active or associate Medical Staff membership is held at another Mercy Health Hospital, that membership shall be maintained.

6.3 MEDICAL STAFF DUES

6.3-1 The MEC may impose regular dues, special assessments, late fees, and other fines upon Medical Staff Members.

6.3-2 Failure to pay Medical Staff dues following three (3) written attempts by the Medical Staff Office to collect the delinquent dues will result in an automatic termination of Medical Staff appointment and Privileges pursuant to the applicable procedure set forth in the Medical Staff Bylaws.

6.3-3 The Medical Executive Committee shall approve all expenditures of Medical Staff dues.

ARTICLE VII BOARD CERTIFICATION

7.1 QUALIFICATION

7.1-1 Unless otherwise provided herein, all Physicians, Podiatrists, and Oral Surgeons shall be board certified (or board eligible) in the specialty in which the Practitioner seeks Privileges at the time of initial application for Medical Staff appointment and Privileges as follows:

(a) **Physicians**: By the American Board of Medical Specialties board applicable to the Physician's specialty/sub-specialty; or, by the American Osteopathic Board; or, by the Royal College of Physicians and Surgeons of Canada.

(1) A Physician who is board certified in a subspecialty is not required to also maintain certification with the primary board unless otherwise required by the applicable certifying board or Delineation of Privileges (*e.g.,* a Physician who is board certified in gastroenterology is not also required to maintain internal medicine board certification).

(b) **Podiatrists**: By the American Board of Podiatric Medicine or the American Board of Foot and Ankle Surgery.

(c) **Oral Surgeons**: By the American Board of Oral & Maxillofacial Surgery.

7.1-2 A Physician, Podiatrist, or Oral Surgeon who is a qualified candidate for board certification at the time of initial application for Medical Staff appointment and/or Privileges shall have the time period, as set by the applicable certifying board, following the date of completion of residency or fellowship training to become board certified.

(a) If the applicable certifying board does not specify a time period for board certification, the Physician, Podiatrist, or Oral Surgeon shall have five (5) years following the date of completion of residency or fellowship training to become certified.

7.1-3 Physicians, Podiatrists, and Oral Surgeons who were granted Medical Staff appointment and Privileges at the Hospital on or before January 1, 2005; who were not board certified at the time Medical Staff appointment and Privileges were initially granted; and who have continuously held appointment and Privileges at the Hospital (without board certification) since the time such appointment and Privileges were initially granted, are not required to be board certified.

7.1-4 Physicians, Podiatrists, and Oral Surgeons who are granted Medical Staff appointment and Privileges at a Mercy Health Hospital (*i.e.,* at the Hospital or an Affiliate Hospital) on or after April 25, 2023 shall continuously maintain board certification in accordance with the requirements of the applicable certification board unless a waiver is otherwise granted by the Hospital Board.

(a) Physician maintenance of board certification through the National Board of Physicians and Surgeons is acceptable.

(b) For purposes of clarity, the requirement to continuously maintain board certification shall not apply to a Physician, Podiatrist, or Oral Surgeon who has Medical Staff appointment and Privileges at a Mercy Health Hospital (*i.e.,* at the Hospital or an Affiliate Hospital) on or before April 24, 2023.

7.2 WAIVER OF BOARD CERTIFICATION

7.2-1 A written request for a waiver of the board certification qualification may be submitted by the Practitioner for consideration by the Site Credentials Committee, as applicable, the Regional Credentials Committee, MEC, and Board.

7.2-2 Board certification may be waived, at the sole discretion of the Board, based upon the Practitioner's demonstrated exceptional circumstances and a Board determination that such waiver will serve the best interests of patient care.

7.2-3 The Site Credentials Committee, as applicable, and the Regional Credentials Committee, will review the waiver request and provide its recommendation to the MEC. Following consideration of the recommendation from the Site Credentials Committee, as applicable, and the Regional Credentials Committee, the MEC will make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Upon receipt of the MEC's recommendation, the Board shall either grant or deny the waiver request.

7.2-4 Once a waiver is granted, it shall remain in effect from the time it is granted until the Practitioner's resignation or termination of Medical Staff appointment and/or Privileges unless a shorter time period is otherwise recommended by the MEC and approved by the Board. The Practitioner must thereafter reapply for the waiver.

7.2-5 No Practitioner is entitled to a waiver. A determination by the Board not to grant a Practitioner's request for a waiver; or, the Hospital's inability to process an application; or, termination of a Practitioner's Medical Staff appointment and/or Privileges based upon failure to satisfy the qualifications for Medical Staff appointment and/or Privileges does not give rise to any procedural due process rights pursuant to the Medical Staff Bylaws or Fair Hearing Policy nor does it create a reportable event for purposes of federal or state law.

7.2-6 Unless a waiver is requested and subsequently granted, a Practitioner's failure to:

(a) Satisfy the requirement of board certification at the time of initial application shall result in the Hospital's inability to process the application as a result of the Practitioner's failure to meet baseline qualifications.

(b) Continuously satisfy the board certification requirement following attainment of Medical Staff appointment and/or Privileges shall result in termination of Medical Staff appointment and Privileges for failure to meet baseline qualifications.

7.3 WAIVER OF OTHER QUALIFICATIONS

7.3-1 The waiver process set forth in Section 7.2 may be used, at the sole discretion of the Board, in the event that the Site Credentials Committee, as applicable, the Regional Credentials Committee, and the MEC recommend waiver of a qualification(s) other than/in addition to board certification set forth in Section 2.2 of the Medical Staff Bylaws.

CERTIFICATION OF ADOPTION AND APPROVAL BY:

MERCY HEALTH – ANDERSON HOSPITAL LLC
MERCY HEALTH – CLERMONT HOSPITAL LLC
MERCY HEALTH – FAIRFIELD HOSPITAL LLC
MERCY HEALTH – WEST HOSPITAL LLC
JEWISH HOSPITAL, LLC dba THE JEWISH HOSPITAL – MERCY HEALTH

Adopted by the Medical Executive Committee:

Anderson:	April 17, 2023
Clermont:	April 13, 2023
Fairfield:	April 18, 2023
Jewish:	April 11, 2023
West:	April 13, 2023

Approved by the Physicians Council: April 19, 2023

Approved by the Board: April 25, 2023

ADOPTION & APPROVAL BY: MERCY HEALTH – KINGS MILLS HOSPITAL LLC

Adopted by the Interim Medical Executive Committee: June 8, 2023

Approved by the Physicians Council: June 21, 2023

Approved by the Board: June 26, 2023