HARDIN COUNTY GENERAL HOSPITAL

MEDICAL STAFF BYLAWS

PREAMBLE

WHEREAS, Hardin County General Hospital is a non-profit corporation organized under the laws of the State of Illinois; and

WHEREAS, its purpose is to serve as a general acute care hospital providing patient care;

WHEREAS, it is recognized that the Medical Staff is responsible for the quality of medical care in the hospital and must accept and assume this responsibility, subject to the ultimate authority of the hospital's Governing Board, and that the best interests of the patient are protected by a concerted effort, the Physicians, and Dentists practicing in the Hardin County General Hospital hereby organize themselves in conformity with the Bylaws, Rules and Regulations hereinafter stated.

WHEREAS, in keeping with the hospital's Mission, the Medical Staff as well as the Governing Board, and professional service staff shall demonstrate a consistent endeavor to deliver optimal care in an environment of minimal risk. Hardin County General Hospital will continue to strive to have a systematic, coordinated, and continuous approach to improving performance focusing upon the processes and mechanisms that address these important values.

WHEREAS, the hospital-wide Quality/Performance Improvement Program established by the team of Medical Staff and Administration with support and approval from the Governing Board, has the responsibility for monitoring every aspect of patient care, from the time the patient enters the hospital through diagnosis, treatment, recovery, and discharge in order to identify and resolve any breakdowns that may result in sub-optimal patient care and safety, while striving to continuously improve and facilitate positive patient outcomes.

DEFINITIONS

1. The term "Medical Staff" means all Physicians holding unlimited licenses, as well as duly licensed dentists who are privileged to attend patients in the hospital.

2. The term "Governing Body" means the Board of Directors of Hardin County General Hospital.

3. The term "Executive Committee" means the Executive Committee of the Medical Staff unless specific reference is made to the Executive Committee of the Governing Body.

4. The term "Chief Executive Officer" and/or "Administrator" mean the individual appointed by the Governing Body to act in its behalf in the overall management of the hospital.

5. The term "Practitioner" means an appropriately licensed Physician with an unlimited license or an appropriately licensed dentist.

6. The term "he" is used in this manual, not to denote gender, but merely as a pronoun designating male or female.

7. The term "application" refers to the State of Illinois Health Care Professional Credentialing and Business Data Gathering Form and Supplemental Form. These forms will be utilized for the purpose of collecting credentials data on appropriately licensed Physicians and dentists applying for membership on the Medical Staff. Certain sections of the Credentialing and Business Data Gathering Form are not required to be completed by the Practitioner as stated in the Credentialing Supplemental Form. This form will also be utilized for granting of temporary privileges to a Practitioner.

8. The State of Illinois Health Care Professional Re-credentialing and Business - Data Gathering Form and Supplemental Form refer to the forms required for completion by the Practitioner who is currently credentialed and is reapplying for Medical Staff membership. Certain sections of the Re-credentialing and Business Data Gathering Form are not required to be completed by the Practitioner as stated in the Re-credentialing Supplemental Form.

9. The State of Illinois Health Care Professional Update Data Gathering Form is required to be used by Practitioner when making corrections, updates, and modifications to his credentials data. The professional must provide the updated information within five (5) business days as it relates to the following developments:

a. license revocation
b. federal drug enforcement agency license revocation
c. Medicare or Medicaid sanctions
d. revocation of hospital privileges
e. any lapse in professional liability coverage required by the hospital
f. conviction of a felony

Any other changes in the information provided in the forms must be sent within forty-five (45) days from the date the Practitioner "knew of the change."

ORGANIZATION NAME - ARTICLE I

The name of this organization shall be the Medical Staff of Hardin County General Hospital.

PURPOSES - ARTICLE II

The purposes of this organization are:

1. To ensure that all patients admitted to or treated in any of the facilities departments or services of the hospital shall receive the best possible care;

2. To ensure a high level of professional performance of all Practitioners authorized to practice in the hospital through the appropriate delineation of the clinical privileges that each Practitioner may exercise in the hospital, and through an ongoing review and evaluation of each Practitioner's performance in the hospital;

3. To provide an appropriate education setting that will lead to continuous advancement in professional knowledge and skill: (This includes cooperation with educational institutions and programs wherever possible);

4. To initiate and maintain rules and regulations for self-government of the Medical Staff; and

5. To provide a means whereby issues concerning the Medical Staff and the hospital may be discussed by the Medical Staff with the Governing Body and the Chief Executive Officer.

RESPONSIBILITIES - ARTICLE III

The responsibilities of the Medical Staff are:

1. To account for the quality of medical care rendered by all Practitioners, Respiratory Therapists, and any affiliates authorized by the board to practice in the hospital through the following:

> **a. A** credentials program with a process for appointment, reappointment, and the matching of privileges with verified credentials and demonstrated performance.
>
> **b**. An organizational structure that provides for continuous monitoring of patient care.
>
> **c**. A system to evaluate the effectiveness of the monitoring and evaluation of the quality and appropriateness of patient care provided by all individuals with clinical privileges, surgical case review, drug usage evaluation, the medical record review function, blood usage review, the pharmacy and therapeutics function, and other review functions.

d. A continuing education program.

2. To provide recommendations to the Board regarding appointments, reappointments, staff category, clinical privileges, specified services for affiliated Practitioners and corrective action.

3. To provide regular reports and recommendations to the board concerning the quality and efficiency of patient care rendered as determined by patient care evaluation studies and other quality maintenance activities.

4. To initiate and pursue corrective action with respect to Practitioners when warranted.

5. To develop, administer and assure compliance with these Bylaws, the rules and regulations of the staff and other patient care related hospital policies.

6. To participate in the hospital planning process including assessment of community needs, establishing institutional goals, allocating resources to attain these goals, and implementing programs necessitated by these goals.

7. To exercise the authority granted by these Bylaws to fulfill the foregoing responsibilities.

8. To complete a medical history and physical examination no more than (30) days before or (24) hours after admission for each patient. The medical history and physical examination must be completed by a physician or a credentialed Allied Health Professional (Nurse Practitioner or Physician Assistant).

9. If the medical history and physical examination is completed within (30) days before admission, an updated medical record entry must be completed within (24) hours after admission documenting an examination for any changes in the patient's condition.

MEMBERSHIP - ARTICLE IV

Section 1. Nature of Medical Staff Membership

Membership on the Medical Staff of Hardin County General Hospital is a privilege which shall be extended only to professionally competent Physicians and Dentists who continuously meet the qualifications, standards and requirements set forth in these Bylaws. Sex, race, creed, and/or national origin are not used in making decisions regarding the granting or denying of Medical Staff membership or clinical privileges. Membership confers only those clinical privileges and prerogatives granted by the Governing Body.

Section 2. Qualifications for Membership

Only Physicians and dentists who are legally licensed to practice in the State of Illinois and who meet the following basic qualifications will be considered for privileges at Hardin County General Hospital. Each applicant for membership must agree to:

1. provide his patients with an optimal level of quality and efficient care, and pledge to provide continuous care for his patients;

2. initiate and complete in a timely manner, all medical and other required records for all patients admitted or to who care was provided;

3. certify if he has a physical or mental condition which could affect his ability to exercise the clinical privileges requested or would require an accommodation in order for him to exercise the privileges requested safely and competently, and consents to the inspection of records and documents pertinent to his licensure, specific training, experience, current competence, and health status and, if requested, appear for an interview;

4. understand that the professional criteria specified in the Medical Staff Bylaws uniformly applies to all applicants and/or Medical Staff members and constitutes the basis for granting initial and/or continuing Medical Staff membership;

5. indicate and show evidence of adequate professional liability insurance. A minimum of one million dollars of professional liability insurance is required;

6. be oriented to these Bylaws, Rules and Regulations, and hospital policies and agrees in writing that his activities as a member of the Medical Staff will be bound by them. His signature on the Health Care Professional Credentialing and Business Data Gathering Supplemental Form is documentation of his understanding;

7. by acceptance of membership on the Medical Staff shall constitute the staff member's agreement that he will strictly abide by the principles of ethics of his respective profession and such other ethical principles as may be adopted by the Medical Staff as an organized body.

Section 3. Conditions and Duration of Appointment

a. Initial appointments and reappointments to the Medical Staff shall be made by the Governing Body. The Governing Body shall act on appointments only after there has been a recommendation from the Medical Staff provided in these Bylaws; provided that in the event of unwarranted delay on the part of the Medical Staff, the Governing Body may act without such recommendation on the basis of documented evidence of the applicant's or staff member's professional and ethical qualifications obtained from reliable sources other than the Medical Staff.

b. Initial appointments shall be for a period of six (6) months. Reappointment shall be for a period of not more than two Medical Staff years. For the purposes of these Bylaws, the Medical Staff year commences on the 1st day of April and ends on the 31st day of March of each year.

c. Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted by the Governing Body, in accordance with these Bylaws.

d. Every application for staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgment of every Medical Staff member's obligations to provide continuous quality care and supervision of his patients, to abide by the Medical Staff Bylaws, Rules, and Regulations, to accept committee assignments and to accept consultation assignments.

APPOINTMENT AND REAPPOINTMENT - ARTICLE V

Section 1. Application for Appointment

a. All applications for appointment to the Medical Staff shall be in writing, shall be signed by the applicant, and shall be submitted on the state mandated form and the supplemental form prescribed by the Governing Body after consultation with the Executive Committee. The application shall require detailed information concerning the following:

1. applicant's professional qualifications and shall include the name of at least two persons who have had extensive experience in observing and working with the applicant and who can provide adequate references pertaining to the applicant's professional competence and ethical character;

2. if Medical Staff membership status and/or clinical privileges have ever been revoked, suspended, reduced, not renewed, placed on probation, proctored or placed under mandatory consultation or terminated either voluntarily or involuntarily at any other hospital, ambulatory surgery center or institution;

3. if applicant's membership in local, state or national medical societies, or his license to practice any profession in any jurisdiction, ever been limited, restricted, suspended, revoked, cancelled and/or subject to probation either voluntarily or involuntarily or voluntarily relinquished;

4. reference made to certification and re-certification for Board specialties;

5. if applicant has had any reprimands, and/or fines, investigations, complaints or disciplinary actions against him from any state or federal agency, hospital or ambulatory surgery center;

6. any reprimands, exclusions, suspensions, disqualifications or charges against applicant by Medicare, Medicaid, CHAMPUS, PRO's or other third party payers;

7. if applicant's Federal DEA or state controlled substance license has ever been restricted, suspended, limited, revoked, voluntarily relinquished or withdrawn;

8. request information concerning the applicant's entire medical incident, claim, or suit history, including consent to the release of information from his present and past malpractice insurance carrier; and evidence of professional liability coverage which the hospital board of directors considers adequate. Currently the Board of Directors considers a million dollars the minimum requirement.

b. The applicant shall have the burden of producing adequate information for a proper evaluation of his competence, character, ethics, and other qualification, and for resolving any doubts about such qualifications.

c. The completed application shall be submitted to the Chief Executive Officer who in turn collects the references and other materials deemed pertinent. The application, together with all supporting materials shall then be transmitted for evaluation, to the Credentials Committee.

d. By applying for appointment to the Medical Staff, each applicant thereby signifies his willingness to appear for interviews in regard to his application. He also authorizes the hospital to query the National Practitioner Data Bank, to consult with members of Medical Staffs of other hospitals with which the applicant has been associated and with others who may have information bearing on his competence, character, and ethical qualifications. The applicant consents to the hospital's inspection of all records and documents that may be material to an evaluation of his professional qualifications and competence to carry out the clinical privileges he requests, as well as of his moral and ethical qualifications for staff membership. He releases from any liability all representatives of the hospital and its Medical Staff for their acts performed in good faith and without malice in connection with evaluating the applicant and his credentials, and he releases from any liability all individuals and organizations who provide information to the hospital in good faith and without malice concerning the applicant's competence, ethics, character and other qualifications for staff appointment and clinical privileges, including otherwise privileged or confidential information.

The terms "hospital" and "all representatives of the hospital and its Medical Staff" as used in this section are intended to include the Governing Body and the Chief Executive Officer and their authorized representatives, and all members of the Medical Staff who have committee or other responsibility for collecting and/or evaluating the applicant's credentials and/or acting upon his application. The term "character" is intended to include mental and emotional stability.

The application form should contain a statement that fully informs the applicant of the scope and extent of the authorization, release, and consent provisions, and of the immunity provisions contained in Article XIV, entitled, "Immunity From Liability", of these Bylaws.

e. The application form shall include a statement that the applicant has received and has read the Bylaws of the hospital and the Bylaws, Rules and Regulations of the Medical Staff and that the applicant agrees to be bound by the terms thereof, if applicant is granted membership and/or clinical privileges, and is to be bound by the terms thereof without regard as to whether or not he is granted membership and/or clinical privileges in all matters relating to consideration of his application.

Section 2. Appointment Process

a. Within thirty days after receipt of the completed application for membership, the Credentials Committee shall submit a written report of its investigation to the Executive Committee. Prior to making this report, the Credentials Committee shall examine the evidence of the character, professional competence, qualifications and ethical standing of the applicant and shall determine, through information contained in references given by the applicant and from other sources available to the committee, including an appraisal from the Credentials Committee indicating whether or not the applicant has established and has met all of the necessary qualifications for the category of staff membership and the clinical privileges requested by applicant.

b. At its next regular meeting after receipt of the application and the report and recommendation of the Credentials Committee, the Executive Committee shall determine whether to recommend to the Governing Body that the applicant be provisionally appointed to the Medical Staff, that applicant be rejected for Medical Staff membership, or that applicant's application be deferred for further consideration. All recommendations to appoint must also specifically recommend the clinical privileges to be granted, which may be qualified by probationary conditions relating to such clinical privileges.

c. When the recommendation of the Executive Committee is to defer the application for further consideration, it must be followed up within thirty days with a subsequent recommendation for provisional appointment with specified clinical privileges, or for rejection for staff membership.

d. When the recommendation of the Executive Committee is favorable to the applicant, the Chief Executive Officer shall promptly forward it, together with all supporting documentation, to the Governing Body.

e. When the recommendation of the Executive Committee is adverse to the applicant either in respect to appointment or clinical privileges, the Chief Executive Officer shall promptly so notify the applicant by certified mail, return receipt requested. No such adverse recommendation need be forwarded to the Governing Body until after the applicant has exercised or has been deemed to waive his right to a hearing as provided in these Bylaws.

f. If after the Executive Committee has considered the report and recommendation of the hearing committee and the hearing records, and the Executive Committee's reconsidered recommendation is favorable to the applicant, it shall be processed in accordance with subparagraph d. of this Section 2. If such recommendation continues to

be adverse, the Chief Executive Officer shall promptly so notify the applicant, by certified mail, return receipt requested. The Chief Executive Officer shall also forward such recommendation and documentation to the Governing Body, but the Governing Body shall not take any action thereon until after the applicant has exercised or has been deemed to have waived his right to an appellate review as provided in these Bylaws.

g. At its next regular meeting after receipt of a favorable recommendation, the Governing Body or its Executive Committee shall act in the matter. If the Governing Body's decision is adverse to the applicant in respect to either appointment or clinical privileges, the Chief Executive Officer shall promptly notify him of such adverse decision by certified mail, return receipt requested, and such adverse decision shall be held in abeyance until the applicant has exercised or has been deemed to have waived his rights under these Bylaws and until there has been compliance with subparagraph i. of this Section 2. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.

h. At its next regular meeting after all of the applicant's rights under these Bylaws have been exhausted or waived, the Governing Body or its duly authorized committee shall act in the matter. The Governing Body's decision shall be conclusive, except that the Governing Body may defer final determination by referring the matter back for further reconsideration. Any such referral back shall state the reasons therefore, shall set a time limit within which a subsequent recommendation to the Governing Body shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. At its next regular meeting after receipt of such subsequent recommendation, and new evidence in the matter, if any, the Governing Body shall make a decision either to provisionally appoint the applicant to the staff or to reject him for staff membership. All decisions to appoint shall include a delineation of the clinical privileges which the applicant may exercise.

i. Whenever the Governing Body's decision will be contrary to the recommendation of the Medical Staff Executive Committee, the Governing Body shall return the matter to the Executive Committee for review and recommendation and shall consider such recommendation before making its decision final.

j. When the Governing Body's decision is final, it shall send notice of such decision through the Chief Executive Officer to the Secretary of the Medical Staff, to the Chairman of the Executive Committee, and by certified mail, return receipt requested, to the applicant.

Section 3. Reappointment Process

a. The Re-credentialing and Business Data Gathering Form and Supplemental Form will be submitted by the Practitioner to the Chief Executive Officer. At least thirty days prior to the final scheduled Governing Body meeting in the Medical Staff year, the Credentials Committee shall review all pertinent information available on each Practitioner scheduled for periodic appraisal, for the purpose of determining its recommendations for reappointments to the Medical Staff and for the granting of clinical privileges for the

ensuing period, and shall transmit its recommendations, in writing, to the Executive Committee. Where non-reappointment or a change in clinical privileges is recommended, the reason for such recommendation shall be stated and documented.

b. Each recommendation concerning the reappointment of a Medical Staff member and the clinical privileges to be granted upon reappointment shall be based upon if his license to practice any profession in any jurisdiction has been limited, suspended, terminated or voluntarily relinquished, if his narcotic registration has been involuntarily suspended, revoked or voluntarily relinquished; his professional competence and clinical judgment in the treatment of patients, his ethics and conduct, his attendance at Medical Staff meetings and participation in staff affairs, his compliance with the hospital Bylaws and the Medical Staff Bylaws, Rules and Regulations, his cooperation with hospital personnel, with other Practitioners, his general attitude toward patients, the hospital and the public and his history of all medical incidents, claims and suits and the voluntary or involuntary termination of Medical Staff membership or the voluntary termination or involuntary limitation, reduction, loss of clinical privileges at another hospital with the final determination on whether action is necessary being made by the Board.

c. At least thirty days prior to the final scheduled Governing Body meeting in the Medical Staff year, the Executive Committee shall make written recommendations to the Governing Body, through the Chief Executive Officer, concerning the reappointment, non-reappointment and/or clinical privileges of each Practitioner then scheduled for periodic appraisal. Where non-reappointment or a change in clinical privileges is recommended, the reasons for such recommendations shall be stated and documented.

d. Thereafter, the procedure provided in Section 2 of this Article V relating to recommendations or applications for initial appointment shall be followed.

EMERGENCY, DISASTER, AND TEMPORARY PRIVILEGES - ARTICLE VI

Section 1. Emergency Privileges: In case of emergency the Practitioner attending the patient shall be expected to do all in his power to save the life of the patient, including the calling of such consultation as may be available. For the purpose of this section, an emergency is defined as a condition in which the life of the patient is in immediate danger and in which any delay in administering treatment would increase the danger. In the event that the Emergency Management Plan is activated, and the hospital is unable to handle patients' immediate needs, the following procedure will be followed to grant disaster privileges:

a. The Chief Executive Officer and/or the Administrator of Hardin County General Hospital, after conference with the Chief of Staff, shall have the authority to grant disaster privileges to a Practitioner who is not a member of our Medical Staff.

b. The Chief of Staff shall give an authoritative opinion as to the competency and ethical standing of the Physician who is granted disaster privileges. Decisions to grant such privileges will be made on a case-by-case basis at his/her discretion.

c. Individuals who are granted disaster privileges shall be under the direct supervision of the Chief of Staff.

d These individuals will be identified by a temporary name badge supplied by the hospital.

e. The verification process of the credentials and privileges of individuals who were granted disaster privileges will be started by the Medical Staff Coordinator as soon as possible.

Section 2. Disaster Privileges: Disaster privileges may be granted by the Chief of Staff upon receiving any of the following:

a. a current picture hospital ID card;

b. a current license to practice and a valid picture ID issued by a state, federal or regulatory agency;

c. Identification that the individual is a member of a Disaster Medical Assistance Team (DMAT) or an Illinois Medical Emergency Response Team (IMERT);

d. identification that the individual has been granted authority (by a federal, state, or municipal entity) to render patient care, treatment an services in disaster circumstances; or

e. personal knowledge of Practitioner's identity by current hospital or Medical Staff members;

Section 3. Temporary Privileges: The Chief Executive Officer and/or Administrator of Hardin County General Hospital, after conference with the Chief of Staff, shall have the authority to grant temporary privileges to a Physician who is not a member of the Medical Staff. The Chief of Staff shall give an authoritative opinion as to the competence and ethical standing of the Physician who desires such temporary privileges, and in the exercise of such privileges, he shall be under direct supervision of the Chief of Staff. Temporary privileges may not be granted to a Physician for more than ninety 90 days, after which, the Physician to whom temporary privileges have been granted shall be required to become a member of the Medical Staff. Prior to the granting of temporary privileges, the Physician must submit to the Chief Executive Officer a completed State of Illinois Health Care Professional Credentialing and Business Data Gathering Form and Supplemental Form.

CLINICAL PRIVILEGES - ARTICLE VII

Section 1. Clinical Privileges Restricted

a. Every Practitioner practicing at Hardin County General Hospital by virtue of Medical Staff membership shall, in connection with such practice, be entitled to exercise

only those clinical privileges specifically granted to him by the Governing Body, except as provided in Section 2 of this Article VII.

b. Every initial application for staff appointment must contain a request for the specific clinical privileges desired by the applicant. Determination of an applicant‘s qualifications to apply for clinical privileges is based on certain criteria. This criteria is specified in each specialty‘s delineation of privileges. The evaluation of such requests shall be based upon the applicant's education, training, experience, demonstrated competence, references, and other relevant information, including an appraisal by Executive Committee. The applicant shall have the burden of establishing his qualifications and competency in the clinical privileges he requests.

c. Periodic re-determination of clinical privileges and the increase or curtailment of same shall be based upon the direct observation of care provided, review of the records of patients treated in this or other hospitals and review of the records of the Medical Staff which document the evaluation of the member's participation in the delivery of medical care.

Applications for additional clinical privileges must be in writing. To assure uniformity, they shall be submitted on a prescribed form, on which the type of clinical privileges desired and the applicant's relevant recent training and/or experience must be stated. Such applications shall be processed in the same manner as applications for initial appointment.

d. Privileges granted to Dentists shall be based on their training, experience, and demonstrated competence and judgment. All dental patients shall receive the same basic medical appraisal as patients admitted to other surgical services. A Physician member of the Medical Staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization.

Section 2. Temporary Privileges

a. Upon receipt of an application for Medical Staff membership from an appropriately licensed Practitioner, the Chief Executive Officer may, upon the basis of information then available which may be reasonably relied upon as to the competence and ethical standing of the applicant, and with the written concurrence of the Executive Committee, grant temporary admitting and clinical privileges to the applicant; but in exercising such privileges, the applicant shall act under the supervision of the Chief of Staff.

b. Temporary clinical privileges may be granted by the Chief Executive Officer or in his absence by his designated representative for the care of a specific patient to a Practitioner who is not an applicant for membership in the same manner and upon the same conditions as set forth in subparagraph a. of this Section 2, provided that there shall first be obtained such Practitioner's signed acknowledgment that he has received and read copies of the Medical Staff's Bylaws, Rules and Regulations and that he agrees to be bound by the terms thereof in all matters relating to his temporary clinical privileges. Such temporary privileges shall be restricted to the treatment of a specific patient. After the patient has been discharged, the temporary clinical privileges cease.

c. The Chief Executive Officer may permit a Physician serving as a locum tenens for a member of the Medical Staff to attend patients without applying for membership on the Medical Staff for a period not to exceed ninety (90) days, providing all of his credentials have first been approved by the chairman of the Executive Committee.

d. Special requirements of supervision and reporting may be imposed by Chief Executive Officer on any Practitioner granted temporary privileges. Temporary privileges shall be immediately terminated by the Chief Executive Officer upon notice of any failure by the Practitioner to comply with such special conditions.

e. The Chief Executive Officer may at any time, upon the recommendation of the chairman of the Executive Committee terminate a Practitioner's temporary privileges effective as of the discharge from the hospital of the Practitioner's patient(s) then under his care in the hospital. However, where it is determined that the life or health of such patient(s) would be endangered by continued treatment by the Practitioner, the termination may be imposed by any person entitled to impose a summary suspension pursuant to these Bylaws, and the same shall be immediately effective. The Chairman of the Executive Committee shall assign a member of the Medical Staff to assume responsibility for the care of such terminated Practitioner's patient(s) until they are discharged from the hospital. The wishes of the patient(s) shall be considered where feasible in selection of such substitute Practitioner.

CATEGORIES OF THE MEDICAL STAFF - ARTICLE VIII

Section 1. The Medical Staff

The Medical Staff shall be divided into honorary, active, consulting, and courtesy groups. The Medical Staff shall be non-departmentalized. Individuals are granted the privilege to admit patients to inpatient services in accordance with state law and criteria for standards of medical care established by the Medical Staff.

Section 2. The Honorary Medical Staff

The honorary Medical Staff shall consist of Physicians who are not active in the hospital and who are honored by emeritus positions. These may be (a) Physicians who have retired from active hospital service; or (b) Physicians of outstanding reputation not necessarily resident in the community.

The honorary Medical Staff shall have no assigned duties, are not eligible to admit patients, to vote, hold office, or serve on standing committees.

Section 3. The Active Medical Staff

The active Medical Staff shall consist of:

a. Those Physicians who are required to live in the community and who have been selected to transact all business of the Medical Staff and to attend to charity patients

in the hospital and to whom all such patients shall be assigned.

b. Those Physician specialists, such as radiologist and pathologist, who provide specialized services to patients and the hospital on a continuous basis, but who are not required to live in the community.

The active Medical Staff member, with the exception of those Physicians identified in subparagraph b. above, must live close enough to the hospital to provide continuous quality care to their patients and assume all responsibilities of membership on the active Medical Staff including, where appropriate, emergency service care and consultation assignments.

Only the members of the active Medical Staff shall be eligible to vote, hold office, and serve on committees. They shall be encouraged to attend as many Medical Staff and committee meetings as possible.

Section 4. The Consulting Medical Staff

The consulting Medical Staff shall consist of recognized specialists who are active in the hospital or who have signified willingness to accept such appointment. These members do not have admitting privileges.

The duties of the members of the consulting Medical Staff shall be to give their services, without charge, in the care of charity patients on request of any member of the active Medical Staff and also in any case in which consultation is required by the rules of the hospital.

The consulting Medical Staff shall be appointed by the Governing Body upon recommendation of the Executive Committee of the Medical Staff.

Section 5. The Courtesy Medical Staff

The courtesy Medical Staff shall consist of those members of the medical profession, eligible as herein provided for staff memberships, who wishes to attend private patients in the hospital but who do not wish to become members of the active Medical Staff or who, by reason of residence, are not eligible for such appointment.

CORRECTIVE ACTION - ARTICLE IX

Section 1. Procedure

a. Whenever the activities or professional conduct of any Practitioner with clinical privileges are considered to be lower than the standards or aims of the Medical Staff or are reasonably probable of being detrimental to patient safety or quality of care or disruptive to the operations of the hospital, corrective action against such Practitioner may be requested by an officer of the Medical Staff, by the chairman of any Medical Staff committee, by the Chief Executive Officer, or by the Governing Body. All requests for corrective action shall

be in writing, shall be made to the Executive Committee, and shall be supported by reference to the specific activities or conduct which constitutes the grounds for the request. No corrective action shall be taken against a Physician in regards to their clinical privileges solely because of economic factors.

b. The Chief of Staff shall proceed with the corrective action procedure and will keep the Chief Executive Officer fully apprised of the progress of the investigation and actions taken thereupon. Prior to the making of such report, the Practitioner against whom corrective action has been requested shall have an opportunity for an interview with the Chief of Staff. At such interview, he shall be informed of the general nature of the charges against him, and shall be invited to discuss, explain, or refute them. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect of hearings shall apply thereto. A record of such interview shall be made by the Chief of Staff and included with its report to the Executive Committee.

c. Within ten (10) days following the receipt of a request for corrective action, or following receipt of a report from the Chief of Staff investigation of a request for corrective action, the Medical Staff Executive Committee shall take action upon the request. If such action could involve a reduction or suspension of clinical privileges, or a suspension or expulsion from the Medical Staff, the affected Practitioner shall be permitted to make an appearance before the Executive Committee prior to its taking action on such request. This appearance shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto. A record of such appearance shall be made by the Executive Committee.

d. The action of the Executive Committee on a request for corrective action may be to:

1. Reject or modify the request for corrective action;
2. Issue a warning, a letter of admonition, or a letter of reprimand;
3. Impose terms of probation or a requirement for consultation;
4. Recommend limitation, reduction, suspension, or revocation of clinical privileges;
5. Recommend that an already imposed summary suspension of clinical privileges be terminated, modified or sustained, or;
6. Recommend that the Practitioner's staff membership be suspended or revoked.

e. Any recommendation by the Executive Committee for reduction, suspension, or revocation of clinical privileges or for suspension or expulsion from the Medical Staff shall entitle the affected Practitioner to the procedural rights provided in these Bylaws.

f. The Chairman of the Executive Committee shall promptly notify the Chief Executive Officer in writing of all requests for corrective action received by the Executive Committee and shall continue to keep the Chief Executive Officer fully informed of all action taken in connection therewith. After the Executive Committee has made its recommendation in the matter, the procedure to be followed shall be as provided in these Bylaws.

Section 2. Summary Suspension

a. Any of the following- the chairman of the Executive Committee, the Chief Executive Officer and the Executive Committee of either the Medical Staff or the Governing Body shall each have the authority, whenever action must be taken immediately in the best interest of patient care in the hospital, to summarily suspend all or any portion of the clinical privileges of a Practitioner, and such summary suspension shall become effective immediately upon imposition.

b. A Practitioner whose clinical privileges have been summarily suspended shall be entitled to request that the Executive Committee of the Medical Staff hold a hearing on the matter within such reasonable time period thereafter as the Executive Committee may be convened in accordance with these Bylaws.

c. The Executive Committee may recommend modification, continuance, or termination of the terms of the summary suspension. If, as a result of such hearing, the Executive Committee does not recommend immediate termination of the summary suspension, the affected Practitioner shall, also in accordance with these Bylaws be entitled to request an appellate review by the Governing Body, but the terms of the summary suspension as sustained or as modified by the Executive Committee shall remain in effect pending a final decision thereon by the Governing Body.

d. Immediately upon the imposition of a summary suspension, the chairman of the Executive Committee shall have authority to provide for alternative medical coverage for the patients of the suspended Practitioner still in the hospital at the time of such suspension. The wishes of the patients shall be considered in the selection of such alternative Practitioner.

Section 3. Automatic Suspension

a. Action by the Illinois Department of Professional Regulation revoking or suspending a Practitioner's license shall automatically suspend all of his hospital privileges.

b. Drug Enforcement Agency (BNDD OR DEA) Number. A Medical Staff member whose DEA number is revoked or suspended shall immediately and automatically be divested of his right to prescribe medications covered by such a number. As soon as possible, the Medical Staff Executive Committee shall convene to review and consider the facts and circumstances under which the permit was revoked or suspended. The medical Executive Committee may then take further corrective action as appropriate to the facts disclosed in the investigation.

c. It shall be the duty of the Chief of Staff to cooperate with the Chief Executive Officer in enforcing all automatic suspensions.

d. Procedural Rights. A Practitioner on automatic suspension shall be entitled to the procedural rights provided in these Bylaws.

HEARING AND APPELLATE REVIEW PROCEDURE - ARTICLE X

Section 1. Right to Hearing and to Appellate Review

a. When any Practitioner receives notice of a recommendation of the Executive Committee that, if ratified by decision of the Governing Body, will adversely affect his appointment to or status as a member of the Medical Staff or his exercise of clinical privileges, he shall be entitled to a hearing before an ad hoc committee following such hearing is still adverse to the affected Practitioner, he shall then be entitled to an appellate review by the Governing Body before the Governing Body makes a final decision on the matter.

b. When any Practitioner receives notice of a decision by the Governing Body that will affect his appointment to a status as a member of the Medical Staff or his exercise of clinical privileges, and such decision is not based on a prior adverse recommendation by the Executive Committee of the Medical Staff with respect to which he was entitled to a hearing and appellate review, he shall be entitled to a hearing by a committee appointed by the Governing Body, and if such hearing does not result in a favorable recommendation, to an appellate review by the Governing Body, before the Governing Body makes a final decision on the matter.

c. All hearings and appellate reviews shall be in accordance with the procedural safeguards set forth in this Article X to assure that the affected is accorded all rights to which he is entitled.

Section 2. Request for Hearing

a. The Chief Executive Officer shall be responsible for giving prompt written notice of an adverse recommendation or decision to any affected Practitioner who is entitled to a hearing or to an appellate review, by certified mail, return receipt requested.

b. The failure of a Practitioner to request a hearing to which he is entitled by these Bylaws within the time and in the manner herein provided shall be deemed a waiver of his right to such hearing and to any appellate review to which he might otherwise have been entitled on the matter. The failure of a Practitioner to request an appellate review to which he is entitled by these Bylaws within the time and in the manner herein provided shall be deemed a waiver of his right to such appellate review on the matter.

c. When the waived hearing or appellate review relates to an adverse recommendation of the Executive Committee of the Medical Staff or of a hearing committee appointed by the Governing Body, the same shall thereupon become and remain effective against the Practitioner pending the Governing Body's decision on the matter. When the waived hearing or appellate review relates to an adverse decision by the Governing Body, the same shall thereupon become and remain effective against the Practitioner in the same manner as a final decision of the Governing Body provided for in Section 7 of this Article X. In either of such events the Chief Executive Officer shall

promptly notify the affected Practitioner of his status by certified mail, return receipt requested.

Section 3. Notice of Hearing

a. Within ten (10) days after receipt of a request for hearing from a Practitioner entitled to the same, the Executive Committee or the Governing Body, whichever is appropriate, shall schedule and arrange for such a hearing and shall, through the Chief Executive Officer, notify the Practitioner of the time, place and date so scheduled, by certified mail, return receipt requested. The hearing date shall not be less than fifteen (15) days, nor more than thirty (30) days from the date of receipt of the request for hearing; provided, however, that a hearing for a Practitioner who is under suspension which is then in effect shall be held as soon as arrangements therefore may reasonably be made, but not later than thirty (30) days from the date of receipt of such Practitioner's request for hearing.

b. The notice of hearing shall state in concise language the acts or omissions with which the Practitioner is charged, a list of specific or representative charts being questioned, a list of witnesses expected to testify for the professional review body, and/or the other reasons or subject matter that was considered in making the adverse recommendation or decision.

Section 4. Composition of Hearing Committee

a. When a hearing relates to an adverse recommendation of the Medical Staff Executive Committee, such hearing shall be conducted by an ad hoc hearing committee of not less than three members of the Medical Staff appointed by the Chief of Staff. One of the members so appointed shall be designated a chairman. Insofar as possible, no staff member who has actively participated in the consideration of the adverse recommendation shall be appointed a member of this hearing committee.

b. When a hearing relates to an adverse decision of the Governing Body that is contrary to the recommendation of the Executive Committee, the Governing Body shall appoint a hearing committee to conduct such hearing and shall designate one of the members of this committee as chairman. At least one representative from the Medical Staff shall be included on this committee.

Section 5. Conduct of Hearing

a. There shall be at least a majority of the members of the hearing committee present when the hearing takes place, and no member may vote by proxy. A majority of the appointed members shall constitute a quorum.

b. An accurate record of the hearing must be kept. The mechanism shall be established by the ad hoc hearing committee, and may be accomplished by use of a court reporter, electronic recording unit, and detailed transcription of by the taking of adequate minutes.

c. The personal presence of the Practitioner for whom the hearing has been scheduled shall be required. A Practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his rights in the same manner as provided in Section 2 of this Article X and to have accepted the adverse recommendation or decision involved, and the same shall thereupon become and remain in effect as provided in said Section 2.

d. Postponement of hearings beyond the time set forth in these Bylaws shall be made only for good cause shown and in the sole discretion of the hearing committee.

e. The affected Practitioner shall be entitled to be accompanied by and/or represented at the hearing by an attorney, a member of the Medical Staff in good standing or by a member of his local professional society. The hospital and hospital Medical Staff shall also be entitled to representation by an attorney at the hearing.

f. The chairman of the hearing committee or his designee, shall preside over the hearing to determine the order of procedure during the hearing, to assure that all participants in the hearing has a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum.

g. The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objection in civil or criminal action. The Practitioner for whom the hearing is being held shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of procedure or of fact and such memoranda shall become a part of the hearing record. In reaching a decision, official notice may be taken by the hearing committee, either before or after submission of the matter for decision, of generally accepted technical or scientific matter relating to the issues under consideration at the hearing and of any facts that may be judicially noticed by the courts of the state of Illinois.

Participants in the hearing shall be informed of the matters to be noticed and those matters shall be noted in the record of the hearing. The Practitioner for whom the hearing is being held shall be given the opportunity, on request, to refute the officially noticed matters by evidence or by written or oral presentation of authority, the manner of such refutation to be determined by the hearing committee. The committee shall also be entitled to consider any pertinent material contained on file in the hospital, and all other information that can be considered in connection with applications for appointment to the Medical Staff and for clinical privileges pursuant to these Bylaws.

h. The Executive Committee, when its action has prompted the hearing, shall appoint one of its members or some other Medical Staff member to represent it at the hearing, to present the facts in support of its adverse recommendation, and to examine witnesses. The Governing Body when its action has prompted the hearing, to present the facts in support of its adverse decision and to examine witnesses. It shall be the obligation

of such representative to present appropriate evidence in support of the adverse recommendation decision, but the affected Practitioner shall thereafter be responsible for supporting his challenge to the adverse recommendation or decision by an appropriate showing that the charges or grounds involved lack any factual basis or that such basis or any action based thereon is either arbitrary, unreasonable or capricious.

i. The affected Practitioner shall have the following rights: to call and examine witnesses, to introduce written evidence, to cross-examine any witness or any matter relevant to the issue of the hearing, to challenge any witness and to rebut any evidence.

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

j. The hearings provided for in these Bylaws are for the purpose of resolving, on an intra-professional basis, matters bearing on professional competence and conduct.

k. The hearing committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The hearing committee may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the Practitioner for whom the hearing was convened.

l. Within ten (10) days after final adjournment of the hearing, the hearing committee shall make a written report and recommendation and shall forward the same together with the hearing record and all other documentation to the Executive Committee or to the Governing Body, whichever appointed it. The report may recommend confirmation, modification, or rejection of the original adverse recommendation of the Executive Committee or decision of the Governing Body. Thereafter, the procedure to be followed shall be as provided in Section 2 of Article V of these Bylaws.

Section 6. Appeal to the Governing Body

a. Within ten (10) days after receipt of a notice by an affected Practitioner of an adverse recommendation or decision made or adhered to after a hearing as above provided, he may, by written notice to the Governing Body delivered through the Chief Executive Officer by certified mail, return receipt requested, request an appellate review be held only on the record on which the adverse recommendation or decision is based, as supported by the Practitioner's written statement provided for below, or may also request that oral argument be permitted as part of the appellate review.

b. If such appellate review is not requested within ten (10) days, the affected Practitioner shall be deemed to have waived his right to the same, and to have accepted such adverse recommendation or decision, and the same shall become effective immediately as provided in Section 2 of this Article X.

c. Within thirty days after receipt of such notice of request for appellate review, the Governing Body shall schedule a date for such review, including a time and place for oral argument if such has been requested, and shall, through the Chief Executive Officer, by written notice sent by certified mail, return receipt requested, notify that affected Practitioner of the same. The date of the appellate review shall not be less than seven (7) days, nor more than forty-five (45) days from the date of receipt of the request for such review, except than when the Practitioner requesting the review is under a suspension which is then in effect, such review shall be scheduled as soon as the arrangements for it may be reasonable made, but not more than forty-five (45) days from the date of receipt of such notice.

d. The appellate review shall be conducted by the Governing Body or by a duly appointed appellate review committee of the Governing Body of not less than five members.

e. The affected Practitioner shall have access to the report and record (and transcription, if any) of the ad hoc hearing committee and all other material, favorable or unfavorable, that was considered in making the adverse recommendation or decision against him. He shall have fifteen (15) days to submit a written statement in his own behalf, in which those factual and procedural matters with which he disagrees, and his reasons for such disagreement, shall be specified. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the Governing Body through the Chief Executive Officer by certified mail, return receipt requested, at least seven days prior to the scheduled date for the appellate review. A similar statement may be submitted by the Executive Committee of the Medical Staff or by the chairman of the hearing committee appointed by the Governing Body, and if submitted, the Chief Executive Officer shall provide a copy thereof to the Practitioner at least seven days prior to the date of such appellate review by certified mail, return receipt requested.

f. The Governing Body or its appointed review committee shall act as an appellate body. It shall review the record created in the proceedings, and shall consider the written statements submitted pursuant to subparagraph e. of the Section 6, for the purpose of determining whether the adverse recommendation or decision against the affected Practitioner was justified and was not arbitrary or capricious. If oral argument is requested a part of the review procedure, the affected Practitioner shall be present at such appellate review, shall be permitted to speak against the adverse recommendation or decision, and shall answer questions put to him by any member of the appellate review body.

g. New or additional matters not raised during the original hearing or in the hearing committee report, nor otherwise reflected in the record, shall only be introduced at the appellate review under unusual circumstances, and the Governing Body or the committee thereof appointed to conduct the appellate review shall in its sole discretion determine whether such new matters shall be accepted.

h. If the appellate review is conducted by the Governing Body, it may affirm, modify or reverse its prior decision, or, in its discretion, refer the matter back to the

Executive Committee of the Medical Staff for further review and recommendation with thirty days. Such referral may include a request that the Executive Committee of the Medical Staff arrange for a further hearing to resolve specified disputed issues.

i. If the appellate review is conducted by a committee of the Governing Body, such committee shall, within seven days after the scheduled or adjourned date of the appellate review, either make a written report recommending that the Governing Body affirm, modify or reverse its prior decision, or refer the matter back to the Executive Committee for further review and recommendation within thirty days. Such referral may include a request that the Executive Committee of the Medical Staff arrange for a further hearing to resolve disputed issues. Within thirty days after receipt of such recommendation after referral, the committee shall make its recommendation to the Governing Body as above provided.

j. The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Section 6 have been completed or waived. Where permitted by the hospital laws, all action required of the Governing Body may be taken by a committee of the Governing Body duly authorized to act.

Section 7. Final Decision by Governing Body

a. Within thirty days after the conclusion of the appellate review, the Governing Body shall make its final decision in the matter and shall send notice thereof to the Executive Committee and, through the Chief Executive Officer, to the affected Practitioner, by certified mail, return receipt requested. If this decision is in accordance with the Executive Committee's last recommendation in the matter, it shall be immediately effective and final, and shall not be subject to further hearing or appellate review. If this decision is contrary to the Executive Committee's last such recommendation, the Governing Body shall refer the matter back to the Executive Committee for further review and recommendation within thirty days, and shall include in such notice of its decision a statement that a final decision will not be made until the Executive Committee's recommendation has been received. At its next meeting after receipt of the Executive Committee's recommendation, the Governing Body shall make its final decision with like effect and notice as first above provided in this Section 7.

b. Notwithstanding any other provision of these Bylaws, no Practitioner shall be entitled as a right to more than one hearing and one appellate review or any matter which shall have been the subject of action by the Executive Committee of the Medical Staff, or by the Governing Body, or by a duly authorized committee of the Governing Body, or by both.

MEDICAL STAFF OFFICERS - ARTICLE XI

Section 1. Officers of the Medical Staff

The officers of the Medical Staff shall be:

1. Chief of Staff
2. Vice Chief of Staff
3. Secretary

Section 2. Qualification of Officers

Officers must be members of the active Medical Staff at the time of nomination and election and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

Section 3. Election of Officers

Officers shall be elected at the last scheduled Medical Staff meeting of the Medical Staff year. This is considered the annual meeting and is held in March of each year. Only members of the active Medical Staff shall be eligible to vote. A majority of the votes cast shall be necessary to elect. Nominations shall be made from the floor for each office. The staff shall vote on the persons nominated. The person receiving the largest number of votes, so long as it is a majority, shall be the officer elected.

Section 4. Term of Office

All officers shall serve a one-year term to be effective the first day of the Medical Staff year that is April 1 through March 31. Officers shall take office on the first day of April.

Section 5. Vacancies in Office

Vacancies in office during the Medical Staff year, except for the Chief of Staff, shall be filled by the Medical Staff Executive Committee. If there is a vacancy in the office of the Chief of Staff, the Vice Chief of Staff shall serve out the remaining term.

Section 6. Duties of Officers

a. Medical Staff officers serve the interest of the Governing Body in assuring optimal care for all patients with the hospital.

b. Duties of **Chief of Staff**

The Chief of Staff shall serve as the Chief Administrative Officer of the Medical Staff to:

1. Act in coordination and cooperation with the Chief Executive Officer in all matters of mutual concern within the hospital;

2. Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;

3. Serve on the Medical Staff Executive Committee;

4. Serve as ex officio member of all other Medical Staff committees without vote;

5. be responsible for the enforcement of Medical Staff Bylaws, rules and regulations, for implementation of sanctions where these are indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a Practitioner.

6. Appoint committee members to all standing, special, and multi-disciplinary Medical Staff committees except the Executive Committee;

7. Attend Governing Body meetings and represent the view, policies, needs and grievances of the Medical Staff to the Governing Body and to the Chief Executive Officer;

8. Receive, and interpret the policies of the Governing Body to the Medical Staff and report to the Governing Body on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care;

9. be responsible for the educational activities of the Medical Staff; and

10. Be the spokesman for the Medical Staff in its external professional and public relations.

c. **Duties of Vice Chief of Staff**

The vice Chief of Staff in the absence of the Chief of Staff, shall:

1. Assume all the duties and have the authority of the Chief of Staff in the absence of the Chief of Staff;

2. be a member of the Executive Committee of the Medical Staff;

3. Automatically succeed the Chief of Staff when the latter fails to serve for any reason.

d. Duties of Secretary

The secretary shall:

1. be a member of the Executive Committee of the medical staff;

2. Keep accurate and complete minutes of all Medical Staff meetings;

3. Attend to all correspondence; and

4. Perform such other duties as ordinarily pertain to his office.

Section 7. Corrective Action for Unsatisfactory Performance of Officers

a. Whenever any action of any Medical Staff officer that might negatively affect this staff membership such as repeated lack of attendance of Medical Staff meetings, failure to comply with any agreements with the hospital, failure to fulfill the obligation of the office as set forth in these Bylaws, or any other activity considered to be lower than the standard aims of the Medical Staff, corrective action against such officer may be requested by an officer of the Medical Staff, chairman of any Medical Staff committee, by the Chief Executive Officer, or by the Governing Body. All requests for corrective action shall be in writing, shall be made to the Executive Committee, and shall be supported by reference to specific activities or conduct that constitutes the grounds for the request.

b. The Chief of Staff shall proceed with the corrective action procedure and will keep the Chief Executive Officer fully apprised of the progress of the investigation and actions taken thereupon. Prior to the making of such report, the Practitioner against whom corrective action has been requested shall have an opportunity for an interview with the Chief of Staff. At such interview, he shall be informed of the general nature of the charges against him, and shall be invited to discuss, explain, or refute them. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto. A record of such interview shall be made by the Chief of Staff and included with its report to the Executive Committee.

c. Within ten (10) days following the receipt of a request for corrective action, or following receipt of a report from the Chief of Staff investigation of a request for corrective action, the Medical Staff Executive Committee shall take action upon the request. If such action could involve the removal of the officer from office, the affected officer shall be permitted to make an appearance before the Executive Committee prior to its taking action on such request. This appearance shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto. A record of such appearance shall be made by the Executive Committee.

d. The action of the Executive Committee on a request for corrective action may be to:

1. reject or modify the request for corrective action
2. issue a warning, a letter of reprimand
3. impose terms of probation or a requirement for consultation
4. recommend removal from office.

e. Any recommendation by the Executive Committee for reduction of authority or removal from office shall entitle the affected Practitioner to the procedural rights provided in Article X of these Bylaws.

COMMITTEES - ARTICLE XII

Section 1. Medical Executive Committee

a. Composition: the medical Executive Committee shall consist of the officers of the Medical Staff and the CEO.

b. Duties: The duties of the medical Executive Committee shall be:

1. To represent and to act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws;

2. to coordinate the activities and general policies of the Medical Staff;

3. to receive and act upon committee reports;

4. To implement policies of the Medical Staff not otherwise the responsibility of other departments;

5. to provide liaison between Medical Staff and the Chief Executive Officer and the Governing Body;

6. to recommend action to the Chief Executive Officer on matters of a medico-administrative nature;

7. To make recommendations on hospital management matters to the Governing Body through the Chief Executive Officer;

8. to review periodically all information available regarding the performance and clinical competence of staff members and other Practitioners with clinical privileges and as a result of such reviews to make recommendations for reappointments and renewal or changes in clinical privileges;

9. to take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all members of the Medical Staff including the initiation of and/or participation in Medical Staff corrective or review measures when warranted;

10. to report at each general Medical Staff meeting and bring appropriate issues to the Medical Staff for resolution;

11. to review the credentials of all applicants and to make recommendations for staff membership, assignments and delineation of clinical privileges;

c. Meetings: the Executive Committee shall meet at least once a month and maintain a permanent record of its proceeding and actions.

Section 2. Credentials Committee

a. Composition: The credentials committee shall consist of all officers of the active Medical Staff.

b. Duties: The duties of the Credentials Committee shall be:

1. to review the credentials of all applicants and to make recommendations for membership and delineation of clinical privileges in compliance with these Bylaws;

2. to make a report to the Executive Committee on each applicant for Medical Staff membership or clinical privileges;

3. to review periodically all information available regarding the competence of staff members and as a result of such reviews to make recommendations for the granting of privileges, reappointments in compliance with these Bylaws;

4. To investigate any breach of ethics that is reported to it;

5. To review reports that are referred by other committees and by the Chief of Staff.

c. Meetings: The credentials committee shall meet as often as necessary to review initial application, reappointments, reports, etc., but at least annually and shall maintain a permanent record of its proceedings and actions.

Section 3. Utilization Review Committee

a. Composition: The utilization review committee shall consist of:

1. Active Medical Staff Physicians;
2. Chief Executive Officer or his designee
3. Director of Nursing
4. Social Services/Discharge Planning Coordinator
5. Health Information Representative
6. PRO/UR/RM Coordinator
7. Others as designated and published in the committee assignment list.

b. Duties:

1. Utilization Review Studies. The Utilization Review Committee shall conduct studies designed to evaluate the appropriateness of admissions to the hospital, lengths of stay, discharge practices, use of medical and hospital services and all related factors that may contribute to the effective utilization of hospital and Physician services including Tissue and Blood Utilization.

2. Establish systems of utilization review that are consistent with policies, rules, and regulations established by the cognizant PRO.

3. It shall work toward the assurance of proper continuity of care upon discharge through, among other things, the accumulation of appropriate data on the availability of other suitable health care facilities and services outside the hospital.

4. The committee shall communicate the results of its studies and other pertinent data to the entire Medical Staff and shall make recommendations for the optimum utilization of hospital resources and facilities commensurate with quality of patient care and safety.

5. Written Utilization Review Plan. It shall also formulate a written Utilization Review Plan for the hospital. Such plan, as approved by the Medical Staff and Governing Body, must be in effect at all times.

c. Meetings:

The Utilization Review Committee shall meet monthly and maintain a permanent record of its findings, proceedings, and actions.

Section 4. Infection Control Committee

a. Composition: The Infection Control Committee shall consist of:

1. Pathologist who shall be the Chairman
2. Physician from the active Medical Staff
3. Chief Laboratory Technologist or designee
4. Infection Control Nurse
5. Chief Executive Officer or his designee
6. Others as designated and published in the committee assignment list.

b. Duties: The Infection Control Committee shall be responsible for the surveillance of inadvertent hospital infection potentials, the review and analysis of actual infections, the promotion of a preventative and corrective program designed to minimize

infection hazards, and the supervision of infection control in all phases of the hospital's activities including:

1. Sterilization procedures by heat, chemicals or otherwise:
2. Isolation procedures;
3. Prevention of cross-infection by inhalation therapy equipment;
4. Testing of hospital personnel for carrier status;
5. Disposal of infectious material; and
6. Other situations as requested by the Medical Staff or Chief Executive Officer.

c. Meetings: The Infection Control Committee shall meet quarterly and maintain a permanent record of its proceedings.

Section 5. Health Information Committee

a. Composition: The Health Information Committee shall consist of:

1. Chairman (Physician)
2. Physician
3. s Supervisor
4. Director of Nursing
5. Quality Improvement Coordinator
6. Others as designated and published in the committee assignment list.

b. Duties: The Health Information Committee shall be responsible for:

1. Assuring that all medical records meet the highest standards of patient care;

2. Conduct a quarterly review of medical records to ensure that they properly describe the condition and progress of the patient;

3. Review all proposed chart forms to ensure that they serve a unique and important purpose;

4. Conduct a review of records completion activities to ensure all Practitioners are completing records accords according to policy;

5. Audit discharged patient charts to determine their promptness, pertinence, adequacy, and completeness.

c. Meetings: The Health Information Committee shall meet at least quarterly and shall maintain a permanent record of their proceedings and actions.

Section 6. Pharmacy and Therapeutics Committee

a. Composition: The Pharmacy and Therapeutics Committee shall consist of:

1. Chairman (Registered Pharmacist)
2. Two Physicians
3. Director of Nursing
4. Chief Executive Officer or his designee
5. Others as designated and published in the committee assignment list.

b. Duties: The Pharmacy and Therapeutics Committee shall be responsible for the following:

1. development and surveillance of all drug utilization policies and practices within the hospital in order to assure optimum clinical results and a minimum potential for hazard;

2. assisting in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and all other matters relating to drugs in the hospital;

3. assisting in the drug usage evaluation using criteria-based, ongoing, planned and systematic process for monitoring and evaluating the prophylactic, therapeutic, and empiric use of drugs to help assure that they are provided appropriately, safely, and effectively;

4. Periodically review and update a formulary or drug list for the hospital;

5. Evaluate clinical data relative to drug use, new drugs, or preparations requested for use in the hospital;

6. Review reports of drug reactions and make recommendation;

7. Establish standards for the use of investigational drugs;

8. Review and recommend changes in antibiotic use based upon findings of the Infection Control - Tissue, Blood Utilization Committee;

9. Serve as an advisory group to the hospital Medical Staff;

10. Make recommendations concerning drugs to be stocked on the nursing floor and in the emergency room;

11. Prevent unnecessary duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients;

12. Ensure that procedures and practices pertaining to drug use in the hospital conform to state laws.

c. Meetings: The Pharmacy and Therapeutics Committee shall meet at least quarterly and maintain a permanent record of its proceedings and actions.

MEETINGS - ARTICLE XIII

Section 1. General Medical Staff Meetings

The primary objective of the general Medical Staff meeting is improvement in the care and treatment of patients in the hospital. Meetings shall take place monthly. The March meeting shall be the last meeting of the Medical Staff year. A permanent record of its proceedings and actions shall be maintained.

Section 2. Quorum

Fifty percent of the total membership of the active Medical Staff shall constitute a quorum.

Section 3. Special Meetings

The Chief of Staff shall be empowered to call a special meeting of the Medical Staff at any time. No business shall be transacted at a special meeting other than the purpose stated in calling the meeting. The notice may be given orally or in writing.

Section 4. Agenda

a. Regular meetings

1. Call or order
2. Reading of the previous minutes
3. Acceptance of the minutes from previous meeting
4. Unfinished business
5. Communications
6. Reports of standing and of special business committees
7. New business
8. Adjournment

b. Special meetings

1. Reading of the notice calling the meeting
2. Transaction of the business for which the meeting was called
3. Adjournment

IMMUNITY FROM LIABILITY - ARTICLE XIV

The following shall be express conditions to any Practitioner's application for or exercise of, clinical privileges at Hardin County General Hospital:

Section 1. Privileged Communication

Any act, communication, report, recommendation, or disclosure, with respect to any such Practitioner, performed or made in good faith and without malice and at the request of an authorized representative of this or any other healthcare facility, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extent permitted by law.

Section 2. Extension of Privilege

Such privilege shall extend to members of the hospital's Medical Staff and of its Governing Body, its other Practitioners, its Chief Executive Officer and his representatives, and to third parties, who supply information to any of the foregoing authorized to receive, release, or act upon the same. For the purpose of this Article XIV, the term "third parties" means both individuals and organizations from which information has been requested by an authorized representative of the Governing Body or of the Medical Staff.

Section 3. Immunity from Liability

There shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed privileged.

Section 4. Scope of Liability

Such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care institution's activities related, but not limited to: (1) applications for appointment or clinical privileges, (2) corrective action, including summary suspension, (3) hearings and appellate reviews, (4) utilization reviews and (5) other hospital, departmental, service or committee activities related to quality patient care and inter-professional conduct.

Section 5. Subjects of Immunity

The acts, communications, reports, recommendations and disclosures referred to in this Article XIV may relate to a Practitioner's professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on patient care.

Section 6. Release of Liability

In furtherance of the foregoing, each Practitioner shall upon request of the hospital execute releases in accordance with the tenor and import of this Article XIV in favor of the individuals and organizations specified in Section 2, subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of the State of Illinois.

Section 7. Applicability

The consents, authorizations, releases, rights, privileges and immunities provided by Section 1 and 2 of Article V of these Bylaws for the protection of this hospital's Practitioners, other appropriate hospital officials and personnel and third parties, in connection with applications for initial appointment, shall also be fully applicable to the activities and procedures covered by this Article XIV.

RULES AND REGULATIONS - ARTICLE XV

Section 1. General Provisions

The Medical Staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Governing Body. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each Practitioner in the hospital. Such rules and regulations shall be a part of these Bylaws, except that they may be amended or repealed at any regular meeting at which a quorum is present and without previous notice or at any special meeting on notice, by a two-thirds vote of those present of the active Medical Staff. Such changes shall become effective when approved by the Governing Body.

Section 2. Professional Liability Insurance

Every Practitioner granted clinical privileges shall continuously maintain in force professional liability insurance in the minimum amount of one million dollars per occurrence. The designated amount shall be determined by resolutions of the Medical Staff Executive Committee and the Governing Body.

ALLIED HEALTH PROFESSIONALS – ARTICLE XVI

Section 1. Definition

Hardin County General Hospital defines an Allied Health Professional as a non-Physician individual who is qualified to provide care to hospital patients. These

individuals may be, but not limited to, a Physician Assistant, a Nurse Practitioner, a Physical Therapist, and a Certified Nurse Anesthetist. This professional is licensed and/or certified and qualified by training, education, and experience to provide services under the direct supervision of the Physician of Record. In the absence of the Physician of Record, an alternate supervising Physician may be appointed by the Chief of Staff and/or the Administrator.

An Allied Health Professional is not a member of the Medical Staff. He is however credentialed and re-credentialed through the same process and is entitled to the same hearing and appeal rights as a Medical Staff member. The allied health professional shall also be required to comply with and be governed by the Medical Staff Bylaws, Rules, Regulations, policies, and procedures of Hardin County General Hospital.

Section 2. Qualifications

Allied Health Professionals must be legally licensed/certified in the State of Illinois and meet the following criteria to be considered to provide care to hospital patients.

a. submit a completed and signed State of Illinois Health Care Credentialing and Business Data Gathering Form and Hardin County General Hospital Allied Health Professional Supplemental Form.

b. document his education, experience, and training and demonstrated ability to provide quality care to hospital patients.

c. are determined through the credentialing process to have good physical and mental health.

d. Has the ability to work well with others and adhere to generally recognized standards of professional ethics.

Where appropriate, the Medical Staff and the Administrator may establish particular qualifications/criteria required of specific categories of all allied health professionals requesting privileges at Hardin County General Hospital. These specific qualifications/criteria will be listed in a contract and/or delineation of privileges for the Allied Health Professional.

Section 3. Description of Services

The Medical Staff and the Administrator shall develop guidelines for services provided by Allied Health Professionals to hospital patients. These guidelines include the following for each category of Allied Health

Professional.

a. Definition of services and procedures to be performed.

b. Definition of the degree of assistance that may be provided to a Practitioner by the Allied Health Professional in the treatment of hospital patients; any limitations of the Allied Health Professional, including the degree of required supervision by the "Physician of Record' will be also be defined.

Section 4. Responsibilities

The responsibility of an Allied Health Professional shall be to:

a. Provide specific patient care services under supervision or direction of a Physician of the Hardin County General Hospital Medical Staff.

b. Perform services/procedures only to extent approved by the Hardin County General Hospital Medical Staff, Administrator, and Board of Directors and within the scope of the Allied Health Professional's license/certificate.

c. Serve on hospital committees; attend staff meetings and hospital education programs as assigned.

d. Maintain appropriate responsibility within his area of professional competence for the care and supervision of each patient in the hospital for whom he is providing services.

e. Participate as appropriate in the quality improvement activities, patient care audits, and evaluations as required.

Section 5. Suspension of Privileges

The privileges of an Allied Health Professional may be suspended in the same manner as stated in these Bylaws for Practitioners. The hearing and appeal process shall also be in the same manner as stated in these Bylaws for Practitioners.

ADOPTION - ARTICLE XVII

These Bylaws together with the appended rules and regulations, shall be adopted and may be amended at any regular meeting at which a quorum is present and without previous notice or at any special meeting on notice, by a two-thirds vote of those present of the active staff and shall replace any previous Bylaws, Rules and Regulations, and shall become effective when approved by the Governing Body of Hardin County General Hospital. These Bylaws, rules, and regulations will be reviewed at least every year to ascertain currency, necessary amendments, revisions, or revocations.

ADOPTED by the active Medical Staff on March 11, 2015

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Marcos N. Sunga, M.D.,
Chief of Staff

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Joshua D. Hastie, M. D.
Secretary of Medical Staff

APPROVED by the Governing Body on March 26, 2015

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Wendell Robinson,
President, Board of Directors

MEDICAL STAFF RULES AND REGULATIONS

Section 1. Meetings

The monthly meeting of the entire active Medical Staff shall be held in the Education Room at Hardin County General Hospital. The date and time is published in the monthly calendar of events.

The Medical Staff discussions at meetings shall constitute a thorough review and analysis of the clinical work done in the hospital, including consideration of deaths, unimproved cases, infections, complications, errors in diagnosis, and results of treatment from among significant cases in the hospital at the time of the meeting and significant cases discharged since the last meeting, and analysis of clinical reports and reports of committees of the active Medical Staff.

Section 2. Physician Orders

No medication, treatment or diagnostic test shall be administered to a patient except on the written order of a member of the Medical Staff with the exceptions of influenza and pneumococcal polysaccharide vaccines and mammograms. The vaccines may be administered by Medical Staff approval after an assessment for contraindications has been completed by the Registered Nurse.

Verbal orders of authorized Medical Staff members are accepted and transcribed by a staff Registered Nurse, Pharmacist, or Registered Dietitian. The order is to be dated, timed, and identified by the name of the individual who gave it and received it. These orders shall be signed before the member of the Medical Staff leaves the area.

Telephone orders shall be used sparingly and countersigned by the responsible Physician within 48 hours.

All countersignatures by the Medical Staff members will include the date.

There is an automatic stop order for drug orders when a patient undergoes surgery.

Section 3. Autopsy

1. Every member of the Medical Staff is expected to be actively interested in securing autopsies. Criteria that identify deaths in which an autopsy should be performed shall include all reportable deaths:

a. deaths in which an autopsy may help explain unknown and unanticipated medical complications;
b. deaths in which the cause is not known with certainty on clinical grounds;
c. cases in which an autopsy may help allay concerns of the family and/or the public regarding the death, and provide reassurance to them regarding the same;

d. deaths occurring in patients who have participated in clinical trials (protocols) approved by institutional review boards;
e. all obstetric deaths;
f. all neonatal and pediatric deaths;
g. deaths at any age in which it is felt that autopsy would disclose a known or suspected illness which may also have a bearing on survivors or recipients of transplant organs;
h. deaths known or suspected to have resulted from occupational or environmental hazards;
i. sudden, unexpected, or unexplained deaths in the hospital which are apparently natural and not subject to a forensic medical jurisdiction;
j. unexpected or unexplained death occurring during or following any dental, medical, or surgical diagnostic or therapeutic procedure;
k. natural deaths that are ordinarily subject to a forensic jurisdiction such as following:

a. persons dead on arrival at the hospital,
b. deaths occurring in the hospital within 24 hrs. of admission,
c. death of a patient who sustained an injury while hospitalized;
d. deaths resulting from high-risk infections or contagious disease.
(Refer to nursing policies and procedures on autopsies for specific detailed criteria.)

2. Provisional anatomic diagnosis shall be recorded on the medical record within 72 hours and the complete protocol should be made a part of the record within three months.

Section 4. Admissions

1. A patient may be admitted to the hospital only by a member of the Medical Staff. All Practitioners shall be governed by the official admitting policy of the hospital.

2. Patients for admission who have no attending Physician shall be assigned to members of the active Medical Staff on duty in the emergency room.

3. Except in emergency, no patient shall be admitted to the hospital until after a provisional diagnosis is stated and the consent of the Administrator or his designee is secured. In case of emergency, the provisional diagnosis shall be stated as soon after admission as possible.

4. Each patient admitted to the hospital shall have laboratory work done only on an individual basis by order of the attending Physician.

5. A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the hospital. Whenever these responsibilities are transferred to another staff member, a note covering the

transfer of responsibility shall be entered on the order sheet of the medical record.

6. Each Practitioner must ensure timely, adequate professional care of his patients in the hospital by being available or having available through his office an eligible alternate member of the Medical Staff with whom prior arrangements have been made and who has at least equivalent clinical privileges at the hospital. Failure of an attending Practitioner to meet these requirements could result in loss of clinical privileges.

7. The Medical Staff shall define the categories of medical conditions and criteria to be used in order to implement patient admission priorities and the proper view thereof.

8. In an emergency case in which it appears the patient will have to be admitted to the hospital, the Practitioner shall when possible first contact the admitting office or nurses' station to ascertain whether there is an available bed.

9. Complete records, medical and dental, shall be required on each patient and shall be a part of the hospital records.

10. The hospital shall admit patients suffering from all types of diseases except the following: NO EXCEPTIONS.

11. Physicians admitting patients shall be held responsible for giving such information as may be necessary to ensure that the protection of other patients from those who are a source of danger from any cause whatsoever including protection of the patient from self harm.

Section 5. Discharges

Patients shall be discharged only on order of the attending Practitioner. At the time of discharge, the attending Physician shall ensure that the record is complete, state his final diagnosis, and sign the record. Should a patient leave the hospital against the advice of the attending Practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record and an A.M.A. paper shall be signed by the patient.

Section 6. Surgery

1. The appropriateness of an operative or other invasive procedure for each patient is determined, in part, on an assessment of the patient's history, physical status, diagnostic data, risk and benefits of procedures, and the need to administer blood or blood components.

2. Except in cases of emergency, a surgical operation shall be performed only on consent of the patient, or his legal representative.

3. All operative procedures performed shall be dictated or written by the operating surgeon immediately following the procedure.

4. Any foreign body or pieces of tissue as deemed appropriate by the Physician, no matter how remote, removed within the hospital during a surgical operation, shall be sent to the reference lab which shall make such examination as they consider necessary to arrive at a pathological diagnosis. The findings shall be made a part of the patient's medical record and the pathologist shall sign the report.

Section 7. Emergency Room

1. Each member of the active Medical Staff utilizing the hospital privileges on a regular basis is assigned coverage of the emergency room on an equal rotational basis as scheduled by the Chief of Staff.

2. Only Physicians with appropriate clinical privileges or another person qualified by experience and training will perform medical screenings such as an RN, Advanced Practice Nurse or Physician Assistant (PA) acting pursuant to protocols to identify an emergency medical condition.

Section 8. Mass Casualties

In case of mass casualty, all Physicians shall be assigned to posts and it is their responsibility to report to their assigned stations. The Chief of Staff and the Administrator will work as a team to coordinate activities and directions. In case of evacuation of patients from one place to another, the Chief of Staff will authorize the movement of patients by direction of the Administrator. All Physicians on the Medical Staff agree to relinquish direction of professional care of their patients to the Chief of Staff in cases of emergency. This plan for Care-of-Mass-Casualties shall be rehearsed twice a year by key hospital personnel.

Section 9. Medical Records

1. For each patient there shall be an adequate, accurate, timely, and complete medical record. Minimum requirements for the medical record contents are as follows: Patient identification and admission information; history of patient as to chief complaints, present illness and pertinent past history, family history, physical examination report; provisional diagnosis; diagnostic and therapeutic reports on laboratory test results; x-ray finds; any surgical procedure performed; any pathological examination; any consultation; and any other diagnostic or therapeutic procedures performed; orders and progress notes made by the attending Physician and when applicable by other members of the Medical Staff and Allied Health Personnel; and conclusions as to the primary and any associated diagnosis, brief clinical resume, disposition at discharge to include instructions and/or medications and any autopsy findings in case of a hospital death.

2. A complete medical history and physical examination shall in all cases be written no more than (30) days before or (24) hours after admission. If the medical history and physical examination is completed within (30) days before admission; an updated medical record entry must be completed within (24) hours after admission documenting an examination for any changes in the patient's condition.

3. When the history and physical examination are not recorded before a scheduled operation or any potentially hazardous diagnostic procedure, the procedure shall be canceled, unless the attending Practitioner states in writing that such delay would be detrimental to the patient.

4. All medical records are the property of the hospital and may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute.

5. In case of readmission of a patient, all previous records shall be available for the use of the attending Practitioner. This shall apply whether the patient is attended by the same Practitioner or by another.

6. Free access to all medical records of all patients shall be afforded to the staff Physicians in good standing for study and research, consistent with preserving the confidentiality of personal information concerning individual patients. Subject to the discretion of the Administrator, former members of the Medical Staff shall be permitted access to information from the medical records of their patients covering periods during which they attended such patients in the hospital.

7. Medical charts must be completed in the current patient's file in the Health Information office within thirty 30 days after discharge.

8. Complete records, medical and dental, shall be required on each patient and shall be a part of the hospital records.

9. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.

10. Medical records for maternity patients shall include findings during the prenatal period if available, including medical and obstetric history; observations and proceedings during labor, delivery and the postpartum period and laboratory results and x-ray findings. The record shall contain recordings of the mother's temperature, pulse, and respiration at least twice a day unless the mother has fever in which case, temperatures will be recorded four times a day.

11. Records for infants shall include the physical examination following birth and at the time of discharge with special consideration to deformities and abnormalities, temperature readings at least twice daily, the number and character of the stools, the condition of the skin and eyes, the presence of jaundice, bleeding from the umbilical cord or from mucous membranes, type and time of feedings, the infant's reaction to the feedings

and infant weight. The hospital shall maintain sufficient information within the medical record to duplicate the birth certificate. All reports to the state shall be filed as required including report of maternal death, death certificate, birth certificate and stillbirth report.

12. Documentation is required in the medical record of the use of special treatment procedures that require special justification and include at least restraint or seclusion. (Refer to hospital-wide policies and procedures on restraints/seclusions for specific detailed criteria.)

13. Physicians are encouraged to complete their medical records in a timely manner. However, justifications for a delay in completing medical records may include:

a. The attending Physician is ill, on vacation, out of town, or otherwise unavailable for a period of time.
b. The Practitioner is waiting for a late report result and the record is otherwise complete.
c. The missing reports have been dictated and are delayed in transcription by the hospital.

MEDICAL STAFF RULES AND REGULATIONS

ADOPTED by the active Medical Staff March 11, 2015 .

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Marcos N. Sunga, M.D.,
Chief of Staff

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Joshua D. Hastie, M. D.
Secretary of Medical Staff

APPROVED by the Governing Body on March 26, 2015 .

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Wendell Robinson,
President, Board of Directors

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