Shore Medical Center

Medical Staff Credentials Manual

Approved by:
Medical Executive Committee: July 15, 2014
Medical Staff: August 19, 2014
Board of Trustees: October 6, 2014

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TABLE OF CONTENTS

ARTICLE I

MEDICAL STAFF MEMBERSHIP

Section 1.1 ELIGIBILITY AND QUALIFICATIONS FOR MEMBERSHIP

The basic eligibility criteria and qualifications for membership on the Medical Staff of Shore Medical Center are found in the Medical Staff Bylaws in Article II, Section 2.1. In addition, the Board, after requesting input from the MEC, may impose further requirements on specific Practitioners where it believes these are warranted after a review of the Practitioner's credentials file, peer review and performance data, or other relevant material.

Section 1.2 CONDITIONS AND DURATION OF APPOINTMENT

1.2.1. Initial Appointment and Reappointment

(a) Initial appointment and reappointment to the Medical Staff shall be made by the Board. The Board shall act on appointments and reappointments only after there has been a recommendation or an opportunity for a recommendation from the Medical Executive Committee.

(b) Appointment to the staff may be for up to twenty-four (24) calendar months.

(c) Appointment to the Medical Staff shall confer on the appointee only such clinical Privileges as have been granted by the Board.

Section 1.3 LEAVE OF ABSENCE (LOA)

1.3.1. Written Notice

A Medical Staff member may request, in writing, a voluntary leave of absence from the Medical Staff. Acceptable reasons for leave may include, but are not limited to, medical reasons, being physically absent from the area for three or more months, or an educational sabbatical to participate in a significant educational program. Such request shall be received in Medical Staff Services, at a minimum of thirty (30) days prior to the requested leave date, except in the case of an emergency. Such request shall state the reason the Medical Staff member requests the leave and the exact period of leave time requested, which may not exceed one (1) year. Such request shall be submitted to the member's Department Chair, Credentials Committee, and MEC, which shall review such requests and recommend approval or disapproval to the Board, and which may be subject to conditions. The Board shall make the final decision whether to approve or disapprove such request. In the event that such request is approved, the Staff member shall make necessary arrangements to provide alternate coverage for proper and necessary patient care during his or her absence and shall meet all obligations listed in 1.3.2 below. During the period of a leave, the Staff member's membership status, Department

affiliation, privileges and prerogatives, duty to pay Medical Staff dues, if any, and attendance requirements at Medical Staff and Department meetings shall be suspended. In the event that the Board disapproves such request, the affected Staff member shall not be entitled to procedural rights as outlined in the Corrective Action and Fair Hearing Manual of the Medical Staff Bylaws.

1.3.2. Obligations

A request for Leave of Absence shall not be considered until all obligations to the Hospital have been met, including completion of all medical records, payment of any outstanding dues, and fulfillment of any Emergency Department or other call obligations.

1.3.3. Request to Return from LOA

Not less than thirty (30) days prior to the termination of the leave, the Medical Staff member must request, in writing, reinstatement of his/her membership and/or privileges and submit such request to Medical Staff Services. The Medical Staff member must also submit a written summary of his/her relevant activities during the leave along with supporting documentation if so requested by members of the Department, Credentials or MEC. Reinstatement will be made by action of the MEC. If the MEC denies reinstatement, the matter will be forwarded to the Board for a final decision. If the requested return date is past the time for the member's reappointment, he or she must submit a reapplication form and be reappointed by the Board before resuming his or her staff position and privileges. The Practitioner may be subject to Focused Professional Practice Evaluation upon their return, depending upon the circumstances.

1.3.4. Failure to Request to Return from LOA

The failure of a Medical Staff member to request reinstatement from a LOA shall result in automatic relinquishment of membership status and privileges. The affected Member shall not be entitled to procedural rights as outlined in the Corrective Action and Fair Hearing Manual of these Bylaws. A request for Medical Staff membership subsequently received by a Medical Staff so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

1.3.5. Impact on Adverse Actions and Recommendations

A leave of absence will not impact or interfere with any adverse action or recommendation made with respect to the Medical Staff member requesting the leave.

Section 1.4 PHYSICAL HEALTH STATUS

1.4.1. Health Requirements

Members of the Medical Staff and Practitioners holding privileges must maintain the physical and mental ability to deliver patient care and exercise privileges safely and at an appropriate level of quality at all times.

1.4.2. Notification of Health Status

A Practitioner holding Privileges at Shore Medical Center must immediately report in writing to his/her Department Chair (or her designee), Chair of the Credentials Committee, or an Officer of the Medical Staff when he or she has a mental or physical condition that has the potential or likelihood to impair judgment or affect functional capability to perform granted privileges safely and at an appropriate level of quality at all times (as determined by the staff member, a treating physician, or a health care facility). Failure to do so may result in Corrective Action.

1.4.3. Health Evaluation

At any time that there is any reason to question whether a Practitioner holding clinical Privileges at Hospital has the requisite physical and/or mental health required to care for patients safely and with an appropriate level of care and skill, the officers of the Medical Staff, Chief Executive Officer, Chief Medical Officer, Credentials Committee, MEC or Board may require that member to undergo an appropriate health evaluation. The nature and scope of the evaluation (including random or for cause drug or alcohol testing) and the examining clinician may be determined at the discretion of the MEC and/or Board. Where there is a concern that a Practitioner may be impaired by use of or addiction to drugs or alcohol, such examination may include the imposition of random drug or alcohol testing. Refusal of a Practitioner to comply with a request to submit a health examination and/or drug or alcohol testing will be considered a voluntary resignation from the Medical Staff and relinquishment of Privileges.

ARTICLE II

PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

Section 2.1 GENERAL PROCEDURE

The Medical Staff through its designated departments, committees, and officers shall evaluate and consider each application for appointment or reappointment and clinical privileges and each request for modification of staff membership or privileges and shall adopt and transmit recommendations to the Board.

Section 2.2 APPLICATION FOR INITIAL APPOINTMENT

2.2.1. Application Form

Each application for appointment to the Medical Staff shall be in writing, submitted on the prescribed form issued by Medical Staff Services, and signed by the applicant. Any qualified Physician who wishes to apply for membership on the Medical Staff and any Practitioner who wishes to be privileged through Medical Staff processes shall contact Medical Staff Services. Medical Staff Services shall forward to eligible Practitioners an application form, a copy of the Medical Staff Bylaws and its manuals, selected associated policies and procedures

of the Medical Staff, a Delineation of Privilege request form, and other specific Hospital-required documents.

2.2.2. Content of Application Form:

The completed application for appointment shall be in a form determined by the Hospital in consultation with the Medical Staff Credentials Committee and MEC. The completed application and its attachments shall include, but is not limited to, the following information:

(a) Acknowledgement and Agreement: A statement signed by the applicant to the effect that he/she has read and agrees to be bound by the Bylaws and its manuals, and any Medical Staff rules, regulations or policies that are provided to the applicant as part of the application process. The applicant also agrees to be bound by these documents in all matters relating to consideration of his or her application whether or not he/she is granted membership and/or staff privileges and to promptly provide the Medical Staff Office with a written update concerning all information on his membership application if and when changes occur. Furthermore, the applicant agrees that if he/she is granted Medical Staff membership and/or privileges, he/she agrees to follow and be bound by any and all Medical Staff and Hospital policies, rules, or regulations and meet all the responsibilities of Medical Staff membership.

(b) Qualifications: Detailed information concerning the applicant's qualifications, including information in order to satisfy the Basic Eligibility and Qualifications of Medical Staff Membership and of any additional qualifications necessary to be granted any privileges requested.

(c) Requests: Specific requests stating the Department and the clinical Privileges for which the applicant wishes to be considered.

(d) Peer References: The names of at least three (3) practitioners in the same professional discipline as the applicant (e.g. physician, dentist, podiatrist, nurse practitioner) who have worked with applicant and observed his or her professional performance and who can provide references as to the applicant's medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills and l, such that patients treated by him/her receive quality care delivered in a professional and efficient manner. Information provided by the reference should address the applicant's abilities with regard to the general competencies adopted from time to time by the American College of Graduate Medical Education (ACGME). In general, peer references should be submitted on a peer reference or evaluation form provided by Medical Staff Services and/or the reference should answer specific questions posed on this form. If the applicant is within five (5) years of completing residency or other training, one reference must include the Director of the training program.

(e) Ethical Pledges: Agrees to the provision of providing professional services in an ethical manner, providing continual care for his patients, seeking consultation when necessary, refraining from delegating the responsibility for diagnosis or care of hospital patients to a medical practitioner who is not qualified to undertake this responsibility, and to provide treatment and medical services without discrimination.

(f) Professional Sanctions: Information as to whether the applicant's membership status and/or Medical Staff privileges have ever been (or is currently pending) voluntarily or involuntarily revoked, suspended, reduced, non-renewed, subjected to restrictions or limitation not applicable to all other Practitioners in the same Medical Staff category, or not renewed at any other hospital, health care institution, or health plan, including whether any of the following has ever been voluntary or involuntarily suspended, revoked, or denied:

(i) Membership/fellowship in a local, state or national professional organization;

(ii) Staff membership status or clinical privileges at any other hospital or health care entity including ambulatory surgery centers;

(iii) Specialty board certification;

(iv) Licensure to practice any profession in any jurisdiction;

(v) Drug Enforcement Administration (DEA) number or a state controlled substance license; or

(vi) Information as to any current or pending sanctions, affecting participation in any Federal Healthcare Program or any actions which cause the Practitioner to become ineligible for such programs.

If any such actions were ever taken or if any such actions are currently pending, the particulars of these actions shall be included.

In addition, completion of the Medicare CHAMPUS Attestation Acknowledgement Statement is required.

(g) Criminal Proceedings: Information as to whether the applicant has ever been named as a defendant in any criminal proceedings, regardless of the outcome.

(h) Felony Convictions: Information as to whether the applicant has ever been convicted of a felony or submitted a plea of guilty or no contest, if a felony prosecution is now pending against the applicant, and the particulars of any such conviction, settlement or prosecution, if any.

(i) History of Medical Staff Membership: A chronological history listing all of the applicant's past Medical Staff memberships and associated privileges, including the full addresses of the facilities at which such memberships or privileges were held and/or applied for

(j) Professional Employment History: A chronological history of applicant's entire employment history as a health care professional.

(k) Education and Training History: A chronological history of the applicant's undergraduate education, all graduate education in the healthcare field, and all post-graduate training (internships/residencies/fellowships) in any health care field.

(l) Notification of Release and Immunity Statement: Such releases, waivers, and authorizations as are presented to the applicant by Medical Staff Services. These will include a statement signed by the applicant authorizing and consenting to allow Medical Staff and Hospital representatives to provide other hospitals, medical associations, licensing boards, and other organizations concerned with provider performance and the quality and efficiency of patient care with any relevant information the Hospital or Medical Staff may have concerning the applicant. This statement will also release from liability the Hospital, its Medical Staff, and their representatives for sharing with appropriate health care and licensing entities information concerning the professional competence, ethics, and other qualifications of the applicant for staff appointment and privileges, including information otherwise privileged or confidential, to the full extent permitted by New Jersey law.

(m) Professional Liability Actions: All particulars regarding medical malpractice claims ever filed against the applicant, any adverse and/or pending malpractice decisions or settlements, and of any cancellation, non-renewal, or limitation of malpractice insurance coverage.

(n) Contact information: Home and office address, mobile phone number, pager number, and email address.

(o) Information regarding whether the applicant has been convicted of any type of insurance fraud, been found guilty under the False Claims Act, has been suspended from or is on the OIG Excluded Provider list for Medicare and Medicaid.

(p) Miscellaneous Information: Such other information relating to evaluation of the applicant's professional qualifications, ethical character and professional conduct, current competence, and prior professional experience, including utilization of hospital resources, as may be deemed relevant by the MEC and the Board.

(q) Minimum Basic Criteria: The following basic criteria must be appropriately documented and the information reasonably confirmed:

(i) Evidence of Current Licensure: (unrestricted New Jersey State License, unrestricted Federal DEA as appropriate to specialty). Licensure is verified with the primary source.

(ii) Relevant Training and/or Experience: At the time of appointment and initial granting of clinical privileges, Hospital may require verification of relevant training or experience from the primary source(s), when feasible.

(iii) Current Competence: Recent letters of verification from the applicant's residency program Director or designee, if residency training was within five

years of initial application. Confirmation of board certification or qualification for certification from the appropriate specialty board. Written documentation from individuals personally acquainted firsthand with the applicant's recent professional and clinical performance including, if available and applicable, types of surgical procedures performed, outcomes for invasive procedures performed, types of medical conditions managed as the responsible physician, clinical judgment and technical skills, and professional conduct. References should also provide information on the applicant's abilities regarding the six general competencies as described by the Accreditation Council for Graduate Medical Education (ACGME): patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.

(iv) Ability to Perform Privileges Requested (Health Status): A health status statement provided by Medical Staff Services and signed by the applicant indicating that no physical or mental health problems exist that could affect his/her practice or ability to perform the privileges requested.

(v) Evidence of PPD testing and other required health screenings.

(vi) Documentation of malpractice insurance in the amounts required by the Medical Staff Bylaws.

(vii) A government issued photo identification document and a reproducible digital image of the Practitioner.

(viii) Where appropriate, evidence of the capability to provide timely and continuous coverage for inpatients in a manner acceptable to the MEC

Section 2.3 APPLICATION FEE

A non-refundable fee, in an amount established by the Board after consultation with the MEC, shall be payable upon request at the time of application for appointment or reappointment. Applications submitted without an accompanying fee will not be accepted for processing.

Section 2.4 EFFECT OF APPLICATION

By applying for appointment, reappointment or clinical privileges to the Medical Staff, the applicant:

(a) Agrees to execute general and specific releases and provide documents when requested by the President, Chair of the Credentials or Medical Staff Peer Review Committees, the Hospital CEO or CMO or their respective designees in order to evaluate a Practitioner's credentials or quality of care.

(b) Agrees to provide in a timely fashion any additional information and to resolve any questions relating to his application that are requested or posed by Medical Staff, Hospital, or Board representatives.

(c) Agrees to appear for interview(s) upon request.

(d) Authorize representatives of the Hospital and of the Medical Staff to solicit, procure, provide, and/or act upon information bearing on or reasonably believed to bear upon the Practitioner's professional abilities and qualifications;

(e) Agrees to be bound by the provisions of the Hospital's Bylaws including associated manuals and Medical Staff rules, regulations and policies regardless of whether membership or clinical Privileges are granted or subsequently restricted;

(f) Acknowledges that the provisions of this Article are express conditions to an application for, or acceptance of, staff membership, and the continuation of such membership and/or the exercise of clinical Privileges or provision of specified patient care services at the Hospital;

(g) Agrees not to sue and to release from legal liability and hold harmless Hospital, its affiliates, its Medical Staff, and any representative of the Hospital or Medical Staff who acts to carry out Medical Staff or Hospital policies or functions, including all persons engaged in credentialing, peer review, and performance improvement activities.

(h) Authorizes and consents to the Hospital and Medical Staff representatives and their designees providing other hospitals, medical associations and other health care providers where the applicant seeks or exercises clinical privileges, payors and insurance companies, potential employers and other organizations concerned with provider performance and the quality and efficiency of patient care with any information relevant to such matters that the Hospital and Medical Staff and their designees may have concerning applicant, whether in an oral or written form.

(i) Agrees not to sue and to release from legal liability and hold harmless any individual who or entity which provides information (including peer review information) regarding the applicant to the Hospital, the Medical Staff or its representatives, including otherwise privileged or confidential information, and consents to and directs the production of information related to the applicant, whether in a written or oral form.

(j) Agrees to consent to evaluation related to the applicant's mental or physical status and/or for drug and/or alcohol testing when requested by the Credentials Committee, the MEC, an officer of the Medical Staff, the Hospital CEO or Hospital CMO because of a suspicion of improper use of a restricted or illegal substance and/or impairment of ability to safely care for patients.

(k) Authorizes the Hospital and its designees to consult with and query the New Jersey Division of Consumer Affairs Health Care Professional Information Clearing House for the purpose of evaluating the applicant for hiring, continued employment or continued privileges and otherwise in connection with the application and exercise of privileges.

(l) Authorizes Hospital representatives to consult with medical staffs and others associated with other hospitals, facilities, institutions and practice settings where the applicant has been trained, medical societies, professional and certifying boards, insurance companies, current and former employers and with others who may have information bearing on the applicant's qualifications, clinical competence, character, moral, ethical and other qualifications for Medical Staff membership or privileges.

(m) Consents to the inspection by Hospital representatives of all records and documents that may be material to an evaluation of his professional and ethical qualifications for Staff membership, including the results of any criminal background checks including discipline.

(n) Agrees that in the event of any adverse recommendations or decisions with respect to staff membership or privileges, as defined in these Bylaws, the applicant shall exhaust the administrative remedies afforded by these Bylaws before resorting to formal legal action.

(o) Signifies that the information submitted in his or her application is true to the best of his/her knowledge and belief and that he/she understands that any significant misstatement(s) on or omission(s) from his/her application and/or failure to provide Medical Staff Services with a written update on all information in his/her application shall constitute grounds for rejection of the application.

(p) If the Practitioner is an applicant to or member of or credentialed through the Medical Staff processes as described in the Bylaws or this Credentialing Manual and such Practitioner is subject to supervision or collaboration as described in these Bylaws, the Medical Staff Credentialing Manual, Hospital policies and/or as required by law, such Practitioner agrees that the appropriate Medical Staff Committee, Medical Staff Officer and/or the CEO or CMO or designee may discuss the Practitioner's application and reappointment application and/or any concerns regarding such Practitioner with the Practitioner's collaborating or supervising Attending Physician.

Section 2.5 PROCESSING OF INITIAL APPLICATIONS

2.5.1. Applicant's Burden

The applicant shall have the burden of producing adequate information for a proper evaluation of his or her experience, background, training, clinical competence, and ability to adequately perform the privileges requested, and of resolving any doubts about these or any of the other qualifications specified in the Medical Staff Bylaws or in their associated Medical Staff manuals or policies. The applicant must be able to demonstrate to the satisfaction of the MEC and Board proficiency in the following six general competencies as described by the Accreditation Council for Graduate Medical Education (ACGME): patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. An application will not be processed by the Medical Staff until it is deemed complete by Medical Staff Services. If a Department Chair,

Medical Staff committee, or the Board request additional information from the applicant to process the application, the application will be deemed incomplete. If the application remains incomplete for more than sixty days, it will be considered to have been voluntarily withdrawn by the Practitioner who submitted the application.

2.5.2. Applicant Interview

All applicants for appointment to the Medical Staff and/or clinical privileges may be required to participate in an interview at the discretion of the Department Chair or designee, Credentials Committee, MEC, or Board. The interview may take place in person or by telephone, video, or computer link at the discretion of the party calling for the interview. The interview will be used to gather information about the applicant and to communicate information to the applicant concerning Medical Staff responsibilities and expectations.

2.5.3. Verification Of Information

The applicant shall deliver a completed application to the Hospital, which shall in a timely fashion, seek to collect or verify the references, licensure, and other qualifications evidence submitted. The Hospital will verify that the applicant requesting approval is the same practitioner identified in the credentialing documents by viewing a current picture hospital ID card or a valid picture ID issued by a state or federal agency (i.e., driver's license or passport). The Hospital shall promptly notify the applicant of any problems in obtaining the information required, and it shall then be the applicant's obligation to obtain the required information and provide it to the Hospital in a timely manner. Once collection and verification is completed, the Hospital shall forward a complete verified application and its supporting materials to the Chair of the Department to which the applicant will be assigned if granted staff membership.

2.5.4. Department Chair/Division Chief Review

The relevant Department Chair, or designee, shall review the completed application and supporting documentation for completeness and for the purposes of determining the character, professional competence, qualifications, and ethical standing of the applicant to fulfill the requirements of Staff membership and/or the Privileges requested. The Division Chief or designee shall review and provide comments.

The Department Chair, or designee, may conduct an interview with the applicant and may request additional information from the applicant or elsewhere as needed to carry out his or her evaluation of the applicant. The Chair shall transmit to the Credentials Committee and MEC a written report and recommendation as to Staff appointment and, if appointment is recommended, as to the Staff category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The Department Chair may also recommend that the MEC defer action on the application. The reason for each recommendation shall be stated and supported by reference to the completed application and all other documentation considered by a Chair, all of which shall be transmitted with the report.

2.5.5. Credential Committee Action

The Credentials Committee shall review each application, its supporting documentation, the Department Chair's report and recommendations, and such other information

available to it that may be relevant to consideration of the applicant's qualifications. The Committee may choose to conduct a personal interview with the applicant.

After its review of the applicant's credentials, the Credentials Committee shall submit, together with the recommendation of the Department Chair, a written recommendation to the MEC. This recommendation shall address the applicant's Medical Staff membership and category, Department affiliation, privileges, and any specific conditions relating to appointment and/or privileges. Minority views regarding any or all recommendations of the Credentials Committee may also be included.

2.5.6. Medical Executive Committee Action

At its next monthly meeting after receipt of the reports and recommendations of the Department Chair and the Credentials Committee, the MEC shall review the applicant's request for membership and/or privileges. The MEC may utilize appropriate additional sources of information, including personal interviews with the applicant, as it deems necessary to complete its evaluation.

After completing its review of the applicant's qualifications, the MEC shall transmit to the Board a written report and recommendation regarding appointment and/or privileges for the applicant, indicating whether the applicant's requests should be accepted, accepted with modifications or qualifications, or rejected. Where appointment is recommended, the MEC shall also recommend Staff category and Department affiliation. Where the MEC recommends that the applicant's requests for membership and/or privileges be rejected, modified, qualified, or otherwise restricted, the report of the MEC shall set forth reasons for such recommendation(s). If an MEC recommendation is not unanimous, a minority report may be submitted to the Board.

2.5.7. Effect Of Medical Executive Committee ("MEC") Action

(a) Favorable Recommendation: When the recommendation of the MEC is favorable to the applicant, the recommendation shall be forwarded to the Board.

(b) Deferred: Any action by the MEC to defer the application for further consideration must be followed up within ninety (90) days with a subsequent recommendation.

(c) Adverse Executive Committee Recommendation: When the MEC recommends denial or a restriction of membership or a requested privilege based an applicant based on a determination of unprofessional conduct or inadequate clinical competence, the President of the Medical Staff shall inform the Practitioner by special notice within ten (10) days. Physicians shall be entitled to the procedural rights as provided in the Corrective Action and Fair Hearing Manual of the Medical Staff Bylaws. The Hospital CEO and Board shall also be notified.

2.5.8. Board Subcommittee Action (Expedited Credentialing)

A subcommittee of the Board may provide expedited approval for initial appointments and reappointments to the Medical Staff and for granting Clinical Privileges when criteria for that process are met. Expedited appointment requires a quorum of no less than two (2) Board members by unanimous vote. Available subcommittee members shall meet or convene a conference call to approve or disapprove the MEC's recommendation for appointment within seven (7) days of receipt of such recommendation. The subcommittee shall make a report to the Board at its next regular meetings for ratification of the expedited appointment by the full Board. Recommendations for appointment that do not receive subcommittee approval shall be referred back to the MEC at its next regularly scheduled meeting. Applicants are ineligible for the expedited process if any of the following has occurred: the applicant submits an incomplete application; the MEC makes a recommendation that is adverse or has limits; there is a current challenge or previously successful challenge to the applicant's licensure or registration; the applicant has received an involuntary termination of medical staff membership at another hospital; the applicant has received involuntary limitation, reduction, denial or loss of clinical privileges; and/or the Hospital determines that there has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

2.5.9. Action Of The Board

(a) At its next meeting after receipt of the reports and recommendations of the MEC regarding an initial application for membership and/or Privileges, the Board shall consider and act on such recommendations. If the Board decides to defer action on the application pending further consideration by the MEC, or if the Board does not accept the recommendation of the MEC, it shall refer the application back to the MEC for further consideration, subject to the requirement that a final recommendation be provided to the Board by the MEC within ninety (90) days. At the meeting next following the receipt of the second report of the MEC, the Board shall render its final decision regarding the application.

(b) If the recommendation of the MEC is adverse to the applicant, as defined under these Bylaws, the Board shall postpone its final decision on the applicant, pending the applicant's decision to utilize or waive procedural rights. If an eligible applicant waives his or her right to a fair hearing and appellate review, the Board will then determine its final decision on the request for membership and/or privileges. If an eligible applicant requests a fair hearing, the Board will make a determination on the applicant's requests following a final recommendation from the MEC which takes into consideration the findings of the hearing panel. Where the applicant further requests an appellate review by the Board, its final determination will result from the decision made by the review panel.

(c) When the Board decides to appoint an applicant to the Medical Staff, its decision and the notice of appointment shall include:

(i) the Staff category to which the applicant is appointed;

(ii) the Department to which he is assigned;

(iii) the Privileges he may exercise; and

(iv) any special conditions attached to the appointment or exercise of Privileges.

2.5.10. Conflict Resolution

Whenever the Board's proposed decision will be contrary to the MEC's recommendation, the Board shall submit the matter to a Joint Conference as provided in the Medical Staff Bylaws. This Joint Conference will be held as soon as practicable and the Board will postpone any final determination on an applicant until such conference is held.

2.5.11. Notice Of Final Decision

(a) The Hospital CEO, Chief Medical Officer, or designee shall provide an approved applicant with notice of the Board's action on membership and/or Privileges and special notice of any adverse action on the application in a timely manner.

(b) The Board shall give notice of its final decision through the Hospital Chief Medical Officer to the President of the Medical Staff, the MEC, and the Chair of the affected Department.

2.5.12. Time Periods For Processing

(a) Applications for Medical Staff appointment and/or Privileges shall be considered in a timely and good faith manner by all individuals and groups required by the Medical Staff Bylaws or policies to act upon them and a shall be processed whenever possible within the time periods specified in this section. Any incomplete application after six (6) months shall be considered voluntarily withdrawn.

(b) Within fifteen (15) calendar days after receipt by the Department Chair of a completed application for membership and/or clinical privileges, the Chair of the Department shall submit a written report of his or her recommendations to Credentials Committee.

(c) Within sixty (60) calendar days after the receipt of the Department's recommendation, the Credentials Committee or its Chair shall submit a written recommendation to the Medical Executive Committee.

(d) Within sixty (60) calendar days after receipt of recommendations from the Credentials Committee or its Chair, the MEC shall submit a recommendation regarding appointment and/or privileges to the Board.

(e) The Board will act on recommendations from the MEC at its next regularly scheduled meeting.

(f) The time periods in this section are guidelines and deviations will not entitle the applicant to any procedural due process rights.

Section 2.6 REAPPOINTMENT PROCESS

2.6.1. Application For Reappointment

Reappointment will be for a period of up to two (2) years. At least one hundred eighty (180) calendar days prior to the expiration date of his or her current appointment of membership and/or Privileges, the Hospital shall provide each Practitioner with an updated application form for reappointment and any required hospital specific forms and documents for completion which must be received prior to the reappointment application being acted upon. Each Practitioner who desires reappointment shall, at least one hundred twenty (120) calendar days prior to such expiration date, must complete such forms and return them to the Hospital. Failure to return the completed form(s) prior to such expiration date may, at the discretion of the Hospital, be considered a voluntary resignation of membership and clinical Privileges effective at the end of the Staff member's current term.

2.6.2. Content Of Application

The application for reappointment shall be in a prescribed form setting forth, without limitation, requirements for the following information:

(a) Specific requests setting forth the category of Staff membership to which the applicant seeks to be reappointed, the Department to which the applicant seeks membership, and the Privileges for which the applicant wishes to be considered.

(b) Continuing training, education, and experience that qualify the Staff member for the Privileges sought on reappointment. At least fifty (50%) percent of continuing education hours must relate to the Privileges requested and documentation is provided to the Hospital upon request.

(c) A statement that no health problems exist that could affect the applicant's ability to perform the Privileges requested.

(d) The name and address of any other health care organization or practice setting where the applicant professional services during the preceding appointment period.

(e) Any membership, awards, or other recognition conferred or granted by any professional health care societies, institutions or organizations.

(f) Current, unrestricted New Jersey lcense, and an unrestricted Drug Enforcement Administration (DEA) number and New Jersey CDS license, as applicable.

(g) Information as to whether the applicant's membership status and/or Medical Staff Privileges have ever been (or is currently pending) voluntarily or involuntary revoked, suspended, non-renewed, reduced, subjected to restrictions or limitation if not

applicable to all other Practitioners in the same Medical Staff category, or not renewed at any other hospital or health care institution, and as to whether any of the following has ever been voluntary or involuntarily suspended, revoked, or denied:

(i) staff membership status or clinical privileges at any other hospital or health care entity including ambulatory surgery centers;

(ii) membership/fellowship in a local, state or national professional organization;

(iii) specialty board certification;

(iv) licensure to practice any profession in any jurisdiction; or

(v) Drug Enforcement Administration (DEA) number/CDS.

If any such actions were ever taken or if any such actions are now pending, the particulars thereof shall be included.

(h) Information as to whether the applicant has ever been prosecuted for, convicted of or pled no contest to a felony and, if so, the particulars of any such convictions.

(i) Information as to whether the applicant has ever been named as a defendant in any criminal proceedings, regardless of the outcome.

(j) Evidence of continuous malpractice insurance coverage, minimum of $1 million per occurrence, $3 million aggregate or higher if required by the State of New Jersey,

(k) A list of all malpractice complaints filed against the applicant and the particulars regarding any adverse malpractice decisions or settlements.

(l) Such other specific information about the applicant's professional ethics, qualifications, and ability that may bear on his ability to provide medical or surgical care in the Hospital.

(m) Information regarding whether the applicant has been convicted of any type of insurance fraud, been found guilty under the False Claims Act, has been suspended from or is on the OIG Excluded Provider list for Medicare and Medicaid.

(n) An official government issue photo identification and a reproducible digital image of the applicant.

2.6.3. Completion And Verification Of Information

The information provided on each application for reappointment and all other supporting materials and documentation, including information regarding the Staff member's professional activities, performance and conduct in the Hospital and query reports from the

National Practitioner Data Bank shall be collected and verified. The applicant shall have the burden of producing adequate information for a proper evaluation of his or her qualifications and of resolving any questions regarding such qualifications and to promptly provide Medical Staff Services with a written update concerning all information on his reappointment application if and when changes occur. When collection and verification has been completed, and Medical Staff Services has determined that the application is complete, it shall transmit the application and all supporting material to the Chair of the Department to which the applicant is assigned.

2.6.4. Department Chair Review

The Department Chair or designee shall review the application for reappointment and all other pertinent information, including the application and all supporting documentation. Such review shall consist of an appraisal of the following factors, without limitation:

(a) Professional performance, including applicant's patterns of practice monitored by the Hospital and Medical Staff performance improvement programs, data from ongoing professional practice evaluation (OPPE), findings based on utilization review, infection control activities, blood utilization monitoring, operative and invasive procedure review, medical records review, and pharmacy and therapeutic review, as appropriate.

(b) The Privileges currently exercised by applicant and the basis for any requested modifications.

(c) Applicant's health status, where relevant to his or her ability to exercise assigned privileges safely and competently.

(d) Applicant's participation in relevant continuing education programs.

(e) Applicant's attendance at meetings of the Medical Staff and of the Department.

(f) Applicant's service on Medical Staff and Hospital committees.

(g) Applicant's record relating to timely completion of medical records.

(h) Applicant's demonstrated ability to work cooperatively with other Practitioners and hospital personnel, to comply with policies on professional conduct, and to avoid unprofessional conduct in the Hospital that may have a disruptive effect on patient care or impede the efficient and safe operation of the Hospital.

(i) Applicant's record of compliance with the Medical Staff Bylaws, rules, regulations and policies of the Medical Staff, and with Hospital policies applicable to Medical Staff members or Practitioners granted Privileges.

2.6.5. Action Of The Department Chair

The Department Chair shall review the application and information in the Practitioner's file and shall submit his/her recommendation to the Credentials Committee regarding the reappointment of and/or privileges to be exercised by such member. The Division Chief or designee shall review and provide comments. The recommendation of the Department Chair shall contain the following, without limitation:

(a) Recommendations for reappointment or denial of reappointment, including any suggested restrictions or conditions on reappointment.

(b) Recommendation for Department affiliation and Staff category.

(c) The Privileges to be granted, including any restrictions on such Privileges.

2.6.6. Credentials Committee Action

The Credentials Committee shall review each application and all other relevant information available to it, including the report and recommendation of the Chair of the Department in which the applicant has been a member. The Credentials Committee may choose to interview the applicant prior to rendering a formal recommendation to the MEC. The Credentials Committee shall make a report to the MEC regarding its recommendations on the application for reappointment. The report of the Credentials Committee shall contain the same specific types of recommendations contained in the report of the Department Chair as set forth in the section above. The report of the Credentials Committee shall be accompanied by all relevant documentation, including the application, supporting information, and the report of the Department Chair.

2.6.7. Medical Executive Committee Action

The MEC shall review each application for reappointment and all other relevant information available to it. The MEC may choose to interview the applicant prior to rendering a recommendation. The MEC shall make a report to the Board regarding its recommendations on the application for reappointment of membership and Privileges. The report of the MEC shall contain the same specific types of recommendations contained in the report of the Credentials Committee, and the report of the MEC be accompanied by all relevant documentation, including the application, supporting information, and the report of the Credentials Committee.

2.6.8. Final Processing And Board Action

Following the report of the MEC to the Board, the procedure provided in the Credentials Manual relating to initial applications shall be followed, including the provisions regarding expedited credentialing to the extent applicable, and the Board shall render a decision prior to the expiration date of the applicant's appointment. Where the Board disagrees with the recommendation of the MEC, the matter will be brought to a Joint Conference as described in 2.5.10 above.

2.6.9. Basis For Recommendation

Each recommendation concerning the reappointment of a Practitioner's membership and/or Privileges shall be based upon review not only of those matters set forth in the Medical Staff Bylaws and policies pertaining to such Practitioner, but also on any other information bearing on the ability and willingness of the Practitioner to contribute to the rendering of quality health care within the Hospital and to contribute to the mission of the Hospital.

Section 2.7 REQUESTS FOR MODIFICATION OF MEMBERSHIP STATUS AND/OR PRIVILEGES

A Medical Staff member may, either in connection with reappointment or at any other time, request modification of Staff category, Department affiliation, or clinical Privileges by submitting a written application to Medical Staff Services in such form as may be prescribed by the MEC and the Board. Such Staff member shall have the burden of justifying such modification(s). Such application shall be processed in substantially the same manner as applications for reappointment of membership and/or Privileges.

Section 2.8 EFFECTIVE DATE OF REAPPOINTMENT/MODIFICATIONS OF APPOINTMENTS AND/OR STAFF PRIVILEGES

Reappointments approved by the Board, including Privileges awarded in connection with such reappointments, modifications of categories of Staff membership, Department affiliation, and/or privileges, shall take effect on the date such modifications are approved by the Board.

ARTICLE III

DETERMINATION OF PRIVILEGES

Section 3.1 EXERCISE OF PRIVILEGES

Practitioners providing clinical services at the Hospital shall be entitled to exercise only those Privileges specifically granted to them by the Board, or emergency or disaster privileges as described in this Manual.

Section 3.2 DELINEATION OF PRIVILEGES IN GENERAL

3.2.1. Requests

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific clinical Privileges desired by the applicant. Practitioners who are ineligible for Medical Staff membership may nevertheless apply for Privileges by requesting a Privileges application form from the Hospital. A request by a Practitioner for Privileges or the modification of Privileges must be supported by all requested documentation regarding appropriate licensure, training and the evidence of current competence. Privilege requests will

not be processed where the applicant does not meet the eligibility requirements to be granted the Privilege at Shore Medical Center.

3.2.2. Basis for Determinations of Privileges

(a) Privileges shall be determined on the basis of the Practitioner's prior and continuing education, training, experience, utilization patterns and demonstrated current competence, including observed professional performance and documented results of Practitioner-specific performance improvement activities. Information concerning professional performance obtained from other sources will be considered when available, especially from other institutions and health care settings where a Practitioner exercises privileges. It is the burden of the Practitioner applying for privileges to provide all information requested by the Medical Staff and Board as they determine necessary to evaluate the request. The Hospital shall query the National Practitioner Data Bank (NPDB) when clinical privileges are initially granted, at the time of renewal of privileges, and when a new privilege(s) is requested.

(b) Residents or Fellows in training in an approved ACGME program and acting under the auspices of that program will not be required to request specific privileges. They must carry out any clinical care in accordance with the written educational protocols developed by the Hospital CMO and the training program. These protocols must delineate the roles, responsibilities, and scope of clinical activities applicable to such trainees. They must also describe the requirements for oversight of trainees, the types of orders they may write, and when such orders must be countersigned and by whom. The protocols will describe how trainees' level of responsibility and scope of practice may expand over time and how this information will be transmitted to staff and personnel working in the Hospital. These protocols must be periodically reviewed and approved by the MEC. In addition, training programs will periodically communicate with the MEC regarding the performance of its trainees and alert it to any performance concerns or matters that may threaten patient safety. The training program must work with the MEC to assure that all supervising Practitioners hold privileges commensurate with their oversight activities.

3.2.3. Procedure

(a) All requests for clinical Privileges shall be processed pursuant to the procedures outlined in Article II. Requests for Privileges will not be processed where the Board has made a determination that the Hospital will not support or authorize the exercise of a particular Privilege for any Practitioner at the Hospital; where the Privilege requested is covered by an exclusive contract granted by the Board and the requesting Practitioner is not a party to the contract or provider under the contract; or where the requesting Practitioner does not meet the eligibility requirements to request or exercise a Privilege as described in the Hospital's Delineation of Privileges documents.

(b) In the event a Practitioner requests a Privilege for which the Hospital has not adopted criteria (e.g., for a new technology or procedure), the request may be tabled for a reasonable period of time, usually not in excess of ninety (90) calendar days. During this time the MEC and Board will review the community, patient, and Hospital need for the

Privilege and determine if the institution can make available the necessary resources to adequately support the exercise of that Privilege. The MEC will research appropriate eligibility criteria for the safe and effective exercise of the requested Privilege and establish, with the approval of the Board, the necessary education, training, experience, and evidence of current competence that will be required to request and be granted the Privilege. Once these steps are taken, a request for the Privilege will be evaluated.

Section 3.3 TEMPORARY CLINICAL PRIVILEGES

3.3.1. Circumstances

Temporary Privileges may be granted to a Practitioner to address an important patient care or service need for a limited time, up to one hundred twenty (120) days. Temporary Privileges may be granted to a Practitioner upon the recommendation of either the applicable clinical Department Chair or the President and who meets one of the following circumstances and the minimum criteria as defined below:

3.3.2. Care of Specific Patients:

In special circumstances upon receipt of a written request for specific temporary Privileges an appropriately licensed Practitioner of documented competence, who is not an applicant for membership, may be granted temporary Privileges for the care of one or more specific patients. The following documentation is required for temporary Privileges:

(i) Unrestricted New Jersey State License

(ii) Unrestricted Federal DEA and New Jersey CDS license if appropriate

(iii) Current valid professional liability insurance coverage in a certificate form and in amounts satisfactory to the Hospital

(iv) Current standing from primary practicing facility, if applicable

(v) National Practitioner Data Bank report (processed by Medical Staff Services)

(vi) A verbal reference which establishes current competency.

3.3.3. Locum Tenens:

Upon receipt of a written request for specific temporary Privileges, an appropriately licensed Practitioner of documented competence who is serving as a Locum Tenens for a member of the Medical Staff may, without applying for membership on the Staff, be granted temporary Privileges for an initial one hundred twenty (120) days. He shall be limited to treatment of the patients of the Practitioner for whom he is serving as Locum Tenens. He shall not be entitled to admit his own patients to the Hospital unless such privileges are

specifically granted. This request must also be accompanied by a written statement from the affected Medical Staff member that he is utilizing the applicant Practitioner as a locum tenens and this is necessary in order to meet the important needs of his patients.

3.3.4. Conditions

Temporary Privileges shall be granted by the Hospital CEO or designee acting on behalf of the Board and based on a recommendation of the President of the Medical Staff or a Department Chair. Before temporary Privileges are granted, the Practitioner must first acknowledge in writing that he/she has received and read copies of the Medical Staff Bylaws and all other Medical Staff and Hospital policies relevant to his or her performance of temporary Privileges, and that he agrees to be bound by them.

3.3.5. Termination

On discovery of any information or the occurrence of any event of a nature which raises questions about a Practitioner's professional qualifications or ability to exercise any or all of the temporary Privileges granted, the Hospital CEO, Medical Staff President, or the Chair of an appropriate clinical Department may terminate any or all of such Practitioner's temporary privileges, subject to the ultimate approval of the Board. Where the life or well-being of a patient is determined to be endangered by continued treatment by a Practitioner exercising temporary Privileges, the termination may be effected by any person entitled to impose precautionary suspensions under the Bylaws. In the event of such termination, the patients of such Practitioner then in the Hospital shall be assigned to another Practitioner by the President or, in his absence, by the Chair of the appropriate Department. Where feasible, the wishes of the patient shall be considered in choosing a substitute Practitioner.

3.3.6. Procedural Rights

A Practitioner shall not be entitled to procedural rights because of the denial of any request for temporary Privileges, or because of any termination or suspension of temporary Privileges, whether in whole or in part, unless based on a determination of demonstrated incompetence or unprofessional conduct.

Section 3.4 EMERGENCY PRIVILEGES

In case of an emergency, any Medical Staff member attending a patient shall be expected and permitted to do everything in his/her power and to the degree permitted by his or her license, to save the life of the patient or prevent significant and disabling morbidity regardless of the member's Medical Staff status, Department affiliation or Privileges. This duty shall be subject to the Medical Staff member's concurrent duty to take into account or abide by a patient's directive under the New Jersey law to withhold or withdraw life-sustaining procedures, or to take into account and abide by the requirements of sound medical practice. For purposes of this section, an emergency is defined as a condition or set of circumstances in which any delay in administering treatment would increase the danger to the patient's life or the danger of serious harm. When such an emergency situation no longer exists, the patient shall be assigned to an appropriate member of the Medical Staff who holds Privileges appropriate to address the patient's medical conditions.

Section 3.5 DISASTER PRIVILEGES

3.5.1. Authority

The authority to implement disaster Privileges is at the direction of the Hospital Command Center, in consultation with the Medical Staff leadership, in the event the Emergency Management Plan is activated and the Hospital is unable to handle immediate patient care needs. One of the following individuals may grant disaster Privileges once appropriate identification is obtained from a physician who has offered to volunteer during a disaster:

(i) CEO or designee

(ii) Chief Medical Officer

(iii) President or any elected Officer of the Medical Staff

(iv) Credentials Chair

(v) Department Chair

3.5.2. Eligible Physician

Disaster Privileges May Be Granted Only To Physicians Who Hold A License In The State Of New Jersey To Practice Medicine And Who Volunteer Their Services But Do Not Possess Medical Staff Privileges At Shore medical Center.

Primary source verification of licensure will begin as soon as the immediate situation is under control, and is completed within seventy-two (72) hours from the time the volunteer physician presents to the Hospital. Primary source verification applies only to volunteer physicians who actually provided care, treatment and services while under disaster privileges. In extraordinary circumstance in which primary source verification cannot be completed within seventy-two (72) hours, it will be completed as soon as possible and reasons for the delay documented.

3.5.3. Scope of Privileges

(a) Volunteering physicians granted disaster Privileges shall be paired with and supervised by a currently credentialed Medical Staff member. An approved form of ID must be worn at all times while volunteering at the Hospital. Scope of Privileges for the volunteering physician shall be consistent with minimum core Privileges for the Practitioner's specialty and as determined by the onsite-supervising physician.

(b) Within seventy-two (72) hours of disaster Privileges being granted, the Medical Staff leadership will make a determination of the professional practice of the volunteer physicians and the need for continuation of disaster privileges granted.

3.5.4. Termination of Privileges

Disaster Privileges will be for the duration of the emergency situation. Privileges will automatically be canceled when it is determined by the Hospital that an emergency situation no longer exists. In the event that any information received through the verification process or the professional practice review indicates adverse information suggesting the person is not capable of rendering services in an emergency such Privileges shall be immediately terminated. Practitioner's granted disaster Privileges will not be eligible for the due process rights afforded under these Bylaws and the exercise of disaster Privileges will be considered a waiver by the Practitioner to any and all rights to contest or appeal the restriction or termination of such Privileges.

3.5.5. Eligible Licensed Independent Practitioners

Disaster privileges may also be granted to licensed independent practitioners pursuant to the Hospital's policies regarding such privileging.

Section 3.6 TELEMEDICINE PRIVILEGES

3.6.1. Delineation of Clinical Services:

The Medical Staff Executive Committee, in conjunction with the medical staff of the distant site (i.e., the site where the Practitioner providing the telemedicine service is located), will recommend the clinical services to be provided by telemedicine. The clinical services to be provided by telemedicine shall be consistent with commonly accepted quality standards.

3.6.2. Privileging Process:

(a) Practitioners requesting Privileges to provide telemedicine services for the treatment and diagnosis of patients will be subject to the credentialing and privileging processes set forth in this Credentialing Manual, and will be assigned to a specific Department/Division.

(b) The verification process may utilize credentialing information from the distant site if the distant site is a Joint Commission-accredited institution so long as the Practitioner is privileged at the distant site for those Clinical Services to be provided at the Hospital and the distant site provides the Hospital with a current list of the Practitioner's Privileges. Alternatively, the Hospital may use the credentialing and privileging decision of the distant site to make a final privileging decision with respect to a Practitioner if (i) the distant site is a Joint Commission-accredited institution; (ii) the Practitioner is privileged at the distant site for those services to be provided at the Hospital; (iii) the distant site provides the Hospital with a current list of licensed independent practitioners' privileges; and (iv) the Hospital has evidence of an internal review of the Practitioner's performance of the requested privileges and sends to the distant site information that is useful to assess the Practitioner's quality of care, treatment and services for use in privileging and performance improvement. At a minimum, this information shall include adverse outcomes related to sentinel events considered reviewable by the Joint Commission that result from the telemedicine services provided, and complaints about the distant site Practitioner from patients, members of the Medical Staff and/or Hospital staff.

(c) Telemedicine Privileges shall only be granted to those specialized Practitioners who are under arrangement to provide telemedicine services to the Hospital.

ARTICLE IV

PRACTICE EVALUATION

Section 4.1 FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

A period of focused professional practice evaluation (FPPE) shall be implemented for all initially requested clinical privileges during a member's provisional appointment period and when a Practitioner has requested a new clinical privilege where there is no documented evidence of the Practitioner having performed competently the clinical Privilege at the Hospital. The MEC may also prescribe a time-limited period of FPPE to monitor a member's performance when issues affecting the provision of safe, high quality patient care are identified or upon a member's return from a leave of absence depending upon the circumstances. The decision to assign a period of performance monitoring to further assess current competence is based on the evaluation of a practitioner's clinical competence, practice behavior, and ability to perform the requested Privilege. The FPPE shall not be considered corrective action as described in the Corrective Action & Fair Hearing Manual and does not entitle the member to a hearing and appellate review in accordance with the Corrective Action & Fair Hearing Manual. FPPE and the measures employed to resolve performance issues identified during FPPE shall be consistently implemented for all members of the Medical Staff in accordance with the requirements and criteria set forth in this Section and in the applicable Medical Staff Policy and Procedure.

Section 4.2 ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)

Each member of the Medical Staff shall be subject to an ongoing professional practice evaluation (OPPE) in accordance with the requirements and criteria set forth in this Section and in the Medical Staff policy incorporated by reference herein. OPPE information is factored into the decision to maintain existing Privilege(s), to revise existing privilege(s), or to revoke an existing Privilege prior to or at the time of renewal. The ongoing professional practice evaluation shall not be considered corrective action as described in the Corrective Action & Fair Hearing Manual and does not entitle the member to a hearing and appellate review in accordance with the Corrective Action & Fair Hearing Manual.

ARTICLE V

PRACTITIONERS PROVIDING CONTRACTED SERVICES

Section 5.1 Medical Administrative Officers

5.1.1. A medical administrative officer is a Practitioner engaged by the Hospital in a management capacity which may also include clinical responsibilities such as direct patient care, clinical supervision and/or collaboration of residents, fellows, students and/or Allied Health

Practitioners, or the proctoring of privileged Practitioners. Medical administrative officers must hold Medical Staff appointment and clinical Privileges appropriate their clinical activities and discharge Medical Staff obligations appropriate to their staff category.

5.1.2. The terms of the officer's contract with the Hospital will govern the effect of that contract's termination on the appointment and Privileges of the officer. The officer will not be entitled to the procedural due process rights in the Corrective Action and Fair Hearing Manual of these Bylaws where membership and Privileges are terminated as a matter of contract. The officer will be entitled to the same procedural rights as other staff members in the event an adverse change in appointment or Privileges is the result of a determination of demonstrated incompetence or unprofessional conduct.

Section 5.2 Exclusive Contracts

Whenever the Board determines that certain Hospital facilities or services will be staffed on an exclusive basis it will do so under contracts (or letters of agreement) that identify which Practitioners may work pursuant to the contract. Except in emergency or disaster situations, only Practitioners authorized under the exclusive contract may hold Privileges for the clinical services covered by the contract. Requests for such Privileges from Practitioners not so authorized will not be processed by the Medical Staff or Board. Practitioners not authorized under the contract who were granted Privileges prior to the contract will not be allowed to exercise those Privileges once an exclusive agreement is signed by the Hospital. Ineligibility to exercise or request Privileges covered by an exclusive contract will not entitle a Practitioner to the procedural due process rights described in the Corrective Action and Fair Hearing Manual of these Bylaws.

ARTICLE VI

AMENDMENT

Section 6.1 This Medical Staff Credentials Manual may be amended or repealed, in whole or in part, as described in Article XI of the Medical Staff Bylaws.

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