ARTICLE I

DEFINITIONS AND PURPOSE

1.1 DEFINITIONS

The following terms, when capitalized, shall have the meanings set forth herein; when not capitalized they shall have the meanings generally accorded to them by a dictionary:

"Advanced Practice Providers or "APPs" means advanced practice registered nurses and physician assistants granted clinical privileges to attend patients at the Hospital.

"Bylaws" means these Medical Staff Bylaws.

"Chief Executive Officer" or "CEO" means the administrator of the Hospital, who is selected by the Officers of the Corporation with recommendations of the Governing Body and the Medical Executive Committee to be responsible for the day-to-day management of the Hospital.

"Chief of Staff-President" or "COS" means the medical doctor or osteopathic physician elected by the Medical Staff to serve as the chief officer of the Medical Staff. .

"Clinical Privileges" means the permission granted to a Practitioner and/or Advanced Practice Provider by the Governing Body to render specific diagnostic, therapeutic, medical, dental, podiatric, psychological, surgical, or other professional services.

"Corporation" means Rural Wellness Anadarko, Inc., the entity which holds the Hospital license and operates the Hospital.

"Federal Health Care Program" means any plan or program that provides health benefits whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government or a State health care program (with the exception of the Federal Employees Health Benefits Program). The most significant Federal health programs are Medicare, Medicaid, Blue Cross Federal Employee Program (FEP)/Tricare/Champus and the Veterans programs.

"Governing Body" means the body legally responsible for all services and the quality of patient care provided at the hospital. The majority of members of this body must be residents of the incorporated community or service area of the hospital. The governing body may be an organized board or owner designated individual(s).

"Governing Body Bylaws" means the bylaws adopted by the Corporation defining the Governing Body's duties and authority

"Hospital" means Clinton Regional Hospital Authority d/b/a Clinton Regional Hospital.

"Joint Conference Committee" means an ad hoc special-purpose Governing Body committee consisting of an equal number of Governing Body members (selected by the Board) and Medical Staff Appointees (selected by the MEC).

"Medical Executive Committee" or **"MEC"** means the medical executive committee of the Medical Staff.

"Medical Staff" means the organizational component of the Hospital consisting of all Practitioners and APPs who have been appointed to the Medical Staff pursuant to these Bylaws.

"Practitioner" means M.D.s, D.O.s, D.M.D.s, D.D.S.s, D.P.M.s or psychologists licensed in the state of Oklahoma.

"Vice-President, Medical Affairs/Chief Medical Officer" means a medical doctor or osteopathic physician who is a member of the Medical Staff designated by the Governing Body, who serves as liaison between the Medical Staff and the Hospital administration.

1.2 PURPOSE OF BYLAWS

The Hospital is a rural primary care hospital providing health care services to the community. The primary purpose of the Hospital is to provide the highest quality of health care at the lowest possible cost consistent with the maintenance of high standards of care, the availability of resources, and the expectations of the Practitioners, APPs and the community served by the Hospital. In order to do so, the Medical Staff must cooperate with and be subject to the ultimate authority of the Governing Body, and the cooperative efforts of the Medical Staff, the Governing Body, and the CEO are necessary, subject, however, in all instances to the authority of the Governing Body. These Bylaws have been adopted to set forth the mechanisms by which such purposes will be achieved.

ARTICLE II

GENERAL PROVISIONS APPLICABLE TO MEDICAL STAFF

2.1 STAFF APPOINTMENT AND PRIVILEGES

In order for any Practitioner or APP to practice in the Hospital, such individual must first be appointed to the Medical Staff and be granted specific Clinical Privileges. These Bylaws set forth (a) the procedures by which, and criteria pursuant to which, such appointments are to be made and such Clinical Privileges granted; (b) the procedures by which, and criteria pursuant to which, appointments and Clinical Privileges may be modified or terminated; (c) the duties and responsibilities of appointees to the Medical Staff; (d) and the procedures and systems of governance of the Medical Staff.

2.2 NATURE OF APPOINTMENT

Appointment to the Medical Staff is a privilege extended by the Hospital and not a right of any Practitioner or APP Appointment to the Medical Staff or the exercise of Clinical Privileges shall be extended to and maintained by only professionally competent Practitioners who continuously meet the qualifications, standards, and requirements set forth in these Bylaws. Appointment to the Medical Staff shall confer on the appointee only such Clinical Privileges and prerogatives as have been granted by the Governing Body in accordance with these Bylaws. No Practitioner or APP shall admit or provide services to patients in the Hospital unless (a) he/she is appointed to the Medical Staff and has been granted the necessary Clinical Privileges in accordance with the procedures set forth in these Bylaws or (b) he/she has been granted the necessary temporary or emergency Clinical Privileges.

2.3 CRITERIA FOR APPOINTMENT AND PRIVILEGES

(a) **Permissible Criteria** – Medical Staff appointments and Clinical Privileges shall be granted based upon, at a minimum, an individual's: (i) character; (ii) competence; (iii) training; (iv) experience; and (v) judgment. Medical Staff Appointments and Clinic Privileges also be granted based on criteria set forth in: (i)these Bylaws, (ii) the Medical Staff rules and regulations, (iii) Hospital policies, and (iv) as other criteria imposed by the Governing Body. Such criteria shall be designed to address the legitimate need of the Hospital to render quality care in a cost-effective manner and the legitimate need of the patients to receive affordable quality care and will be consistent with the Hospital's capability and capacity. Whether a particular Practitioner meets the criteria established herein shall be judged in this context. The Governing Body shall have the right and authority to interpret the standards set forth herein and to establish standards of competence consistent with the criteria set forth herein. The Governing Body may at any time make the standards more stringent, provided that the higher standards are applied fairly and on a nondiscriminatory basis. Every effort shall be made to provide a uniform quality of care throughout the Hospital, regardless of the department, staff category, and licensure of the Practitioner; however, it is recognized that special needs in particular areas of practice may require the implementation of higher or lower standards.

(b) Impermissible Criteria

(1) Discrimination - No aspect of Staff appointment or particular Clinical Privileges shall be denied on the basis of sex, race, creed, color, age, national origin, or handicap; except that handicap may be considered to the extent that it affects the delivery of quality patient care.

(2) Other Affiliations - No Practitioner or APP shall be entitled to Medical Staff appointment or to the exercise of particular Clinical Privileges merely because he/she is licensed to practice any profession in this or in any other state, is a member of any professional organization, is certified by any clinical board, is affiliated with one or more current appointees to the Medical Staff, or had or has Medical Staff appointment or particular Clinical Privileges at this Hospital, at another health care facility, or in another practice setting.

(3) Anticompetitive Motives - Decisions regarding Medical Staff appointment and Clinical Privileges shall not take into consideration the effect of such decision on another Practitioner's ability to compete against the individual under consideration.

2.4 LOYALTY; INDEMNITY

Any person assisting the Hospital in any quality improvement, peer review, or similar activity shall be treated as an agent of the Hospital and shall be protected to the fullest extent permitted by the laws pertaining to confidentiality and indemnity, provided that such person acts in the best interest of the Hospital in adherence to the purposes and standards expressed in these Bylaws, acts in good faith and without malice, acts in strict compliance with these Bylaws, communicates only with persons entitled to participate in the process, communicates with such persons only within the proper forum of a committee meeting or as otherwise expressly permitted by these Bylaws, and makes a reasonable effort to ascertain (pursuant to the procedures set forth in these Bylaws) the truthfulness of the information being relied upon.

2.5 DIVISION OF FEES

Any division of fees by Practitioners or APPs is forbidden and any such division of fees shall be cause for exclusion from the Medical Staff.

ARTICLE III

ORGANIZATION OF THE MEDICAL STAFF

3.1 OFFICERS AND OFFICIALS; GENERAL PROVISIONS

(a) General Provisions. Due to the size of the Medical Staff, there shall be only one general officer of the Medical Staff. The Medical Staff shall be represented by, and certain duties of the Medical Staff shall be discharged by, the President of the Medical Staff. The duties and role of the President will be performed by the Chief of Staff employed by the Hospital unless 2/3rds of the Medical Staff vote not to approve the Chief of Staff serving as the President. Unless removed from office by a 2/3rds vote of the Medical Staff, the term of the President will be coterminous with the employment of the Chief of Staff. – The Chief of Staff and President must be appointees in good standing to the active category of the Medical Staff throughout their term of office. Failure to maintain such status shall result in the immediate termination of the term of office, creating a vacancy to be filled by the Governing Body. They must demonstrate professional competence and leadership and the ability to willingly and faithfully discharge all duties and exercise the authority of the office held and to work cooperatively with other members of the Medical Staff, Hospital administrative personnel, whether employed by the Hospital or a management company, and the Governing Body.

(b) Resignation, Conditions, and Mechanisms for Removal of Officer- An officer of the Medical Staff may be removed from office with or without cause by the Governing Body. An officer of the Medical Staff may resign at any time by submitting his/her written resignation to the Governing Body or by terminating his/her employment agreement with the Hospital and/or a contracted hospital management company or employee leasing company, whichever is applicable.

(c) Duties

(i) Chief of Staff - The chief of staff shall have the following duties, in addition to any other duties indicated in his/her employment agreement:

- aid in coordinating the activities and concerns of Hospital administration and management, nursing, and other non-Medical Staff Hospital services and functions with those of the Medical Staff;
- be responsible to the Governing Body, in conjunction with the MEC, for the quality and efficiency of clinical services and professional performance within the Hospital and for the effectiveness of patient care evaluations and the quality improvement functions delegated to the Medical Staff;
- develop and implement, in cooperation with MEC, methods for credentials review and for delineation of Privileges, continuing education programs, utilization review, continual monitoring functions, and patient care evaluation studies;

- participate in the selection of Medical Staff representatives to Medical Staff and Hospital management committees;

- communicate and represent the policies, opinions, concerns, needs, and grievances of the Medical Staff to the Governing Body and Hospital administration and management;

- be responsible to the Governing Body for Medical Staff compliance with these Bylaws, the rules and regulations, policies, procedures, and other standards of the Hospital;

- be responsible to the Governing Body for enforcement of sanctions imposed against any appointee;

- call, preside at, and be responsible for the agenda of all meetings of the Medical Staff;

and

- serve as an appointee to and chairperson of the MEC, and as a nonvoting member of all other Medical Staff committees.

3.2 Vice-President of Medical Affairs/Chief Medical Officer.

(a) Appointment. The Vice-President of Medical Affairs/Chief Medical Officer shall be appointed by the Chief Executive Officer with consultative input from the Medical Executive Committee and approval by the Governing Body.

(b) Responsibilities

i. The Vice-President of Medical Affairs/Chief Medical Officer's duties shall be delineated by the Board of Directors in keeping with the general provisions set forth in subparagraph (ii) below. The Medical Executive Committee approval shall be required for any Vice-President of Medical Affairs/Chief Medical Officer duties that relate to authority to perform functions on behalf of the Medical Staff or directly affect the performance or activities of the Medical Staff.

ii. In keeping with the foregoing, the Vice-President of Medical Affairs/Chief Medical Officer shall:

1. Serve as administrative liaison among Hospital administration, the Governing Body, outside agencies and the Medical Staff;

2. Assist the Medical Staff in performing its assigned functions and coordinating such functions with the responsibilities and programs of the hospital; and

3. In cooperation and close consultation with the Chief of Staff and the Medical Executive Committee, supervise the day-to-day performance of the Medical Staff services.

(c) Participation in Medical Staff Committees. The Vice-President of Medical Affairs/Chief Medical Officer: a. Shall be an ex officio member of all Medical Staff Committees, except the Joint Conference Committee (which the Vice-President of Medical Affairs/Chief Medical Officer shall attend as a resource person) and any hearing committee. b. May attend any meeting of any department or section

3.3 MEDICAL STAFF, MEDICAL EXECUTIVE COMMITTEE AND OTHER COMMITTEE FUNCTIONS

(a) Composition - The Medical Staff as a whole serves as the Medical Executive Committee and the MEC will perform all the functions of the committees required by Oklahoma State Department of Health Standards applicable to critical access hospitals, as revised from time to time, including, but not limited to: credentials, medical records, tissue and pharmacy and therapeutics. The Hospital Chief Executive Officer will attend all MEC meetings, without vote. The Chief of Staff shall be the chairperson of the MEC and shall preside at its meetings.

(b) Functions - The functions of the MEC shall be to:

(1) receive and act upon reports and recommendations of the departments, services, committees, officers, and other officials of the Medical Staff concerning matters within the purview of the Medical Staff;

(2) report results and recommendations concerning Medical Staff functions to the Medical Staff and the Governing Body;

(3) coordinate the activities of and policies adopted by the Medical Staff, its services, and its committees;

(4) review applications for appointment and reappointment to all categories of the Medical Staff as often as needed and at least biennially;

(5) make recommendations to the Governing Body on all matters relating to appointments, reappointments, Medical Staff category, Clinical Privileges, and the removal or limitation thereof, and assure the qualifications and competence of Practitioners and APPs through a credentials procedure, including mechanisms for appointment and reappointment and the delineation of Clinical Privileges;

(5) initiate an investigation of any incident, course of conduct, or allegation indicating that an appointee to the Medical Staff may not be complying with the Bylaws, may be rendering care below the standards established for appointees to the Medical Staff, or may otherwise not be qualified for continued enjoyment of Medical Staff appointment or Clinical Privileges without limitation, further training, or other safeguards; and, if necessary, make recommendations to the Governing Body to terminate Medical Staff membership consistent with Article VI – Removal of Medical Staff Privileges.

(6) account to the Governing Body and to the Medical Staff for the overall performance improvement and efficiency of medical care rendered to patients at the Hospital, including an annual reappraisal of the Hospital's performance improvement program;

(7) make recommendations on matters pertaining to the management and administration of the Hospital;

(8) participate in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs;

(9) review the utilization of Hospital resources based on the requirements of the Hospital's utilization review plan;

(10) develop and monitor compliance with these Bylaws, and the rules and regulations, policies, and other Hospital standards;

(11) establish and maintain the other committees of the Medical Staff as set forth below, or discharge the duties and functions thereof in the absence of such a committee;

(12) represent and act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws;

(13) recommend the organizational structure of the Medical Staff to the Governing Body;

(14) supervise the maintenance of medical records at the required standard of completeness;

(15) review and evaluate all surgery performed in the Hospital on the basis of agreement or disagreement among the pre-operative, post-operative, and pathological diagnoses, and on the acceptability of the procedure undertaken;

(16) assist in the formulation of broad procurement, storage, distribution, use and safety procedures, an all other matters relating to drugs in the Hospital and shall advise the Medical Staff and the pharmacist;

(17) assist with the development of an antibiotic stewardship program and perform quality improvement activities related to the use of antibiotics and to present a summary of the findings of these activities to the Medical Staff as needed; .and

(19) establish a mechanism for fair hearing procedures.

3.4 MEETINGS OF THE MEC?MEDICAL STAFF

(a) Regular Meetings .

(1) **Schedule of Meetings** - The MEC/Medical Staff shall meet monthly.

(2) **Order of Business; Agenda** - The Chief of Staff shall determine the order of business at all regular meetings of the MEC/Medical Staff. The agenda shall include at least the following:

- approval of the minutes of the last regular meeting and of all special meetings held since the last regular meeting;
- review reports from the Hospital Chief Executive Officer, , the Chief of Staff, and committee chairpersons, if applicable and as indicated;
- recommendations for maintenance and/or improvement of patient care;
- review of quality improvement projects; and
- action on other old and new business as appropriate.;

(b) Notice of MEC/MedicalStaff Meetings - The Chief of Staff shall give written notice of all regular and special meetings of the Medical Staff to all Practitioners and APPs entitled to attend. The notice of meeting shall set forth the date, time, and place of the meeting; and if the meeting is a special meeting, the notice shall also set forth the matters to be discussed. The notice of meeting shall be delivered personally, by email or electronic means no less than three days prior to the date of the meeting.

c) Quorum - A quorum must be present before any action may be taken at a meeting, but once a quorum is established any actions taken thereafter shall be valid even though less than a quorum may be present at a later time in the meeting. For the purpose of all meetings of the Medical Staff, a quorum shall exist when the Chief of Staff and 50% of the Medical Staff Members are present.

(d) Voting and Attendance - Unless otherwise specifically set forth herein, a resolution shall require the affirmative vote of a majority of the votes cast in order to pass. No action of the members shall be valid unless taken at a meeting at which a quorum is present, except that any action which may be taken at a meeting may be taken without a meeting if a consent in writing, setting forth the action so taken, is signed by a majority of the members entitled to vote. Regular and special meetings of the Medical Staff may be conducted via videoconference or teleconference.

eg) Electronic Participation. Participation in MEC/Medical Staff meetings may be accomplished by video, electronic and/or telephonic means. Electronic voting on medical staff matters is authorized, provided there is: a) an active and viable forum for all Medical Staff members to discuss the proposal and ask questions; and b) a system to verify the eligibility of each individual voting.

(f) Minutes - The Chief of Staff (or his/her designee) shall prepare accurate minutes of each meeting thereof. The minutes shall contain a record of attendance and the vote taken on each matter, including matters which are not successfully passed. The minutes shall be signed by the Chief of

Staff and maintained as permanent records. Copies of the minutes of all meetings shall be made available upon request to those having a right to attend the meeting and shall be furnished automatically to the Hospital CEO and the Governing Body. Copies of committee minutes shall be furnished in addition to the MEC. Notwithstanding the foregoing, patient and peer review information must be kept confidential and minutes containing any such information should be carefully prepared, redacted, or segregated to maintain protect such information and only shared or disclosed as required. Minutes related to reviewing reapplications for Medical Staff appointment, reviewing applications or reapplications for Clinical Privileges, investigating the activities of specific appointees to the Medical Staff, or otherwise dealing with confidential credentialing information shall be confidential and shall not be divulged to the subject Practitioner except as otherwise expressly required by these Bylaws.

ARTICLE IV

MEDICAL STAFF
QUALIFICATIONS, RESPONSIBILITIES, AND PRIVILEGES

4.1 MEMBERSHIP

Membership is conveyed at the time the Medical Staff application and clinical privileges are approved by the Governing Body. The granting of temporary privileges does not constitute membership.

4.2 QUALIFICATIONS

In order to be eligible for obtaining and maintaining appointment or reappointment to the Medical Staff and/or Clinical Privileges, a Practitioner or APP must at a minimum:

(a) maintain license in good standing in the State of Oklahoma.

(b) be eligible to participate in Medicare, Medicaid and Tricare/CHAMPUS and to have not been excluded from participation in such federal payment programs.

(c) possess the necessary education, training, experience, background, professional ability, physical and mental health, communications skills, and judgment such that any patient treated by him will receive care of the generally recognized professional level established by the Hospital;

(d) adhere strictly to the ethics of his/her profession;

(e) practice in such a manner that his/her activities do not interfere with the orderly and efficient rendering of services by the Hospital or by other Practitioners in the Hospital;

(f) meet state requirements for continuing medical education;

(g) work cooperatively with others in a hospital setting;

(h) participate in the discharge of Medical Staff responsibilities and abide by these Bylaws;

(i) continuously maintain in force professional liability insurance in the minimum amount of $1,000,000 per occurrence per named insured, $3,000,000 aggregate and provide evidence of such coverage to Hospital and notify Hospital immediately of any changes to his/her policy.

(j) provide a needed service within the Hospital;

(k) if an APP, have a collaborative agreement with a physician as required by his/her Practice Act;

(l) meet such other criteria as may be established by the Governing Body.

Any qualification set forth above may be waived at the discretion of the Governing Body only upon a

determination that such waiver is necessary in order to serve the best interests of the patients and the community, and such interests cannot be met in any other way.

4.3 DUTIES AND RESPONSIBILITIES

As a prerequisite for continued enjoyment of Medical Staff appointment and Clinical Privileges, each appointee to the Medical Staff, regardless of category, shall have an ongoing duty to and shall agree in writing to:

(a) provide his/her patients with continuous and timely care at or greater than the generally recognized professional level of quality and efficiency required by the Hospital and provide adequate substitute coverage during his/her absence;

(b) abide by these Bylaws, the rules and regulations, policies, and other standards of the Hospital as they may exist now or in the future;

(c) prepare and complete in a timely fashion the medical and other required records for all patients he/she admits or in any way provides care to in the Hospital;

(d) refrain from ordering unnecessary tests, procedures, or services for patients;

(e) notify the CEO immediately, within 24 hours, if

(1) his/her professional license in any state is suspended, revoked, limited or resigned (voluntarily or involuntarily)

(2) his/her Drug Enforcement Agency (DEA) number is suspended, revoked, limited or resigned (voluntarily or involuntarily)

(3) his/her professional liability insurance is modified or terminated,

(4) he/she is named as a defendant, or is subject to a final judgment or settlement, in any court proceeding alleging that he/she committed professional negligence,

(5) he/she receives notice of actual sanctions against him in connection with Medicare or Medicaid participation,

(6) his/her staff appointment or clinical privileges at another facility are suspended, revoked, limited or resigned (voluntarily or involuntarily) or

(7) he/she ceases to meet any of the standards of requirements set forth herein for continued enjoyment of Medical Staff appointment and/or Clinical Privileges;

(f) upon the joint request of the Chief of Staff and the CEO, submit to examinations and tests designed to determine the Practitioner's or APP's physical and/or mental health and provide full copies of the results to the Chief of Staff and the CEO; and

(g) account to the Governing Body and discharge such Medical Staff, committee, and Hospital functions for which he/she is responsible by appointment, election, or otherwise.

(h) continuing education is an adjunct to maintaining clinical skills and current competence and evidence of continuing education should be submitted at time of reappointment.

Failure to fully discharge these duties and responsibilities constitutes grounds for termination or nonrenewal of the Practitioner's or APP's Medical Staff appointment and Clinical Privileges. Acceptance of Medical Staff membership or exercise of Clinical Privileges shall constitute an agreement to strictly abide by these Bylaws, the Rules and Regulations and, as appropriate, the Principles of Medical Ethics of the American Medical Association and the American Osteopathic Association, the Code of Ethics of the American Dental Association or other appropriate ethical standards governing the Practitioner's or APP's practice (including legal and ethical requirements relating to the prohibition on illegal fee-splitting and division of fees). No person shall be appointed to the Medical Staff or granted Clinical Privileges if the Hospital is unable to provide adequate facilities and supportive services for the applicant and his or her patients.

4.4 CATEGORIES OF THE MEDICAL STAFF

The Medical Staff shall be composed of the following categories: Active, Courtesy, Consulting, , Appointees to each category shall meet the qualifications, have the prerogatives, and discharge the duties set forth below, in addition to meeting the qualifications and discharging the duties applicable to appointees of the Medical Staff in general. The Practitioner's or APP's failure to meet the qualifications and fully discharge the responsibilities of his/her Medical Staff category constitutes grounds for termination or nonrenewal of his/her Medical Staff appointment and Clinical Privileges. Any qualification set forth below may be waived in the discretion of the MEC and Governing Body only upon a determination that such waiver is necessary in order to serve the best interests of the patients and the community, and such interests cannot be met in any other way. The prerogatives set forth under each staff category are general in nature and may be subject to limitation by special conditions attached to a Practitioner's or APP's Medical Staff appointment, by other sections of these Bylaws, by action of the MEC and Governing Body, and by other policies or agreements of the Hospital.

4.5 Particular Qualifications.

(a) Practitioners.

(i) be a graduate of an accredited medical, osteopathic, dental, podiatry or psychology institution or an equivalent certificate from a foreign graduate program.

(ii) have completed a residency in the specialty area which is appropriate for the Clinical Privileges being sought.

(b) Advanced Practice Providers. An Advanced Practice Provider may be eligible for appointment to the Medical Staff only if he or she is:

(i) a graduate of an advanced practice registered nursing program or physician assistant program; and

(ii) have a collaboration agreement with a licensed physician as required by State law.

4.6 Basic Responsibilities. Except as otherwise provided in these Bylaws, each Medical Staff member shall: (a) provide continuous care to his or her patients at the generally recognized professional level of quality and efficiency established by the Hospital; (b) abide by these Bylaws, the Rules and Regulations, and all other rules and policies of the Hospital; (c) discharge such Medical Staff and Hospital functions for which or he or she is responsible, including emergency call coverage and emergency service care; and (d) prepare and complete in a timely manner the medical and other required records for all patients for whom he or she provides care in the Hospital. Each Medical Staff members granted Clinical Privileges to perform histories and physicals must ensure that every patient receives a history and physical within twenty-four hours of admission, unless a previous history and physical performed within thirty days of admission is on record, in which case that history and physical will be updated within forty-eight hours of admission. In addition, every patient admitted for surgery must have a history and physical within twenty-four hours prior to surgery, unless a previous history and physical performed within thirty days prior to the surgery is on record, in which case that history and physical will be updated within twenty-four hours of the surgery.

(a) Active Staff

(1) Qualifications - In order to qualify for appointment to the active staff of the Medical Staff, a Practitioner or APP shall:

- maintain his/her primary residence and his/her primary office sufficiently close to the Hospital (as determined by the Governing Body) to provide continuous and timely care to his/her patients;
- treat (including consultations) a sufficient number of patients to allow the Medical Staff and Hospital to assess the quality of care.

(2) Prerogatives - The prerogatives of an active staff appointee shall be to:

- admit an unlimited number of patients to the Hospital, unless otherwise provided in these Bylaws or rules and regulations;
- exercise such Clinical Privileges as may be granted pursuant to these Bylaws;
- vote on all matters presented at general and special meetings of the Medical Staff and of committees of which he/she is a member.;

(3) Responsibilities - Each active staff appointee shall:

- retain responsibility within his/her area of professional competence for the continuous care and supervision of each patient in the Hospital for whom he/she is providing services, or arrange for such care and supervision by another Practitioner or APP possessing the necessary Clinical Privileges;

- actively participate in quality improvement, utilization review, and other activities of the Medical Staff;

- provide coverage within his/her area of professional competence for emergency patients, whether inpatients or outpatients;

- and

- satisfy such other obligations of the Medical Staff as may arise from time to time.

(b) Courtesy Staff

(1) Qualifications - In order to qualify for appointment to the courtesy staff of the Medical Staff, a Practitioner or APP shall:

- be an appointee to the active staff of another hospital where he/she actively participates in the performance improvement program and provide to the Hospital upon request all information regarding his/her exercise of Clinical Privileges at such other hospital or hospitals; or

- by waiver of the Medical Executive Committee and the Governing Body, to be subject to assessment; and

- either maintain his/her primary residence and his/her primary office sufficiently close to the Hospital (as determined by the Governing Body) to provide continuous and timely care to his/her patients or provide satisfactory coverage during his/her absence by an appointee to the active staff.

(2) Prerogatives - The prerogatives of a courtesy staff appointee shall be to:

- exercise such Clinical Privileges as may be granted pursuant to these Bylaws.

Appointees to the courtesy staff are not eligible to vote at meetings of the Medical Staff, to serve on committees, or to hold office.

(3) Responsibilities - Each courtesy staff appointee shall:

- retain responsibility within his/her area of professional competence for the continuous care and supervision of each patient in the Hospital for whom he/she is providing services, or arrange for such care and supervision by another Practitioner or APP possessing the necessary Clinical Privileges; and

- provide coverage within his/her area of professional competence for emergency patients, whether inpatients or outpatients.

(c) Consulting Staff.

(1) **Qualifications** - In order to qualify for appointment to the consulting staff of the Medical Staff, a Practitioner or APP shall:

- either reside and practice outside of the Hospital's service area, but provide diagnostic or treatment services to patients via telemedicine devices **or** be recognized by the health care community as an authority within his/her specialty and/or be on the faculty of a health care teaching institution; and

- be an appointee to the active staff of another hospital where he/she actively participates in the quality improvement program and provide to the Hospital upon request all information regarding his/her exercise of Clinical Privileges at such other hospital or hospitals.

(2) **Prerogatives** - The prerogatives of a consulting staff appointee shall be to:

- consult on patients by special invitation of an active or courtesy staff appointee within the area of such Clinical Privileges as may be granted pursuant to these Bylaws; and

- attend by invitation (as a nonvoting visitor) Medical Staff or committee meetings.

Appointees to the consulting staff are not eligible to vote, to serve on committees, or to hold office. Appointees to the consulting staff shall not be the attending physician for patients at the Hospital or hold admitting privileges.

(3) **Responsibilities** - Each consulting staff appointee shall be responsible solely for his/her rendered consultations and ramifications thereof.

4.6 DURATION OF APPOINTMENT AND PRIVILEGES

All appointments, reappointments, and modifications of appointments shall be for a period of two (2) years, Whenever a Practitioner or APP is granted additional Clinical Privileges not previously exercised at the Hospital, such grant of additional Clinical Privileges may be limited in time to less than the remaining term of his/her appointment and shall be subject to verification of the Medical Staff member's skill and experience with the procedure or service for which Clinical Privileges are being sought to to confirm the Practitioner's or APP's ability to exercise such additional Clinical Privileges.

4.7 CONTRACT PRACTITIONERS AND APPS

If the Practitioner or APP is granted Clinical Privileges in an area governed by a written contract, including Practitioners and APPs providing services through telemedicine, and such contract provides for the limitation, termination, or nonrenewal of Clinical Privileges upon the Practitioner's or APP's departure from the contracting entity or upon termination or expiration of said contract, the granting of Medical Staff membership and Clinical Privileges to such Practitioner or APP shall be contingent upon, and shall refer to, the limitations imposed by such contract.

4.8 DELINEATION OF PRIVILEGES

(a) Qualifications - A Practitioner's or APP's qualifications to exercise the Clinical Privileges which he/she has requested must be demonstrated by verified evidence of training and experience, observed clinical performance at other facilities (if the Practitioner or APP has previously exercised such Clinical Privileges at another facility), and observed clinical performance and documented results from quality improvement activities at the Hospital (if the Practitioner or APP has previously exercised such Clinical Privileges at this Hospital). No Practitioner or APP shall use new or experimental drugs, procedures, treatment modalities, therapies, or tests until the qualifications for the exercise of such have been determined and the necessary Clinical Privileges have been granted.

(b) Procedure - Each application for appointment or reappointment to the Medical Staff shall contain a request for the specific Clinical Privileges desired by the applicant. Such requests shall be processed in conjunction with and following the procedures applicable to such application or reapplication for appointment to the Medical Staff. A Medical Staff appointee may request modification of Clinical Privileges prior to the time for reappointment. Such a request shall be processed in the same manner as an initial application for appointment to the Medical Staff, except that the application forms need not include information already on file and may be limited to information pertinent to the requested Clinical Privileges.

(c) Admitting Privileges - Only those Practitioners and APPa expressly granted admitting privileges may admit patients to the Hospital.

(d) Ordering Tests - The ordering of any test or procedure to be performed by another Practitioner or APP at the Hospital shall not constitute the exercise of Clinical Privileges, since the Practitioner or APP would not be personally rendering patient care within the Hospital. Nevertheless, no Practitioner or APP shall be entitled to order tests or procedures to be performed by an appointee to the Medical Staff unless it has first determined (1) that the Practitioner or APP possesses a license in good standing in the state in which his/her practice is located which authorizes him to order, receive, and act upon the results of such tests or procedures (2) the Practitioner or APP has not been excluded or debarred from participation in any Federal health care program; and (3) the ordering of tests or procedures by such Practitioner or APP is in the best interest of patient care.

4.11 TEMPORARY STAFF MEMBERSHIP WITH PRIVILEGES

(a) Circumstance - On the recommendation of the Chief of Staff, the CEO , or in his/her absence, his/her designee may grant temporary privileges in the following circumstances to a practitioner: (i) After receipt of an application for Medical Staff membership which includes a request for temporary privileges, an appropriately licensed practitioner may be granted temporary privileges for a period not to exceed ninety (90) consecutive days, unless extended for one additional period not to exceed ninety (90) consecutive days by the Chief of Staff. It must reasonably appear from the information available that a favorable decision on the application, considering the applicant's qualifications, ability and judgement, is likely. (ii) Upon receipt of a written request, an appropriately licensed practitioner who is not an applicant for Medical Staff privileges may be granted special temporary Staff membership with temporary privileges for the care of one or more specific patients. Such privileges may be restricted to the treatment of a limited

number of patient or for coverage of another Staff Practitioner under limited circumstances, after which such practitioner shall be required to apply for Medical Staff membership with privileges may be granted on the basis of information then available which may reasonably be relied on as to the competence and of the applicant. Temporary privileges may include admitting privileges. Any denial of temporary Medical Staff membership or temporary privileges shall be final and non-appealable.

Temporary privileges should only be granted on a case-by-case basis to a fully qualified applicant with a complete, clean application awaiting review and approval of the MEC and the Governing Body when there is an important patient care need that mandates an immediate authorization to practice

(b) Prerequisites – Temporary Clinical Privileges may be granted only when:

(1) verification from the primary source has been obtained regarding the practitioner's current Oklahoma state licensure, DEA number, postgraduate training (residency), current professional liability insurance coverage, including evidence of coverage for all clinical privileges requested and any pending professional liability actions or proceedings; a check of the OIG Sanction Report; a query to the National Practitioner Data Bank; at least one positive reference from a responsible medical peer, and evidence of current competence.

(2) the information available reasonably supports a favorable determination regarding the Practitioner's or APP's qualifications, ability, and judgment to exercise the Clinical Privileges in question;

(3) the Practitioner or APP agrees in writing to be bound by these Bylaws, the rules and regulations, and Hospital policies, and

(4) where applicable, evidence that the practitioner is a member in good standing from a facility where he/she hold active membership and clinical privileges.

(b) No Urgency - When there is no urgency to the granting of temporary privileges, the practitioner's signed acknowledgment of having received and read the current Bylaws, Rules and Regulations and Governing Body Bylaws and policies and his/her agreement to be bound by their terms in all matters relating to the temporary privileges shall first be obtained. In addition, the CEO shall in such cases verify the practitioner's current licensure and the DEA number. The CEO shall also first obtain current information as to his/her professional liability insurance coverage, including evidence of coverage for all clinical privileges requested, and any pending professional liability actions or proceedings, and evidence that privileges to perform the same procedures or treatments have been granted at another hospital.

(c) Termination - On the discovery of any information or the occurrence of any event of a professionally questionable nature about a practitioner's qualification or ability to exercise any of the temporary privileges granted, the Chief of Staff, after consultation with CEO, may terminate privileges, and such decision shall be final and non-appealable.

(d) Monitoring - In granting temporary privileges, special requirements may be imposed in order to monitor and assess the quality of care rendered by the practitioner exercising such

ARTICLE V

APPOINTMENT AND REAPPOINTMENT TO THE MEDICAL STAFF

5.1 APPLICATION FORM FOR APPOINTMENT

Each application for appointment to the Medical Staff shall be submitted on the Universal Application form approved by the Governing Body and shall be signed by the applicant. The information contained in the application shall be verified and evaluated by the MEC or its delegee consistent with the procedures and standards set forth in these Bylaws and any associated rules and policies to ensure the applicant meets all the qualifications for Medical Staff membership. Following the investigation, the MEC shall recommend to the Governing Body whether to appoint the applicant to Medical Staff membership and/or grant specific privileges to the applicant. An application for appointment to the Medical Staff shall be determined within 120 days from the date that that MEC receives all information it deems reasonably necessary to evaluate the applicant. The time period may be extended for good cause, which may include but is not limited to the need to obtain additional information or further evaluation to determine the applicant's qualifications.

5.2 REAPPOINTMENT.

5.2.1 **Term of Reappointment**. Reappointments to the Medical Staff must be made at least once every two (2) years.

5.2.2 **Reappointment Application**. An applicant for reappointment to the Medical Staff shall fully and accurately complete a written application form approved by the MEC. The application shall, in addition to any other information deemed relevant by the MEC, confirm the applicant's continued qualifications as set forth in these Bylaws; document the applicant's continued agreement to abide by Medical Staff bylaws, rules and policies; specify the privileges requested by the applicant, including any modification of privileges; authorize the disclosure of information relevant to the application; and, to the fullest extent allowed by law, release all persons and entities from any liability that might arise from the disclosure of such information or the investigation of and/or action on the application. The information contained in the application shall be verified and evaluated by the MEC or its delegee consistent with the procedures and standards set forth in these bylaws and any associated rules and policies. Following the investigation, the MEC or a committee thereof shall recommend to the Governing Body whether to reappoint the applicant to Medical Staff membership and/or grant or restrict specific privileges.

5.2.3 **Notice of Expiration of Appointment**. Hospital shall notify Medical Staff members at least 90 days prior to the expiration of the member's current appointment.

.5.2.4 **Submitting/Failing to Submit Reappointment Application**. An applicant for reappointment shall submit his or her completed application for reappointment to Hospital least 60 days prior to the expiration of the member's current appointment. An applicant's failure to timely file a completed application for reappointment shall constitute a resignation of the applicant's membership and privileges and shall result in the automatic termination of the applicant's membership and privileges at the end of the applicant's current appointment. In the event membership terminates for failure to timely submit a reappointment application, the member shall not be entitled to the hearing and appeal rights. The MEC may extend the time for the applicant to submit his or her application for reappointment for up to 60 days for good cause shown.

privileges.

4.12 CONTINUITY OF PATIENT CARE

If a Practitioner or APP dies or resigns his/her Medical Staff appointment, if his/her Clinical Privileges are suspended or terminated pursuant to these Bylaws, or if the Practitioner's or APP's practice at the Hospital is otherwise interrupted under circumstances where the Practitioner or APP is unable to or fails to make arrangements for the continued care of his/her patients, the Chief of Staff shall be responsible for assigning another qualified Practitioner or APP to attend to the affected patients. Each patient shall have the right to consent to the engagement of the Practitioner or APP so selected. Any patient who rejects all qualified Practitioners or APPs having the necessary Clinical Privileges at the Hospital shall be transferred to another facility, if possible, in order to enable the patient to be treated by the Practitioner or APP of his/her choice.

5.2.5 **Extension of Appointment**. If a reappointment application was submitted but has not been fully processed before the member's appointment expires, the member's membership status and privileges shall be automatically suspended until the review is completed unless the MEC exercises its discretion to extend the appointment. The MEC may extend an appointment for a period of up to 60 days for good cause shown, which may include the need to provide continuing care to a patient at Hospital, or circumstances beyond the control of the member caused a delay in the reappointment determination. A member does not have a right to an extension of appointment. A member whose appointment is temporarily extended does not have a right to be reappointed.

5.2.6 **Time for Review**. An application for reappointment to the Medical Staff shall be determined within 60 days from the date that that Medical Staff received all required information. The time period may be extended for good cause, which may include but is not limited to the need to obtain additional information or further evaluation to determine the applicant's qualifications.

5.3 **Telemedicine Credentialing by Proxy**.

Notwithstanding anything else in these Bylaws to the contrary, the MEC may rely on upon the credentialing and privileging decisions of a Distant Site Entity in appointing Providers rendering services via telemedicine if (1) the Governing Body has approved such a process and the Medical Staff complies with the approved process; (2) the Governing Body has an agreement with the Distant Site Entity for the provision of telemedicine services that satisfies the requirements of 42 C.F.R. §§ 482.12, 482.22, or 485.616 as applicable to Hospital and (3) the Distant Site Entity is required under the terms of its agreement with Hospital to employ a credentialing and privileging process that conforms to the provisions of (i) 42 C.F.R. §§ 482.12(a)(8) and (a)(9), 482.22(a)(3) and (a)(4), or (ii) 485.616(c) as applicable to Hospital and as they shall be amended by the .Governing Body

5.3 REQUEST FOR APPLICATION FORM

A Practitioner wishing to be considered for Medical Staff appointment or reappointment and Clinical Privileges may obtain an application form r by submitting his/her written request for an application form to the Hospital CEO or his/her designee. The CEO, or his/her designee, may refuse to furnish an application form based on information from a pre-application questionnaire or any other source that:

a. the Hospital does not have the ability to provide adequate facilities or services for the applicant or the patients to be treated by the prospective applicant,

b. The prospective applicant has interests or activities that are inconsistent with the needs, mission, operations and plans of the Hospital and the communities it serves, including any medical staff development plan.

c. the Hospital has contracted with an individual or group to provide the clinical services sought by the prospective applicant on an exclusive basis, and the prospective applicant will not be associated with the individual or group contracted with,

d. The prospective applicant has been excluded from participation in Medicare or Medicaid,

e. The prospective applicant does not meet the requirements relating to licensure and registration, professional liability insurance, board certification, or reapplication after adverse decision or resignation while under investigation or to avoid an investigation,

f. The prospective applicant is not a type of APP approved by the Governing Body to provide patient care services in the Hospital,

g. The practitioner does not have a valid unrestricted state license, or is subject to any form of counseling, monitoring, supervision, educational requirement or any other ongoing review, condition, requirement or restriction of any kind.

h. The practitioner has been convicted of a felony or convicted of a misdemeanor related to the practitioner's fitness to practice medicine.

i. The prospective applicant has provided materially false or misleading information on any pre-application questionnaire or in connection with any pre-application review process.

No application for reappointment shall be provided to a practitioner who is currently a member of the medical staff or holds clinical privileges if the practitioner has not provided requested information or documents or not responded to requests for comments concerning peer review or quality improvement matters or the practitioner's qualification for medical staff membership and privileges, provided the staff member has been notified in writing of the requested information and has had a reasonable opportunity to respond [has not responded within thirty (30) calendar days]. The applicant or prospective applicant shall be advised of the information relied on as grounds for not providing an application and the applicant or prospective applicant shall have a reasonable opportunity to submit information or evidence that the information relied on is not accurate.

No individual shall be entitled to a hearing or any other procedural rights as a result of a refusal by the Hospital to provide the individual an application form for initial appointment or reappointment.

The CEO's refusal to provide an application form for any of the above reasons shall not entitle the Practitioner to any further procedural rights under these Bylaws. Under any other circumstances, the CEO's refusal to provide an application form shall constitute a denial of the application and shall entitle the Practitioner to all procedural rights which exist under these Bylaws in the event of denial of an application.

5.4 COMPLETION OF APPLICATION FORM

An application shall not be considered complete until all information requested on the application form has been collected and verified and it has been returned to the Hospital.

5. NOTICE OF GOVERNING BODY DECISION

(a) **Favorable Action** - In the event that the Governing Body decision is favorable, such decision shall constitute the final action of the Hospital. The CEO shall promptly inform the applicant that his/her application has been granted. The decision to grant Medical Staff appointment or reappointment, together with all requested Clinical Privileges, shall constitute a favorable action even if the exercise of Clinical Privileges is made contingent upon monitoring, proctoring periodic drug testing, additional education concurrent with the exercise of Clinical Privileges, or any similar form of quality improvement that does not limit the applicant's ability to exercise the requested Clinical Privileges.

(b) **Adverse Action** - In the event that the Governing Body' proposed decision is adverse (i.e., it is not "favorable" as described above), the applicant shall be entitled to a hearing except as set forth in Section 6.10(c) below. The CEO shall immediately deliver to the applicant in person or shall immediately send to him by certified mail, return receipt requested, a letter enclosing the Governing Body' written proposed decision and containing a summary of the applicant's rights.

(c) **Availability and Conduct of Hearing-** In the event that the Governing Body' decision is adverse as described above, and the applicant is entitled to a hearing, and the applicant submits his/her request for hearing within 30 days of the date he/she received notice of the Governing Body' decision, the Governing Body shall conduct a hearing in accordance with Sections _____ below.

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5.6 RESIGNATION OF STAFF APPOINTMENT

Written Notice – A staff member may, at any time, resign his/her staff appointment by giving written notice to the Medical Executive Committee. Such resignation shall specify the reason therefore, and the effective date. Any Medical Staff Member who resigns his/her staff appointment is obligated to fully and accurately complete, with signatures, all portions of all medical records for which he/she is responsible prior to the effective date of the resignation.

ARTICLE VI
REMOVAL OF MEDICAL STAFF PRIVILEGES

6.1 CRITERIA FOR INITIATION OF INVESTIGATION

An investigation shall be initiated whenever there is reason to believe that the activities or professional conduct of any appointee to the Medical Staff:

A. Jeopardizes, or may jeopardize, the safety or best interest, quality of care, treatment or services to the patient, or the safety or best interests of a visitor or employee;

B. Presents a question regarding the competence, character, judgment, ethics, adequacy of mental or physical health, or ability to work cooperatively with others in the provision of safe patient care, treatment and services;

C. Violates these Medical Staff Bylaws, rules and regulations or Hospital policies or procedures; or,

D. Disrupts or has the potential to disrupt the operations of the Hospital.

The activities or conduct forming the basis for an investigation need not have occurred at the Hospital. The events or allegations supporting any of the above criteria may arise out of the routine audit or investigation of any committee of the Hospital or may be known by or disclosed to any individual at the Hospital. The Hospital retains the absolute right to increase its standards for Practitioners and to take appropriate action with respect to appointees who do not meet the higher standards.

6.2 METHOD OF INITIATION

A request for investigation may be made by an appointee to the Medical Staff, by any committee of the Medical Staff, or by the CEO. The request must be in writing and must describe with specificity the alleged activities or conduct which constitute the grounds for the request. Unless otherwise provided by law, the identity of the requesting individual shall be kept confidential if he/she so wishes. The request must be submitted to the Medical Executive Committee, which shall promptly determine whether the request states a sufficient criterion for investigation as set forth above, assuming all the allegations made in the request are true.

6.3 NOTIFICATION OF CEO, GOVERNING BODY, AND APPOINTEE

Promptly upon receipt of any request for investigation, the chairperson for the Medical Executive Committee shall notify the CEO and the Governing Body and shall continue to keep them informed throughout the investigation and any subsequent proceedings. In addition, promptly upon determining that a request for investigation states adequate grounds to investigate the matter, the Medical Executive Committee shall notify in writing the appointee in question that such a request has been received and shall describe the general nature of the allegations. Notwithstanding the foregoing, notice need not be given to the appointee is he/she has already received notice of summary suspension as set forth below. All correspondence sent by the CEO pursuant to the investigation shall be deemed to be sent at the request of the MEC's request or at the request of such other committee then charged with responsibility for the

investigation.

6.4 EFFECT ON PRIVILEGES; SUMMARY SUSPENSION

(a) **General** – Except as set forth below, an appointee who is the subject of an investigation as set forth above shall retain his Medical Staff appointment and Clinical Privileges unless and until the Governing Body makes a final decision to restrict or terminate his/her appointment and/or Clinical Privileges. There will be Medical Staff representation and participation in any hospital deliberation affecting the discharge of Medical Staff responsibilities.

(b) **Criteria for Initiating Summary Suspension** – Notwithstanding the foregoing, any or all of an appointee's Clinical Privileges and Medical Staff appointment may be summarily suspended or modified prior to or during an investigation (and thus prior to a final decision of the Governing Body) if it reasonably appears that failure to do so may result in imminent danger to the health or safety of any individual. If at any time prior to or during the practitioner's term of appointment, the CEO or Chief of Staff have reason to believe that the practitioner is impaired and that he/she may pose a danger to patients or to other persons, the practitioner may be required to undergo immediate testing (including substance abuse or psychological testing) and counseling to determine if a problem exists. Such suspension or modification of any or all of an appointee's Clinical Privileges and Medical Staff appointment prior to a final decision of the Governing Body are hereinafter referred to as "summary suspension". The alleged activities or conduct of the appointee forming the basis of the summary suspension 1) may have predated the commencement of the investigation or, in the case of summary suspension imposed the commencement of the investigation, may have been discovered during the course of the investigation, 2) may arise out of the routine audit or investigation of any committee of the Hospital or may be known to any individual at the Hospital, and 3) need not have occurred at the Hospital. Grounds for summary suspension shall also include the practitioner's failure or refusal to submit to testing for impairment, refusal to participate in an impairment rehabilitation program recommended by the MEC.

(c) **Method of Initiating Summary Suspension** – Summary suspension may be imposed by the CEO or Chief of Staff with the concurrence of each other. It shall be effective immediately upon imposition.

(d) **Notice to Appointee** – Promptly after imposition of summary suspension the CEO shall personally deliver to the appointee or shall send to him/her by certified mail, return receipt requested, a letter informing him/her of the action and the basis therefor.

(e) **Deadlines Shortened** – From and after the time of imposition of summary suspension, the deadlines (noted under each section of this article) for completing each step of the investigation and decision-making process shall apply. Notwithstanding any other provision by these Bylaws to the contrary, the deadlines under summary suspension shall not apply if good cause exists for failure to meet the deadline. Good cause may include, for example, delays occasioned by seeking outside expert opinions and delays due to the absence of necessary parties beyond the Hospital's control.

(f) **Termination of Summary Suspension** – If during the course of the investigation it become clear that no imminent danger to any individual in fact exists, any or all of the appointee's Clinical Privileges and Medical Staff appointment may be reinstated with the consent of either the

CEO or the other party concurring in the imposition of summary suspension. If all of the appointees Clinical Privileges are reinstated, the investigation shall continue under the same procedures and time frames as for a routine investigation. Otherwise the deadlines applicable to summary suspension shall continue to apply. The appointee shall be notified promptly in writing of any such reinstatement. Such reinstatement shall not constitute a termination of the investigation or a determination that there is no basis for action against the appointee.

6.5 INVESTIGATING COMMITTEE

(a) Selection – The MEC shall select an investigating committee composed of at least one and no more than five appointees to the Medical Staff to investigate the allegations regarding the appointee in question. In selecting members of the investigating committee, the MEC shall consider the need for expertise in the fields of practice engaged in by the appointee under investigation and the need for members of the investigating committee to be objective in their investigation into the facts. Preference shall be given to the chairperson of the subject appointee's department on the committee, if appropriate.

(b) Deadline – The MEC shall meet to select an investigating committee as soon as reasonably possible following the MEC's determination that the request for an investigation states adequate grounds. In the event that summary suspension has been imposed, they shall select the investigation committee no later than ten (10) days following the imposition of summary suspension; if the MEC cannot meet within that deadline, the chairperson of the MEC shall appoint the investigating committee.

6.6 CONDUCT OF INVESTIGATION

(a) Scope; Nature – The investigating committee shall diligently pursue the investigation, but the length of the investigation shall be dictated by the complexity of the underlying facts, the need to obtain the opinion of outside experts (if appropriate), and other relevant factors. The investigating committee may interview the appointee in question if the appointee agrees to an interview, but such interview shall be informal in nature and shall not constitute a hearing or give rise to any of the rights appurtenant to a hearing. The investigating committee may enlist the assistance of other committees (such as Quality Improvement, Utilization Management committee) in compiling information or data within the scope of such other committees' expertise. With the approval of the CEO, the investigating committee may obtain the review of outside experts. The members of the investigating committee shall cooperate in all aspects of the investigation and subsequent proceedings, including the presentation of findings and recommendations to the Governing Body if requested.

(b) Broadening the Investigation – If at any time during the investigation additional activities or conduct of the appointee come to light, they shall be included in the investigation. No additional notice to the appointee shall be required, however, unless the additional items are of a different nature than the other matters already under investigation.

(c) Report and Recommendation - Once the investigating committee believes that it has collected the available relevant facts, a designee of the investigating committee shall prepare written findings of fact and recommendations. The report and recommendation must be approved by a majority of the committee members participating in order to constitute the committee's report

and recommendation.

(d) Transmittal, Deadline – Upon completion of the report and recommendation, the committee chairperson shall forward the entire file, together with the committee's report and recommendation, to the CEO. The committee shall diligently conduct and complete the investigation and the report and recommendation. In the event that summary suspension has been imposed, the investigating committee shall submit its report and recommendation to the CEO by the later of, 1) thirty (30) days after the investigating committee was appointed, or 2) thirty (30) days after summary suspension was imposed.

6.7 MEDICAL EXECUTIVE COMMITTEE ACTION

(a) Review – At its next regular meeting following receipt of the investigating committee's report and recommendation, the MEC shall review the supporting materials, reports, and recommendations, and any other relevant information which is available. The committee may decide to defer action pending receipt of additional information.

(b) Deferral – If the MEC decides to defer action on the matter, the chairperson shall notify the CEO of additional information required. The CEO shall immediately deliver to the appointee in person or shall immediately sent to him/her by mail a letter informing him/her that the MEC has decided to defer action on the matter pending receipt of additional information and shall describe the information so requested. Upon receipt of the information so requested, the MEC may, but shall not be required to, consult with the investigating committee. It shall thereupon consider the full file and formulate its report and recommendation as set forth below. In the event that the appointee fails to provide the requested information within sixty days, the MEC shall formulate its report and recommendation as set forth below, but their recommendation shall take into account the applicant's failure to comply with Section 6.10(c) – Burden of Proof.

(c) Report and Recommendation – Following receipt of all necessary information and upon completion of the MEC's review of the file and formulation of a recommendation on the matter, a designee of the MEC shall prepare written findings of fact and recommendations. The report and recommendation must be approved by a majority of the committee members participating in order to constitute the committee's report and recommendation. The report and recommendation may recommend that special conditions be attached to the continued exercise of Clinical Privileges. The reasons for each finding of fact and recommendation shall be stated and supported with reference to the relevant portion of the file. The report shall set forth any minority views and the reasons and supporting references therefor.

(d) Transmittal, Deadline - Upon completion of the report and recommendation, the committee chairperson shall forward the entire file, together with the committee's report and recommendation to the CEO, who shall thereupon submit it to the Governing Body. The MEC shall make every reasonable effort to complete its report and recommendation within 30 days following receipt of all relevant information.

6.8 GOVERNING BODY DECISION

(a) Decision; Deadline – The Governing Body shall review the entire file and reach a proposed decision as to the appropriate action to take based upon the facts as reflected in the file.

The decision shall conform to the standards as set forth below. A designee of the Governing Body shall reduce the proposed decision to writing and shall set forth therein the reasons for the decision. The proposed decision must be approved by a majority of the members participating in order to constitute the Governing Body' proposed decision. The written decision shall not disclose any information which is or may be protected from disclosure to the Practitioner under applicable state or other laws. The Governing Body shall consider the appointee's case at their next regular meeting following the receipt of the MEC's report and recommendation or as soon thereafter as practical. The Governing Body shall make every reasonable effort to render its decision within thirty days following receipt of the MEC's recommendation. They shall proceed diligently to formulate a decision. In the event that summary suspension has been imposed, the Trustees shall render its decision by the later of 1) thirty days following receipt of the MEC's recommendation or 2) thirty days following imposition of summary suspension.

(b) Standards for Action

(1) Criteria for Taking Action – Appropriate action against the appointee shall be taken if the activities or professional conduct of the appointee are

- detrimental to patient safety,
- detrimental to the delivery of quality patient care established by the policies and procedures of the Hospital,
- indicative of unnecessary utilization of Hospital resources,
- disruptive to the efficient operation of the Hospital or any of its departments or services, or
- in violation of these Bylaws.

The activities or conduct forming the basis for any action need not have occurred at the Hospital. The Hospital retains the absolute right to increase its standards for Practitioners to take appropriate action against appointees who do not meet the higher standards.

(2) Structuring Appropriate Action – In determining the appropriate action to take, the needs of the appointee, the needs of the Hospital, and the needs of the patient shall all be considered, but the needs of the patient shall be of paramount importance. Other factors shall include, a) the appointee's capacity to alter the behavior or actions in question through education, therapy, rehabilitation, or other means; b) the appointee's desire to alter the behavior in question as judged by past course of conduct, prior warnings or action on similar matters, the appointee's expressed remorse, and other relevant evidence; and c) the inconvenience, cost, or danger which might exist to others as a result of granting the appointee an opportunity to alter the behavior or actions in question. Broad discretion is granted to formulate the action which is appropriate in each set of circumstances, and the action may include, but not be limited to, the following or any combination thereof:

- take no action,
- issue a warning or reprimand,

- require monitoring or proctoring,
- require consultations or other assistance,
- require successful completion of educational or rehabilitation programs,
- require the appointee to undergo periodic tests for suspected or actual substance abuse,
- require the appointee to undergo psychiatric evaluation or treatment,
- impose a period of probation,
- limit any aspect or portion of the appointee's Clinical Privileges,
- reduce the appointee's Clinical Privileges,
- suspend the appointee's Clinical Privileges,
- alter the appointee's Medical Staff category,
- terminate the appointee's Medical Staff appointment and Clinical Privileges.

(c) **Joint Conference Committee** – In the event that the Governing Body' proposed decision is different from the Medical Executive Committee's recommendation; the matter shall be reviewed by the joint conference committee. The joint conference committee shall be composed of two members of the MEC selected by the MEC and two members of the Governing Body selected by the Governing Body. The joint conference committee shall review the case and all supporting documentation and shall submit its written recommendation to the Governing Body The committee shall make every reasonable effort to submit its recommendation within thirty days following appointment of the committee. [membership?]

6.9 NOTICE OF GOVERNING BODY DECISION

(a) **Favorable Action** - In the event that the Governing Body' decision is favorable, such decision shall constitute the final action of the Hospital. The CEO shall promptly inform the Medical Staff Member of the decision. The decision to leave Medical Staff appointment, together with Clinical Privileges intact shall constitute a favorable action even if the continued exercise of Clinical Privileges is made contingent upon monitoring, proctoring, periodic drug testing, additional education concurrent with the exercise of Clinical Privileges, or any similar form of quality improvement that does not limit the appointee's ability to exercise his/her Clinical Privileges.

b) **Adverse Action** – In the event that the Governing Body' proposed decision is adverse (i.e., it is not "favorable" as described above), the appointee shall be entitled to a hearing except as set forth in Section 6.10(c) below. The shall immediately deliver to the appointee in person or shall immediately send to him/her by certified mail, return receipt requested, a letter enclosing the Governing Body' written proposed decision and containing a summary of the appointee's rights.

6.10 REAPPLICATION FOLLOWING TERMINATION

A Practitioner whose Medical Staff appointment is terminated shall not have the right to reapply for two years following the final decision of the Governing Body. A Practitioner whose Medical Staff appointment is not terminated but whose Clinical Privileges in one or more areas are terminated may reapply for the terminated Clinical Privileges only upon completion of additional education or experience relevant to the terminated Clinical Privileges.

6.11 CONFLICT OF INTEREST

(a) **Policy** – It is the policy of the Hospital to provide a procedure for reviewing each appointee whose activities have been the subject of investigation that is as fair as possible, considering the following factors:

- the size of the Medical Staff,
- the fact that some of the Medical Staff's most qualified appointees may serve as department chairpersons or as members of various committees reviewing the appointee's activities,
- the fact that input from Practitioners having adequate expertise in the appointee's field of practice is necessary but may inevitable constitute input from a competitor or potential competitor of the appointee.

All participants in the investigation and review process are hereby directed to act objectively in the best interest of the Hospital and the patients and not to be influenced by any personal prejudices or motives.

(b) **Participation in Process** – Unless no other practical alternative consistent with the purpose of these Bylaws exists, an individual who has participated as a committee member considering the matter shall not participate as a member of another committee considering the matter.

(c) **Competition** – To the extent reasonably practical, any individual in direct competition with the appointee shall not participate in the investigation or subsequent procedures. Notwithstanding the foregoing, a competitor may provide his/her opinion on the appointee's qualifications. In every case where a competitor does participate in any manner, his/her competition with the appointee shall be considered in assessing the objectivity of his/her views and opinions.

(d) **Other Measures** – If it is impossible to give the Medical Staff Member's case reasonably fair consideration due to conflicts of interest as described above, then, with the Governing Body's prior approval, either oneof the following measures may be taken:

(1) **Arbitrator or Mediator** – The hearing, if one is requested, may be conducted before an arbitrator or mediator mutually acceptable to the appointee and the chairperson of the Governing Body. In such case all reference to "hearing committee" shall mean

"arbitrator" or "mediator" where appropriate. The expenses and fees, if any, of the arbitrator or mediator, shall be borne equally by the Hospital and appointee.

(2) **Outside Expert** – The Hospital may at any stage of the proceedings, obtain the review of one or more medical charts of the appointee by an outside expert in the appointee's field of practice or in another relevant specialty. The use of outside experts is not limited to the situation described above regarding conflicts of interest, and the Hospital may obtain an expert opinion at any time with the Governing Body's prior approval..

Neither of the foregoing measures shall be available to a Medical Staff Member as of right, and it shall be entirely within the Governing Body'sdiscretion whether to use either measure. It is recognized that such measures may be prohibitively expensive and that the Hospital has a duty to preserve its resources to render affordable services to the community.

(e) **Disqualification of Appointee** – Under no circumstances shall the appointee participate in any manner in the review of his/her own case. If the investigation is on the chairperson of the MEC the vice chairperson of the MEC shall preside over the committee's consideration of the case.

6.23 AUTHORITY OF THE GOVERNING BODY

Notwithstanding any other provision hereof to the contrary, in the event that any person or committee fails to discharge his/her or its responsibilities hereunder, the Governing Body shall have the authority to take such action on its own.

ARTICLE VII

AUTOMATIC SUSPENSION OR TERMINATION

7.1 CAUSE FOR AUTOMATIC SUSPENSION OR TERMINATION

(a) **Revocation of License** – The Medical Staff appointment and Clinical Privileges of an appointee whose license to practice his/her profession in this state is terminated or revoked shall automatically and immediately be terminated. The appointee shall immediately inform the CEO regarding the change in status of his/her license.

(b) **Suspension of License** – The Medical Staff appointment and Clinical Privileges of an appointee whose license to practice his/her profession in this state is suspended, limited, or placed on probation shall automatically and immediately be suspended. The appointee shall immediately inform the CEO regarding the change in status in his/her license. The matter shall promptly be referred for investigation and further action (including the right to a hearing to the extent set for herein).

(c) **Revocation of DEA License** – The Medical Staff appointment and Clinical Privileges of an appointee whose Drug Enforcement Agency (DEA) license is terminated or revoked shall automatically and immediately be modified to revoke the right to prescribe medication covered by such a license. The appointee shall immediately inform the CEO regarding the change in status of his/her license.

(d) **Suspension of DEA License** - The Medical Staff appointment and Clinical Privileges of an appointee whose Drug Enforcement Agency (DEA) license is suspended or limited shall automatically and immediately be modified to suspend the right to prescribe medications covered by such a license. The appointee shall immediately inform the CEO regarding the change in status of his/her license. The matter shall promptly be referred for further investigation and further action (including the right to a hearing to the extent set forth herein).

(e) **Insurance** – The Medical Staff appointment and Clinical Privileges of an appointee whose professional liability insurance coverage ceases to comply with these Bylaws shall automatically and immediately be terminated. The appointee shall immediately inform the CEO regarding the change in insurance coverage.

(f) **Medical Records** – If a Medical Staff appointee fails to prepare or complete all delinquent medical records within seven days of being notified by the CEO or the appropriate Medical Staff committee that he/she has failed to prepare or complete his/her medical records in a timely fashion, his/her privileges to admit patients into the hospital shall automatically be suspended at the end of such seven-day period, except that the appointee may attend to any patient for whom he/she was the primary responsible Practitioner until such patient has been discharged or transferred. The suspension shall continue until all such records are prepared or completed unless the appointee satisfied the CEO that he/she has good cause for failure to prepare or complete the records on time. Repeated delinquency in preparing or completing medical records may lead to the complete loss of Medical Staff appointment and Clinical Privileges following an investigation (as to which the appointee shall have the right to a hearing to the extent set for herein.)

(g) Exclusive Practitioner Contracts – It is recognized that Exclusive Contracts may be necessary, appropriate and also in the best interest of efficient hospital management. It is also recognized that Exclusive Practitioner Contracts directly impact patient care and physician to physician relationships. The CEO has complete authority to enter in Exclusive Contracts. However, all Exclusive Contracts will be brought before the MEC and Governing Body, as advisory bodies, for comment and consideration prior to finalization of the contract.

(h) Failure to Reapply - The Medical Staff appointment and Clinical Privileges of a Practitioner shall automatically terminate if his/her term of appointment has expired and he/she does not currently have pending an application for reappointment.

(i) Failure to Request Reinstatement – The Medical Staff appointment of an appointee on leave of absence shall automatically terminate if he/she has expired and he/she fails to make a timely request for reinstatement or if he/she fails to provide a summary of his/her activities during the leave of absence.

(j) Ineligible to Participate in Federal Programs – The Medical Staff and appointment and Clinical Privileges of an appointee who has become an ineligible person or convicted of a criminal offense shall result in immediate automatic suspension from practicing in the Hospital and automatic termination of Medical Staff membership.

7.2 EFFECT OF AUTOMATIC TERMINATION OR SUSPENSION

(a) Notice to Affected Appointee – The termination or suspension of Medical Staff appointment and/or Clinical Privileges shall be effective immediately upon the occurrence of the triggering event even though notice has not yet been given to the appointee by the CEO. Nevertheless, the CEO shall promptly personally deliver to the affected appointee or send to him/her by certified mail, return receipt requested, a letter notifying him/her of the effect on his Medical Staff appointment and Clinical Privileges.

(b) Notice to Others – If the CEO's action was related to an Exclusive Contract, and if such action is required to be reported to any governmental or professional bodies, the notice to each such governmental or professional body shall explain the nature of the action and the fact that it was done for business or legal reasons and was thus unrelated to the Practitioner's qualifications or actions.

(c) No Hearing – A Practitioner is not entitled to a hearing or other review procedures with respect to automatic termination or suspension of his/her Medical Staff appointment and/or Clinical Privileges unless specifically provided for herein.

7.3 REAPPLICATION

An appointee whose Medical Staff appointment is terminated under this article shall not have the right to reapply for a period of two years following the automatic termination. Notwithstanding the foregoing, if the event triggering the termination was a decision by a third party (e.g., licensing body, Health Care Facilities Administration, or the DEA), and such third party or a court reverses the decision due to a finding that the underlying cause for the third party's action did not, in fact, occur, the Practitioner shall be entitled to reinstatement of Medical Staff appointment and Clinical Privileges at any time.

ARTICLE VIII

HEARING AND APPELLATE PROCEDURES

8.01 Application.

The hearing and appeal process described in this Article VIII shall apply to Practitioners with Medical Staff membership and/or privileges, and Practitioner applicants for such membership or privileges, subject to the limitations set forth in these Bylaws and any associated rules and policies. The hearing and appeal process described in this Section shall not apply to APPs or other health care professionals.

8.02 Events that Will Trigger the Hearing Rights.

A Practitioner who has applied for or holds Medical Staff membership or privileges may request a hearing pursuant to this Section whenever an adverse action as defined in these Bylaws is proposed by the MEC or Governing Body. No applicant or member shall be entitled to more than one hearing with respect to an adverse action. Hearings will be offered only when the MEC or Governing Body recommends taking one of the following actions based on a concern about the Practitioner's clinical competence or professional conduct that has adversely affected or could adversely affect the health or welfare of one or more patients:

a. Denial of appointment or reappointment to the Medical Staff.

b. Denial of application for, renewal of, or requested expansion of privileges.

c. Involuntary termination, restriction or reduction of privileges.

d. Involuntary suspension of Medical Staff membership or privileges lasting more than 14 days.

e. Any other adverse action that must be reported to the Oklahoma Board Medical Licensure or Supervision, the Oklahoma Board of Osteopathic Examiners. or the National Practitioners Data Bank except the practitioner's voluntary surrender, relinquishment, or restriction of Medical Staff membership or privileges, or the voluntary withdrawal of an application for the same

8.03 No Entitlement to a Hearing. No Practitioner shall be entitled to a hearing as a result of any action which is recommended or taken which is not reportable to theSstate or the National Practitioner Data Bank, including, but not limited to, the following:

a. Letters of warning, reprimand, or admonition;

b. Imposition of monitoring, proctoring, review or consultation requirements;

c. Requiring provision of information or documents, such as office records, or notice of events or actions;

d. Imposition of educational or training requirements;

e. Placement on probationary or other conditional status;

f. Appointment or reappointment for less than two (2) years;

g. Failure to place a practitioner on any on-call or interpretation roster, or removal of any practitioner from any such roster; or,

h. The refusal of the Governing Body to grant a request for a waiver or extension of time regarding the specialty board certification requirements

j. Termination of medical staff membership and/or clinical privileges as a result of matters which are not related to the Practitioner's professional qualifications, competence or conduct such as

i. failure to pay dues or assessments,

ii. Practitioners employment agreement or professional services agreement is terminated;

iii. failure to meet any objective requirement imposed on all staff members that specific numbers of procedures be performed to maintain or demonstrate clinical competence, or

iv. iii. the Hospital elects to enter into an exclusive contract for the provision of certain services.

If any action is taken which does not entitle the practitioner to a hearing, the practitioner shall be offered the opportunity to submit a written statement or any information which the practitioner wishes to be included in the practitioner's peer review records along with the documentation regarding the action taken.

8.04 Hearing and Appeal Procedure. A Practitioner who is entitled to the hearing and appeal procedure described in this Article VIII shall receive the procedural protections set forth in the Health Care Quality Improvement Act, 42 U.S.C. § 11112(b), as it shall be amended, including the following:

8.04.1 Notice of Proposed Action. A Practitioner who is subject to a proposed adverse action shall be given written notice that describes or explains the proposed adverse action to be taken against the Practitioner; the reasons for the proposed action; the Practitioner's right to request a hearing on the proposed action by submitting a written request to the CEO within 30 days; and the hearing rights described below.

8.04.2 Request for Hearing. A Practitioner may request a hearing within the time and pursuant to the process described in the notice of proposed action. A Practitioner who fails to timely request a hearing shall be deemed to have waived his or her hearing and appeal rights.

8.04.3 Notice of Hearing. If a hearing is timely requested, the subject Practitioner shall be given written notice that explains or describes the place, time and date of the hearing, which date shall not be less than 30 days after the date of the notice unless the Practitioner agrees otherwise. The Practitioner shall also be given a list of witnesses (if any) expected to testify at the hearing on behalf of the Hospital proposing the adverse action.

8.05 Conduct of Hearing.

If a hearing is timely requested:

a. The hearing shall be held before one of the following as determined appropriate by the Hospital acting through the CEO: an arbitrator mutually acceptable to the Practitioner and Hospital; a hearing officer who is appointed by Hospital and who is not in direct economic competition with the subject Practitioner; or a panel of individuals who are appointed by Hospital and who are not in direct economic competition with the subject Practitioner.

b. The subject Practitioner shall waive his or her hearing and appeal rights if he or she fails, without good cause, to appear at the scheduled hearing.

c. At the hearing, the subject Practitioner has the right to representation by an attorney or other person of the Practitioner's choice; to have a record made of the proceedings, copies of which may be obtained by the Practitioner upon payment of any reasonable charges associated with the preparation thereof; to call, examine and cross-examine witnesses; to present evidence determined to be relevant by the arbitrator, hearing officer, or hearing panel, regardless of its admissibility in a court of law; and to submit a written statement at the close of the hearing. If the subject Practitioner intends to be represented by an attorney at the hearing, the practitioner shall so advise the hearing officer at least ten days before the hearing.

8.06 Notice of Recommendation. Upon completion of the hearing, the subject Practitioner has the right to receive the written recommendation of the arbitrator, hearing officer, or hearing panel, including a statement of the basis for the recommendations.

8.07 Notice of Governing Body. The Governing Body shall consider the recommendation of the arbitrator, hearing officer, or hearing panel, and shall decide whether and to what extent adverse action should be taken against the Practitioner. The Practitioner is not entitled to attend, present evidence, or participate in the Governing Body's determination. The Governing Body shall notify the Practitioner in writing of its decision, including a statement of the basis for the decision.

8.08 Request for Reconsideration. Upon receipt of the Governing Body's decision, the subject Practitioner may submit a written request for reconsideration to the Governing Body within 30 days after receipt of the decision. The request shall explain the Practitioner's position concerning the Board's decision, including any alleged error in the hearing officer's recommendation or the Governing Body's decision. In submitting the request, the Practitioner shall not be entitled to present new or different evidence that was not presented at the hearing, and the Practitioner shall not be entitled to appear before the Board or to participate in any hearing before the Board. The Board shall consider the request and render a final decision within 30 days. The Board's decision shall be final.

8.09 Other procedures. The Practitioner and the Hospital proposing the adverse action may agree in writing to alternative procedures.

8.10 Rules. The MEC shall have authority to issue additional rules and policies concerning the hearing and appeal procedure, provided that such rules shall provide at least the procedural protections set forth in this Article unless waived by the subject practitioner.

8.11 Technical and Insignificant Deviations. Technical, insignificant or nonprejudicial deviations

from the procedures set forth in these bylaws and any associated rules or policies shall not invalidate the action taken.

8.12 Exhaustion of Remedies. If an adverse action is taken or recommended, the practitioner must exhaust the remedies afforded by these bylaws before resorting to legal action.

ARTICLE IX

MISCELLANEOUS

9.1 STAFF RULES AND REGULATIONS

The Medical Staff rules and regulations shall implement more specifically the general principles found within these Bylaws with regard to the Medical Staff. Such rules and regulations shall be a part of these Bylaws, and they shall be adopted, modified, and repealed by the MEC and Governing Body for final approval. They shall be reviewed and updated at least bi-annually.

9.2 POLICIES

Hospital policies may be promulgated, modified, or terminated by the Hospital Chief Executive Officer at any time and shall be promptly communicated to all affected Practitioners and APPs. The review period shall not exceed three (3) years.

9.3 INTERPRETATION

Words used in these Bylaws shall be read to include the masculine, feminine, and neutral genders and GBh the singular and plural forms as the context requires. The captions or headings are for convenience of reference only and are not intended to limit or define the scope or effect of any provision of these Bylaws. If any ambiguity or vagueness appears in these Bylaws, it shall be resolved in favor of best serving the needs of the patients and the community.

9.4 NO CONTRACT

Notwithstanding anything in these Bylaws to the contrary, these Bylaws are not intended to be a contract of any nature between the Hospital or its agents or Governing Body members and any other person or entity. Any appointments, Clinical Privileges, or prerogatives granted pursuant to these Bylaws are unilaterally extended by the Hospital subject to the terms, conditions, and limitations imposed and shall not create any rights, contractual or otherwise, in any person.

9.5 AMENDMENT OF BYLAWS

The Bylaws may be amended or repealed only by the following procedure:

(a) **Proposal** - An amendment to or repeal of these Bylaws may be proposed by any Medical Staff appointee, the Hospital Chief Executive Officer or any member of the Governing Body. Proposed Bylaw amendments must be submitted to the Hospital CEO, who will then coordinate with the Chief of Staff to appoint a committee to review the proposal and draft language.

(b) **Medical Staff Action** – Once the committee appointed to consider and draft a Bylaw amendment has submitted its report, the proposal shall be considered at the next regular meeting of the Medical Staff or shall be considered at a special meeting of the Medical Staff if one is called for that purpose pursuant to the requirements set forth in these Bylaws for calling a special meeting of the general Medical Staff. Regardless of whether the meeting is a regular or special meeting, the notice of the meeting shall refer to and have attached to it the proposal and the bylaws committee's report and recommendation. The notice of the meeting shall be personally delivered or mailed no less than thirty (30) days prior to the date of the meeting. Appointees with voting rights shall vote to approve the original proposal, to approve the bylaws committee's version of the proposal (if a modified version is recommended by the committee), or to disapprove the versions of the proposal. The number of affirmative votes necessary to approve a proposal shall be the simple majority. The results shall thereupon be transmitted promptly to the Governing Body.

(c) **Governing Body Action** - The version of the proposal approved by the Medical Staff shall be considered and voted on by the Governing Body. The number of affirmative votes necessary to approve a proposal shall be the same as for Governing Body votes in general. The Governing Body' approval shall not be unreasonably withheld.

(d) **Alternate Method** - If the Medical Staff refuses to consider a proposal for the amendment or repeal of these Bylaws following written direction of the Governing Body to discharge their duty to do so and the passage of a reasonable period of time for discharging their duty, the Governing Body may consider and vote upon the proposal unilaterally. If the Governing Body votes to adopt the proposal, it shall become immediately effective. In addition, if the bylaws committee and the Medical Staff give due consideration to a proposal to amend or repeal these Bylaws, but the Medical Staff votes to disapprove the proposal, and if the Governing Body determines that the passage of the proposal is necessary in order to comply with applicable law, or with the requirements of the Medicare or Medicaid programs or other programs of third-party payment, then the Governing Body may consider and vote upon the proposal unilaterally without the approval of the Medical Staff.

(e) **No Unilateral Amendment** - Other than as specifically set forth above, these Bylaws may not be amended or repealed without the approval of the Medical Staff or, the Governing Body

(f) **Documentation** - Amendments to these Bylaws approved as set forth herein shall be documented by either

(1) appending to these Bylaws the approved amendment, which shall be dated and signed by the Chief of Staff,and the chairperson or Secretary of the Governing Body, or

(2) restating these Bylaws, incorporating the approved amendment and all prior approved amendments which have been appended to these Bylaws since their last restatement, which restated Bylaws shall be dated and signed by the Chief of Staff, and, the chairperson or secretary of the Governing Body

If significant changes are made in the Bylaws, rules and regulations, or policies, medical staff members and other individuals who have delineated clinical privileges are provided with revised texts of the written materials.

9.6 SALE OF HOSPITAL

In the event that the Hospital, or the stock of the Corporation owning the Hospital, is sold, the purchaser shall have the right, at its option, to terminate these Bylaws.

REVIEW AND APROVAL
OF
MEDICAL STAFF BYLAWS

APPROVED BY THE MEDICAL STAFF ON

_____
Chief of Staff

APPROVED BY THE GOVERNING BODY ON

_____

Chairman of the Governing Body