

Bylaws of the Medical Staff of Community Hospital of Bremen

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ARTICLE I

PREAMBLE

These Medical Staff of the Community Hospital of Bremen ("Hospital"), ("Medical Staff") adopt these Medical Staff Bylaws ("Bylaws") in order to provide a framework for discharging its responsibilities to the Hospital Board of Directors ("Board") for matters involving the provision of high quality medical care to patients in the Marshall county, Indiana and surrounding community. These Bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Board of Directors and Hospital Administration, and relations with applicants to and members of the Medical Staff. These Bylaws are subject to the approval of the Board.

ARTICLE II

ESTABLISHMENT AND MISSION STATEMENT

2.1 The Medical Staff of Community Hospital of Bremen believes in providing high quality, compassionate care for patients at our Hospital. We will provide this care to all patients who enter our doors and will work as a team to do our very best for every patient. We will uphold these Bylaws and the related Rules and Regulations as they represent a code of proper conduct for a responsible Medical Staff. No Provider shall admit or provide medical or health-related services to any patient in the Hospital unless he or she has been appointed to the Medical Staff or granted temporary Medical Staff privileges. The Board shall, in the exercise of its discretion, delegate to the Medical Staff the responsibility for providing appropriate professional care to the Hospital's patients. The Medical Staff shall conduct a continuing review and appraisal of the quality of professional care rendered at the Hospital and shall report on such activities and their results to the Board.

2.2 The purpose(s) of the Medical Staff are to:

Assure that all patients admitted to or treated in the Hospital receive the highest quality medical care;

Assure a high level of professional performance of all Providers through the appropriate delineation of clinical privileges and through concurrent and retrospective review of each Provider's performance in the Hospital;

Foster the ongoing medical education of Providers by providing appropriate educational opportunities within the Hospital and by requiring self-directed continuing medical education;

Initiate and maintain Rules and Regulations; and

Provide a means whereby issues concerning the Medical Staff may be discussed with the Board and the Chief Executive Officer of the Hospital.

ARTICLE III

ULTIMATE AUTHORITY

The Board specifically reserves the authority to take any direct action that is appropriate with respect to the Medical Staff or any individual appointed to the Medical Staff. Actions taken by the Board may, but need not, follow the procedures outlined in the Medical Staff Bylaws and Rules and Regulations.

ARTICLE IV

DEFINITIONS

Allied Health Professional or AHP means any individually licensed health care provider who is not a Member of the Medical Staff but who may qualify to exercise specified clinical privileges within the Hospital. AHPs include Nurse Practitioners, Physicians Assistants, Podiatrists, Surgical First Assistants, Certified Registered Nurse Anesthetists, and other non-Physician Providers.

Appellate Review Body means a committee appointed by the Board under the Bylaws to hear a request for appellate review properly filed and pursued by a Provider.

Automatic Suspension means an immediate suspension or restriction of a Provider's Membership on the Medical Staff or all or any portion of a Provider's clinical privileges without a prior hearing for reasons related to administrative circumstances.

Board of Directors or Board shall mean the Board of Directors of Community Hospital of Bremen.

Chief Executive Officer or CEO means the individual appointed by the Board of Directors to act in its behalf in the overall management of the Hospital.

President means the individual duly elected by the Medical Staff to serve as the primary elected Medical Staff officer holding the responsibilities and obligations of Medical Staff Representative to the Hospital administration and Hospital Board of Directors.

Clinical Privileges mean Board-granted privileges and/or other circumstances pertaining to the provision of medical or other patient care under which a Provider is permitted to provide medical or other patient care services to patients at the Hospital and to utilize Hospital resources that are necessary to provide such medical or other patient care services.

Conflicted Medical Staff Member means a Member who is determined to be in direct economic competition with a Provider.

Consultation means the Provider's deliberation with one or more other Providers with respect to the diagnosis or treatment of any particular patient.

Dentists mean individuals who are licensed to practice dentistry in the State of Indiana, who are subject to the Health Care Quality Improvement Act of 1986, and who are Members of, or applicants to, the Medical Staff.

Director of Medical Staff Affairs (DMSA) means the individual appointed by the CEO to provide administrative oversight for the Medical Staff and to fulfill all responsibilities of a Chief Medical Officer. This individual need not be a Member and need not be the President of the Medical Staff, though both of these two positions MAY be held by the DMSA at the will of the Medical Staff Committee.

Hospital means the physical and functional entity of the Community Hospital of Bremen including the acute care Hospital (and any associated outpatient bed-containing units such as an rehabilitation, step-down, or long-term care areas), the Medical Office Suites, and any off-site medical facilities owned and/or operated by the Hospital.

Hospital Bylaws shall refer to Community Hospital of Bremen Bylaws.

Medical Executive Committee (MEC) means a subcommittee of the Medical Staff Committee comprised of the Medical Staff President, the Medical Staff Vice-President, and one at-large Member of the Medical Staff. The MEC also includes the CEO, ex-officio Vice President Nursing Services and ex-officio Vice President Quality.

Medical Staff Committee means all members in good standing of the Medical Staff, acting as a committee of the whole.

Medical Staff Member or Member means all Providers who are duly appointed by the Board as Members of the Medical Staff.

Medical Staff Bylaws or Bylaws shall refer to the Medical Staff Bylaws and related Medical Staff Rules & Regulations as duly approved by the Medical Staff and Board, as more specifically described in such documents.

Monitoring means the observation of a Provider in the course of his or her diagnosis or treatment of any particular patient. The specific method of observation may be broadly defined by the Medical Staff to best serve the purposes of assuring high quality patient care.

Number of Days or Days mean "calendar days" (i.e. including Saturday, Sunday and legal holidays) unless the due date falls on a Saturday, Sunday or legal holiday, in which event the due date shall be the first day immediately following which is not a Saturday, Sunday or legal holiday.

Party or Parties means the Provider(s) who requested the evidentiary hearing or appellate review and the body or bodies upon whose Adverse Decision or Action a hearing or appellate review request is predicated.

Peer Review Committee or Professional Review Body or Quality Committee means the Board, the MEC, any committee of the Medical Staff or Board, or their designated agents having the responsibility for evaluation, recommendation or making a determination concerning qualifications of a Provider, patient care rendered by a Provider or the merits of a complaint

against a Provider. Peer Review Committee or Professional Review Body functions shall include the review of competence and professional conduct of Providers leading to determinations concerning the granting of clinical privileges or Medical Staff Membership, the scope and condition of such clinical privileges or Membership, and the modification of such clinical privileges or Membership.

Personnel of Peer Review Committee means not only members of a Peer Review Committee, but also all of such committee's employees, representatives, agents, attorneys, investigators, assistants, clerks, staff, and any other person or organization who serves such Peer Review Committee in any capacity, including any person under contract or other formal agreement.

Physicians mean doctors of medicine and osteopathy who are licensed to practice medicine in the State of Indiana, who are subject to the federal Health Care Quality Improvement Act of 1986, and who are Members of, or applicants to, the Medical Staff.

Podiatrists mean individuals who are licensed to practice podiatry in the State of Indiana and who are Members of, or applicants to, the Medical Staff.

Provider means an appropriately licensed Physician, dentist, or allied health professional whose activities fall under the oversight of the Medical Staff Bylaws.

Proctoring means the direct supervision of, and recommendations and directions to a Provider with respect to the diagnosis, treatment or management of any particular case.

Professional Review Action means an action or recommendation of a Peer Review Committee which is taken or made based upon a Provider's competence or professional conduct in the conduct of Professional Review Activity or Peer Review Activity that is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician or dentist (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges, or Membership at the Hospital of the physician or dentist. Such term includes a formal decision of a professional review body not to take an action or make a recommendation described in the previous sentence and also includes professional review activities relating to a professional review action.

Professional Review Activity or Peer Review Activity means any of the functions of a Peer Review Committee including a formal decision of such a committee not to take an action or make a recommendation.

Related Manuals means the manuals that are a part of the Medical Staff Bylaws and include the Medical Staff Rules and Regulations.

Special Notice means written notification sent by certified or registered mail, return receipt requested and/or personally delivered by hand. All requests, statements and other communications made by Special Notice shall be copied to the President, Vice-President, and the CEO.

ARTICLE V

MEDICAL STAFF MEMBERSHIP

5.1 Nature of Medical Staff Membership

Membership on the Medical Staff of Community Hospital of Bremen is a privilege which shall be extended only to professional, competent physicians who continuously meet the qualifications, standards, and requirements set in these Bylaws. Additionally, Membership is extended only to those Physicians with a genuine interest in serving the Bremen community, not to fill requirements only needed to serve in a remote community or with no interest in active involvement with the Medical Staff.

5.2 General Qualifications for Membership

5.2-1 Medical Staff Membership shall include only Physicians licensed to practice in the State of Indiana who satisfactorily:

- a) Document their background, experience, training, and demonstrated competence
- b) Agree to adhere to the ethics of their professions and to work cooperatively and effectively with others to the reasonable satisfaction of the Medical Staff and the Board of Directors that any patient treated by them in the Hospital will be given a high quality of medical care; and
- c) Having received a medical degree in 1980 or after, shall have completed a residency program accredited by the Accrediting Council of Graduate Medical Education (or as grandfathered by accreditation prior to 2015 from the American Osteopathic Association) in the area of specialization in which they choose to practice. Applicants who have received a medical degree prior to 1980, or who are applying for privileges in areas other than those in which they have formal training will be required to present documentation acceptable to the Medical Staff of adequate training in the area in which they are requesting privileges.

5.2-2 An applicant for Membership on the Medical Staff must hold an MD or DO degree issued by a medical or osteopathic school approved at the time of the issuance of such degree by the Medical Licensing Board of Indiana and must also hold a valid and unlimited Indiana license to practice medicine. Physicians who have had limitations or restrictions placed on their licenses may continue to hold Membership on the Medical Staff, if jointly approved by the Board and the Medical Staff and must meet the following specific guidelines:

- a) Document their (1) current licensure, (2) adequate experience, education, and training, (3) current professional competence, (4) good judgment, and (5) adequate physical and mental health status, so as to demonstrate to the satisfaction of the Medical Staff that they are professionally and ethically

competent and that patients treated by them can reasonably expect to receive quality medical care;

- b) Agree (1) to adhere to the ethics of their profession (2) to work cooperatively and effectively communicate with others so as not to affect patient care adversely, and (3) to participate in and properly discharge those responsibilities determined by the Medical Staff;
- c) Submit proof that he or she has qualified as a health care provider under Indiana's Medical Malpractice Act.

5.3 Particular Qualifications

- 5.3-1 Denial of admission to or removal from the Medical Staff of another licensed hospital due to issues of professional competency or conduct or violation of professional ethics may automatically disqualify an applicant for admission to the Medical Staff. Additionally, discovery of such activity once appointed to the Medical Staff may result in immediate automatic suspension of privileges pending additional investigation.
- 5.3-2 The applicant shall have his/her practice in the Marshall county, Indiana community or within a reasonable distance from this Hospital.
- 5.3-3 The applicant shall submit a "pre-application" certifying their understanding of the Nature of Medical Staff Membership, their agreement and ability to comply with these General and Particular Qualifications, and their willingness to comply with the responsibilities of Membership including to comply with these Bylaws and the related Rules and Regulations.

5.4 Effect of other Affiliations

No person shall be entitled to Membership on the Medical Staff merely because he or she holds a particular degree, is licensed to practice in Indiana or in any other state, is a member of any professional organization, is certified by any clinical board, is a resident of the community served by the Hospital, or because such individual had, or presently has, membership or clinical privileges at another licensed health care facility.

5.5 Nondiscrimination

No aspect of Medical Staff Membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, or national origin.

5.6 Basic Responsibilities of Membership

The ongoing responsibilities of each Member of the Medical Staff shall include;

- 5.6-1 Providing patients with a quality of care meeting the professional standards of the Medical Staff of this Hospital.

- 5.6-2 Abiding by the Medical Staff Bylaws and Medical Staff Rules and Regulations and the Hospital Bylaws and Hospital Policies.
- 5.6-3 Discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of Medical Staff Membership, including committee assignments.
- 5.6-4 Preparing and completing in timely fashion appropriate and accurate medical records for all the patients to whom the member provides care in the Hospital.
- 5.6-5 Abiding by the lawful and ethical principles of the American Medical Association or the American Osteopathic Association.
- 5.6-6 Aiding in any Medical Staff approved educational programs for medical student, interns, resident Physicians, and non-Physician Providers.
- 5.6-7 Working cooperatively with Members, nurses, Hospital administration and others so as not to affect patient care adversely.
- 5.6-8 Making appropriate arrangements for coverage of patients as determined by the Medical Staff.
- 5.6-9 Refusing to engage in improper inducements for patient referral.
- 5.6-10 Participating in continuing education programs as determined by the Medical Staff.
- 5.6-11 Participating in such emergency service coverage or consultation panels as may be determined by the Medical Staff.
- 5.6-12 Notifying the Medical Staff and the Hospital administration of any adverse actions taken against the Physician by any health care facility, state licensure board, drug enforcement administration, Indiana Pharmacy Board, or court of law in a malpractice action.
- 5.6-13 Maintain eligibility to participate in Medicare, Medicaid and other governmental programs.
- 5.6-14 Discharging such other staff obligations as may be lawfully established from time to time by the Medical Staff.

ARTICLE VI

CATEGORIES OF MEDICAL STAFF

6.1 Active Medical Staff

- 6.1-1 The Active Medical Staff shall consist of Physicians who:

- a) Regularly admit or ~~are involved in the care of patients in the Hospital; are involved in the care of at least 8 patients in the hospital per two (2) year appointment cycle;~~
- b) ~~Who~~ are located within forty (40) minutes of~~closely enough to~~ the Hospital to provide continuous care to their patients; and
- c) ~~Who assume all the functions and responsibilities of Membership on the Active Medical Staff, including where appropriate, emergency service and consultation assignments.~~ take call for inpatients and outpatient follow-up;
- d) assume all the functions and responsibilities of Membership on the Active Medical Staff, including where appropriate, emergency service and consultation assignments;
- e) pay dues as may be required.

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6.1-2 Members of the Active Medical Staff shall be appointed to a specific department, shall be eligible to vote, to hold office and to serve on Medical Staff subcommittees, and as department chairs. Active members shall be required to attend seventy-five percent (75%) of ~~and shall be required to attend~~ Medical Staff meetings. Members of the Active Medical Staff agree to actively participate in patient care audits, peer and quality review processes, utilization review, quality assurance, and other monitoring activities in supervising initial appointees of the same profession.

6.2 Associate Medical Staff

6.2-1 The Associate Medical Staff shall consist of Physicians qualified for staff Membership, but who:

- a) ~~Only occasionally admit patients to the Hospital; or admit fewer than eight (8) patients per two year appointment cycle; or~~
- b) ~~who~~ act only as consultants;
- c) ~~may provide inpatient care;~~
- d) ~~are not requested to take inpatient call but takes call for outpatient follow-up;~~
- e) pay dues as may be required.

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6.2-2 ~~It is anticipated that most Associate Medical Staff Members will have at least 4-6 patient contacts in any 2 year reappointment cycle. Physicians with fewer patient contacts will be reviewed for the need for ongoing Membership at the time of their reappointment.~~ Associate Medical Staff Members shall be appointed to

specific departments. They are not eligible to hold Medical Staff office, vote or serve as department chairs. Committee participation is encouraged but not required. Associate Staff may not supervise initial appointees of the same profession. Associate members must submit outpatient quality logs as may be required by the Medical Staff.

~~6.2-3 Associate Staff members who provide primary care services must attend not less than twenty-five (25%) of Medical Staff meetings. Specialty physicians in the Associate category must attend at least one Medical Staff meeting per calendar year. Associate Medical Staff Members shall be appointed to specific departments and shall be eligible to vote when in attendance at Medical Staff Meetings.~~

~~6.2-4 Associate Medical Staff Members may not hold an elected office in the Medical Staff organization but are still encouraged to serve on Medical Staff committees.~~

6.3 Emeritus Medical Staff

6.3-1 The Emeritus Medical Staff shall consist of Physicians who:

- a) Are not active in the Hospital; or
- b) Hold honorary positions; or
- c) Have retired from active Hospital practice and who are of outstanding reputation, not necessarily residing in the community.

6.3-2 Emeritus Staff Members shall not be eligible to admit patients, to vote, hold office or to serve on standing Medical Staff subcommittees.

6.3-3 Physicians may be nominated for Emeritus Staff status by any Active Medical Staff Member and accepted into Emeritus Medical Staff status by a majority vote of the Medical Staff Committee and approval of the Board.

6.4 Changes in Medical Staff category

6.4-1 If there has been no (or negligible) inpatient volume for a given Physician in any 2 year cycle, that Physician may be reduced or removed from both Active and Associate status without prejudice and without mandatory reporting to the National Practitioner Data Bank.

ARTICLE VII

ALLIED HEALTH PROVIDERS

7.1 Allied Health Providers shall consist of non-Physician medical providers who do not have clinical privileges to admit patients to the Hospital, but who do have clinical privileges to perform certain procedures in the Hospital. AHPs holding a license,

certificate or other appropriate credentials, if any, as required or permitted by Indiana law, which authorizes an AHP to provide certain professional services, are eligible for clinical privileges and Staff Membership. AHPs are not eligible to vote or hold office within the Medical Staff organization.

7.2 Eligibility

7.2-1 AHPs may qualify for specified clinical privileges if they provide adequate documentation of:

- a) Qualify as a "health care provider" under Indiana Code 34-18-2-14;
- b) An unlimited Indiana licensure or registration in their profession where applicable;
- c) Relevant Education, training, experience and demonstrated competence;
- d) Adherence to the ethics of their professions, and their good reputations;
- e) Ability to work with others in a cooperative, professional manner in the provision of patient care;
- f) Maintaining their practice within the service area of the Hospital;
- g) Ability to make efficient use of Hospital facilities so as not to jeopardize the financial stability of the Hospital; and
- h) Good physical, mental and emotional health.

7.2-2 The documentation provided by the AHP provider must be sufficient to assure the Medical Staff and Board that any patient treated by the AHP in the Hospital will be given an appropriate level of medical care.

7.2-3 No AHP shall be entitled to exercise privileges in the Hospital merely by virtue of the fact that he or she is duly licensed to practice his or her profession in this or another state, or that he or she is a member of any professional organization, or that he or she had in the past, or presently has such clinical privileges at this or another Hospital.

7.2-4 No decision on appointment as an AHP with specific clinical privileges will be influenced by an applicant's sex, race, age, creed, color, or national origin.

7.3 Obligations of Allied Health Providers

7.3-1 Application for and/or acceptance of privileges as an AHP shall constitute the agreement of the applicant or AHP to:

- a) Abide by the code of ethics which governs his or her professional organization;

- b) Abide by all of the terms and provisions of these Bylaws as they now exist or as they shall be amended;
- c) Authorize the Members of the Medical Staff as agents of the Board to investigate and to gather any information concerning the AHP with regard to his or her qualifications to exercise privileges in the Hospital;
- d) Authorize all persons and organizations to release such information to the Board, its agents and/or employees;
- e) Release and hold harmless all persons, organizations, the Hospital, Board, its agents and employees and all others who participate in good faith in providing or receiving such information regarding the applicant or Provider;
- f) Abide by the credentialing and peer review process of the Medical Staff, although AHPs shall not be Members of the Medical Staff, shall not vote in Medical Staff elections or deliberations, are not required to attend Medical Staff meetings and are not required to serve on Medical Staff committees.

ARTICLE VIII

APPOINTMENT AND REAPPOINTMENT

8.1 Application for Appointment

8.1-1 The application process for appointment to the Medical Staff shall be as follows :

- a) Initial submission of a satisfactory pre-application and Statement of Interest that will clarify the candidate's appropriateness for application. Once these brief documents are found to be acceptable, then the application packet will be sent.
- c) Submission of application in writing and signed by the applicant on a form prescribed by the Board of Directors after consultation with the Medical Executive Committee.

8.1-2 The prescribed application form will provide for submission of a summary. This includes the Medical Staff applicant's education, names of institutional positions held, dates of services, and relevant data regarding license. Additional information shall be provided related to the following:

- a) Involvement in any professional liability actions;
- b) Previously successful or currently pending challenges to any licensure, registration, clinical privileges or ability to participate in any governmental programs;

- 8.1-3 The Medical Staff applicant shall have the burden of producing adequate information for a proper evaluation of his/her competence, character, ethics, and other qualifications, for resolving any doubts about such qualifications.
- 8.1-4 The completed application shall be submitted to the Medical Staff Coordinator along with a \$200 non-refundable application fee (to be held in an appropriate sub-account of the Hospital Foundation). After collecting the references and other materials deemed pertinent, the Medical Staff Coordinator shall transmit the application and all supporting materials to the Quality Committee. This will include a query of the National Providers Data Bank for any report on file. A criminal check shall be performed on original applications.
- 8.1-5 By applying for appointment to the Medical Staff, each applicant thereby signifies:
- a) A willingness to appear for interviews in regard to his/her application;
 - b) Consent to the Hospital consulting with Members of Medical Staffs of other Hospitals with which the applicant has been associated and with others who may have information bearing on his/her competence, character, and ethical qualifications;
 - c) Consent to the Hospital's inspection of all peer review records related to the applicant including access to the Indiana Peer Review Organization records, and documents that may be material to an evaluation of professional conduct and/or competence to carry out the clinical privileges requested and to assess the applicant's moral and ethical qualifications for staff Membership.
 - d) Releasing the Hospital and all representatives of the Hospital and its Medical Staff from any liability for acts performed in good faith and without malice concerning the applicant's competence, ethics, character, and other qualifications for staff appointment and clinical privileges, including otherwise privileged or confidential information.
- 8.1-6 The application form shall include a statement that the applicant:
- a) Has received and read these Bylaws , Rules and Regulations of the Medical Staff; and
 - b) Agrees to be bound by the terms thereof if he or she is granted Membership and/or clinical privileges and to be bound by the terms thereof without regard to whether or not applicant is granted Membership and/or clinical privileges in all matters relating to consideration of his or her application.
- 8.1-7 The application form shall contain a statement regarding the applicant being free of or with reasonable accommodation, will have under adequate control any significant physical, mental, emotional, or behavioral impairment that would

otherwise interfere with, or present a substantial probability of interfering with his/her ability to safely and competently exercise those privileges.

- 8.1-8 The Medical Staff may require a Medical Staff applicant or Medical Staff Member to be examined by a physician or other appropriate clinician if it has reason to believe that the applicant's or Member's health status may be such as to interfere with or present a substantial probability of interfering with such Physician's ability to safely and/or competently exercise privileges.

8.2 Appointment Process

- 8.2-1 Within ninety (90) days after receipt of a completed application for Membership, the Quality committee shall make a written report of its investigation to the Medical Staff Committee. Prior to making this report, the Quality committee shall examine the evidence of the character, professional competence, qualifications and ethical standing of the Provider and shall determine, through information contained in references given by the Provider and from other sources available to the committee, in which privileges are sought, whether the Provider had established and meets all necessary qualifications for the category of Medical Staff Membership and the clinical privileges requested by him or her.
- 8.2-2 Every department in which the Provider seeks clinical privileges shall provide the Quality committee with specific, written recommendations for delineating the Provider's clinical privileges, and these recommendations shall be made a part of the report. Together with its report, the Quality committee shall transmit to the Medical Staff Committee the completed application and a recommendation that the Provider be either appointed to the Medical Staff as an Active, Associate, or Affiliate Member, rejected for Medical Staff Membership, or that the application be deferred for further consideration.
- 8.2-3 At its next regular meeting after receipt of the application and the report and recommendation of the Quality committee, the Medical Staff Committee shall determine whether to recommend to the Board of Directors that the Provider be appointed to the Medical Staff Membership, or that the application be deferred for further consideration. All recommendations to appoint must also specifically recommend the clinical privileges to be granted, which may be qualified by probationary conditions relating to such clinical privileges.
- 8.2-4 When recommendation of the Medical Staff Committee is to defer the application for further consideration, it must be followed up within sixty (60) days with a subsequent recommendation for appointment to the Medical Staff with specified clinical privileges or for rejection for Medical Staff Membership.
- 8.2-5 When the recommendation of the Medical Staff Committee is favorable to the Provider either in respect to appointment or clinical privileges, the Chief Executive Officer shall promptly forward it, together with all supporting documentation, to the Board of Directors.

- 8.2-6 When the recommendation of the Medical Staff Committee is adverse to the Provider, either in respect to appointment or clinical privileges, the CEO shall promptly so notify the Provider by certified mail, return receipt requested. No such adverse recommendation need be forwarded to the Board of Directors until after the Provider has exercised or has been deemed to have waived his/her right to a hearing as provided in these Bylaws.
- 8.2-7 If, after the Medical Staff Committee has considered the recommendation of the Hearing Committee and if the Medical Staff Committee's reconsidered recommendation is favorable to the Provider, it shall be processed as would any other application. If such recommendation continues to be adverse, the CEO shall promptly so notify the Provider, by certified mail, return receipt requested. The CEO shall also forward such recommendation and documentation to the Board, but the Board shall not take any action thereon until after the Provider has been deemed to have waived his/her right to an appellate review as provided for in these Bylaws.
- 8.2-8 At its next regular meeting after receipt of favorable recommendations, if the decision of the Board is adverse to the Provider in respect to either appointment or clinical privileges, the Chief Executive Officer shall promptly notify him/her of such adverse decision by certified mail, return receipt requested, and such adverse decision shall be held in abeyance until the Provider has exercised or has deemed to have waived his/her rights as outlined in these Bylaws and until there has been compliance with all sections of these Bylaws. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.
- 8.2-9 At its next regular meeting after all of the Provider's rights have been exhausted or waived, the Board's decision shall be conclusive, except that the Board may defer final determination by referring the matter back for further reconsideration. Any such referral back shall:
- a) State the reasons for referral back to the Medical Executive Committee;
 - b) Set a time limit within which a subsequent recommendation to the Board of Directors shall be made; and
 - c) May include a directive that an additional hearing be conducted to clarify issues in doubt.
- 8.2-10 At its next meeting after receipt of either such subsequent recommendation or of new evidence in the matter, if any, the Board shall make a decision either to provisionally appoint the Provider to the Medical Staff or to reject him/her for Membership on the Medical Staff. All decisions to appoint shall include a delineation of the clinical privileges which the Provider may exercise.

8.2-11 Upon a final decision by the Board, it shall send notice of such decision through the CEO to the President, the department representative concerned, and by certified mail, return receipt requested to the Provider.

8.3 Reappointment Process

8.3-1 Each Member applying for reappointment and AHP applying for clinical privileges shall be provided with forms for use in consideration for reappointment and for delineation of clinical privileges, so as to provide appropriate opportunity for completion and delivery to the Medical Staff Coordinator sixty (60) days prior to the end of the Medical Staff year.

8.3-2 Failure without good cause to return a satisfactorily completed form prior to the end of the Medical Staff year will result in expiration of Membership at the end of such Medical Staff year.

8.3-2 Prior to the final rescheduled Board meeting in the Medical Staff year, the Quality committee shall review all pertinent information available on each Provider scheduled for periodic appraisal for the purpose of determining its recommendation for reappointment to the Medical Staff and for the granting of clinical privileges for the ensuing period, and shall transmit its recommendations, in writing, to the Medical Staff Committee. Where non appointment or a change in clinical privileges is recommended, the reason for such recommendation shall be stated and documented.

8.3-3 Each recommendation concerning the reappointment of a Medical Staff Member and the clinical privileges to be granted upon reappointment shall be based upon the Medical Staff Members’:

- a) Professional competence and clinical judgment in the treatment of patients;
- b) Ethics and conduct;
- c) Physical and mental capabilities;
- d) Continuing medical education;
- e) Attendance at Medical Staff meetings;
- f) Participation in staff affairs;
- g) Compliance with the Hospital Bylaws and Rules and Regulations
- h) Cooperation with the Hospital personnel;
- i) Use of Hospital facilities for his or her patients;
- j) Relations with other Providers;
- k) General attitude toward patients, the Hospital and the public;
- l) Appropriateness of admission to the Hospital;
- m) Results of utilization review;
- n) Use ancillary diagnostic services;
- o) Use of discharge planning, length of stay, and consultations, and other factors related to the appropriate utilization of Hospital and physician services; and
- p) Information as reported in the National Provider Data Bank.

8.3-4 At least thirty (30) days prior to the final scheduled Board meeting in the Medical Staff year, the Medical Staff Committee shall make written recommendation to

the Board, through the CEO, concerning the appointment, non-reappointment, and/or clinical privileges of each Provider then scheduled for periodic appraisal. Where non-reappointment of a change in clinical privileges is recommended, the reasons for such recommendations shall be stated and documented.

8.4 Effect of Application.

8.4-1 By applying for appointment or reappointment to the Medical Staff, or for advancement in Medical Staff category, or for particular clinical privileges or changes in clinical privileges, the affected Applicant or Medical Staff Appointee:

- a) Authorizes the Hospital to solicit and act upon information, including peer review and other privileged or confidential information, provided by third parties bearing on his or her credentials and agrees that any information so provided shall not be required to be disclosed to him or her if the third party providing such information does so on the condition that it be kept confidential.
- b) Authorizes third parties to release information, including peer review and otherwise privileged or confidential information, as well as reports, records, statements, recommendations and other documents in their possession, bearing on his or her credentials to any Hospital representative, and consents to the inspection and procurement by any Hospital representative of such information, records and other documents.
- c) Authorizes the Hospital and Hospital representatives to release peer review and other information, when requested by the applicant, to other healthcare entities and their agents, who solicit such information for the purpose of evaluating the Medical Staff applicant's professional qualifications pursuant to the individual's request for appointment, reappointment or clinical privileges.
- d) Authorizes the Hospital to maintain relevant credentialing information concerning the applicant or Medical Staff appointee in a centralized physician data base for the purpose of making aggregate physician information available for use by the Hospital and its affiliates.
- e) Authorizes the Hospital to release confidential information, including peer review and/or quality assurance information, obtained from or about the applicant or Medical Staff appointee to peer review committees of the Hospital and affiliates .
- f) Agrees to appear for a personal interview at any reasonable time requested by any Hospital or Medical Staff representative.

- g) Consents to the reporting by any Hospital representative of information to the National Data Bank established pursuant to the Health Care Quality Improvement Act of 1986 which such Hospital representative believes in good faith is required by law to be reported.
- h) Releases from any liability (1) all Hospital representatives for their acts performed in connection with evaluating his or her credentials or releasing information to other institutions for the purpose of evaluating his or her credentials, in compliance with these Bylaws; and (2) all third parties who provide information, including otherwise privileged or confidential information, to the Hospital and Hospital representatives concerning his or her credentials, unless such information is false and the third party providing it knew it was false.
- i) Agrees that, if any adverse decision is made with respect to his or her Membership or clinical privileges, (1) he or she will follow and exhaust the administrative remedies afforded by these Bylaws and the Fair Hearing procedures contained herein as a prerequisite to any other action, and (2) he or she will have the burden of demonstrating that he or she meets the standards for appointment or continued appointment to the Medical Staff or for the clinical privileges requested.
- j) Agrees that the foregoing provisions are in addition to any agreements, understandings, covenants, waivers, authorizations or releases provided by law or contained in any application or request forms.

ARTICLE IX

CLINICAL PRIVILEGES

9.1 Exercise of Privileges.

Every Member or Provider providing medical services or otherwise practicing at the Hospital by virtue of Medical Staff Membership or granting of clinical privileges as an AHP, shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted to him or her by the Board, except in an emergency or as provided for under "temporary privileges" below.

9.2 Requests

9.2-1 Every initial application for Staff appointment must contain a request for the specific clinical privileges desired by the applicant. The evaluation of such request shall be based upon the applicant's education, training, experience,

demonstrated competence, references, and other relevant information, including appraisal by the clinical department in which such privileges are sought. Only clinical privileges in areas or procedures that can be adequately supported by the Hospital in terms of appropriate support staff, nursing skill level and equipment availability may be granted. Information contained in the applicant's individual appraisal record will be reviewed and considered as part of the reappointment process. The applicant shall have the burden of establishing his/her qualifications and competency in the clinical privileges he/she requests.

9.3 Basis for Privileges Determination

- 9.3-1 Requests for clinical privileges shall be evaluated on the basis of the member's education, training, experience, demonstrated professional competence and judgment, clinical performance, and the documented results of patient care and other quality review and monitoring which the Medical Staff deems appropriate. Privilege determination may also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a member exercises clinical privileges.
- 9.3-2 Periodic re-determination of clinical privileges and the increase or curtailment of same shall be based upon the direct observation of care provided, review of the records of patients treated in this or other Hospitals and review of the records of the Medical Staff which document the evaluation of the Member's participation in the delivery of medical care.

9.4 Temporary Privileges

- 9.4-1 Upon receipt of an application for Medical Staff Membership from an appropriately licensed Provider, the Chief Executive Officer may, upon the basis of information then available which may be reasonably relied upon as to the competence and ethical standing of the applicant, and with concurrence of the MEC, grant temporary admitting and clinical privileges to the applicant; but in exercising such privileges, the applicant shall act under the supervision of the Chairman of the Department to which he or she is assigned.
- 9.4-2 Temporary clinical privileges may be granted by the Chief Executive Officer for the care of a specific patient to a Provider who is not an applicant for Membership in the same manner as set forth in the above section provided that there shall first be obtained such Provider's signed acknowledgement that he/she:
- a) Has received and read copies of these Bylaws and Rules and Regulations; and
 - b) Agrees to be bound by the terms thereof in all matters relating to receiving temporary clinical privileges.

Such temporary privileges shall be restricted to the period of not more than ninety (90) days in any one year by any Provider after which such Provider shall be

required to apply for Membership on the Medical Staff before being allowed to care for additional patients.

- 9.4-3 The CEO may permit a Physician serving a locum tenens for a Member of the Medical Staff to care for patients without applying for Membership on the Medical Staff for a period not to exceed ninety (90) days, providing all of his/her credentials have first been approved by the Quality committee.
- 9.4-4 Special requirements of supervision and reporting may be imposed by the MEC with input from Physicians practicing in the same specialty as the applicant concerning any Provider granted temporary privileges. Temporary privileges shall be immediately terminated by the Chief Executive Officer upon notice of any failure by the Provider to comply with such special conditions.
- 9.4-5 The CEO may at any time, and with the consultation of the MEC, terminate a Provider's temporary privileges effective as of the discharge from the Hospital of the Provider's patient(s) then under his/her care in the Hospital. However, where it is determined that the life or health of such patient would be endangered by continued treatment by the Provider, the termination may be imposed by any person entitled to impose a summary suspension, and the same shall be immediately effective. The MEC shall assign a Member of the Medical Staff to assume responsibility for the care of such terminated Provider's patient(s) until they are discharged from the Hospital. The wishes of the patient(s) shall be considered in selection of such substitute Provider.

9.5 Emergency Privileges

In the case of an emergency, any Member of the Medical Staff, to the degree permitted by his/her license and regardless of service, staff status or lack of it, shall be permitted and assisted to do everything possible to save the life of a patient, using every facility of the Hospital necessary, including the calling for any consultation necessary or desirable. When an emergency situation no longer exists, such Provider must request the privileges necessary to continue to treat the patient. In the event such privileges are denied or he/she does not desire to request privileges, the patient shall be assigned to an appropriate Member of the Medical Staff. For the purpose of this section, an "emergency" is defined as a condition in which serious, permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

ARTICLE X¹

ALLEGATIONS OF SEXUAL HARASSMENT

- 10.1 "Sexual harassment" is defined as any action taken by a manager or supervisor that conditions any aspect of employment on acceptance of sexual advances or favors; and or the creation, by anyone, regardless of position, of a hostile work environment, due to unwanted sexual jokes, advances, touching, lewd behavior, leering, etc. Victims of sexual harassment are not limited to employees, but may include anyone of either gender

who is the target of any of the above actions, or overhear improper comments, or observe such actions that offend them.

- 10.2 Sexual harassment may result in criminal liability. Should a Member of the Medical Staff become aware of an alleged incident of sexual misconduct, he or she should immediately make the information known to the CEO. All reports of inappropriate conduct will be handled promptly, impartially, and with appropriate regard to confidentiality. In appropriate circumstances, allegations of sexual harassment shall be forwarded to law enforcement authorities. If the Hospital conducts an internal investigation, each Physician, regardless of whether he/she is identified as a witness or as an individual alleged to have engaged in inappropriate conduct, shall cooperate fully with the investigation. No individual making a good faith report or participating in an investigation shall be subject of retaliation for doing so.
- 10.3 The Hospital will take prompt and effective action to provide a workplace free from sexual harassment. This may include, but is not limited to, pursuing remedial action in accordance with the Medical Staff Bylaws and/or suspending a Physician's privileges at Community Hospital of Bremen.
- 10.4 Members may, at their option and expense, obtain insurance coverage (or obtain advice on the need to help defray costs in defending against allegations. However, the prevailing law does not allow insurance coverage to indemnify criminal fines and penalties if an allegation of criminal nature is prosecuted.

ARTICLE XI

CORRECTION ACTION

11.1 Requests for Corrective Action

When reliable information indicates that any Provider is considered not to meet the applicable Medical Staff standard of care, or to be disruptive to the operations of the Hospital, any person may request that corrective action be initiated against such Provider. All requests for corrective action shall be in writing, shall be made to the CEO, President, or the MEC, and shall be supported by reference to the specific activities or conduct that constitute the grounds for the request. Furthermore, the Board can take corrective action without first seeking and/or obtaining a recommendation from the MEC. However, if the Board so acts or decides to act without first seeking and/or obtaining a recommendation by the MEC, the affected Member shall be entitled to the applicable hearing and appeal rights set forth in these Bylaws. The following are representative, but not exclusive, of issues which may constitute grounds for a request for corrective action:

11.1-1 Clinical competence;

11.1-2 Care of a particular patient or patients;

11.1-3 Violation of the Hospital Bylaws and policies, Medical Staff Bylaws, and Related Manuals;

- 11.1-4 Violations of professional ethics as outlined by the code of ethics that govern his or her professional organization;
- 11.1-5 The mental, emotional or physical health of the Member, including substance abuse and impaired behavior issues;
- 11.1-6 Conduct disruptive or detrimental to the operation of the Hospital and/or patient care; or
- 11.1-7 Unauthorized release of peer review or patient information.

11.2 MEC Review of Request

- 11.2-1 The individual or committee that receives the request for corrective action shall promptly notify the CEO, President, and/or MEC in writing of any request for corrective action. The request for corrective action shall be reviewed by the MEC which shall keep the CEO fully informed of all action taken concerning the request.
- 11.2-2 After reviewing the request for corrective action, the MEC may determine that:
 - a) The requested corrective action, if implemented, could adversely affect the Member's clinical privileges or Membership on the Medical Staff, in which case the MEC may determine an investigation of the request, including the alleged basis for the request, is appropriate. The MEC may investigate the matter on its own, direct a standing committee of the Medical Staff to investigate the matter, or appoint and direct an ad hoc committee to investigate the matter.
 - b) The appropriate corrective action is summary suspension, in which case the procedure under Section 11.1 herein shall be followed. The initiation of an investigation shall not preclude the imposition of summary suspension under Section 11.1.
 - c) The request for corrective action has no basis and no investigation is necessary.

11.3 Investigative Procedure

- 11.3-1 If the MEC concludes an investigation is warranted, it shall conduct or direct an investigation to be concluded within a reasonable period of time.
- 11.3-2 The Member shall be notified that an investigation is being conducted and shall also be given an opportunity to provide information in a manner and upon such terms as the MEC or investigating committee deems appropriate. The MEC or other investigating committee will review relevant documentation including but not limited to medical records, and incident or occurrence reports and may, but is not obligated to, conduct interviews with the Member and other persons involved; however, such interview(s) shall not constitute a "hearing" as that term is used in

these Bylaws, nor shall the procedural rules with respect to hearings or appeals apply. At such interview(s), the Member shall be informed of the general nature of the questions directed to him or her, and shall be invited to discuss, explain or refute them. A record of such interview shall be made by the MEC or other investigating committee. The Member shall not be entitled to have legal counsel present during any meetings or discussions between the Member and the MEC or other investigating committee. The MEC or other investigation committee must make a reasonable effort to obtain the facts of the matter.

11.3-4 Upon conclusion of any investigation, the MEC or other investigating committee shall prepare a written report of its investigation and in the case of an investigating committee, forward such report to the MEC as soon as practicable. The report shall include any record of the MEC's or other investigating committee's interviews with the Member and other individuals. The report may include a recommendation for corrective action, as the MEC or other investigating committee determines is appropriate.

11.3-4 Regardless of the status of any investigation, at all times the MEC shall retain authority and discretion to take whatever action may be warranted by the circumstances, including the investigative process.

11.4 Ad Hoc Committee

If the MEC decides to appoint an ad hoc committee to investigate the request for corrective action, the President shall appoint three (3) Members of the Medical Staff in good standing to serve on the ad hoc committee. If there are not a sufficient number of Members who meet such criteria, the President may appoint Physicians who are not affiliated with the Hospital to serve on the ad hoc committee.

11.5 MEC Action

11.5-1 Within fifteen (15) days after receiving the investigative report and/or recommendation from the investigating committee or within forty-five (45) days of its own investigation, the MEC may take appropriate action, including:

- a) Determine that no corrective action should be taken and remove any adverse information from the Member's Medical Staff file;
- b) Modify the request for corrective action;
- c) Defer action for a reasonable period of time as circumstances warrant;
- d) Issue a warning, a letter of admonition, or a letter of reprimand;
- e) Order the review of the Member's current and/or previous charting practices, and/or a review of the information reflected in such charts;

- f) Impose terms of probation or a requirement for Proctoring and/or Consultation upon a provisional Member of the Medical Staff;
- g) Recommend requiring a non-provisional Member of the Medical Staff to undergo Proctoring or Consultation;
- h) Recommend reduction, modification, suspension, imposition of conditions, or revocation of clinical privileges;
- i) Impose a summary suspension as provided under Section 11.6 ;
- j) Recommend that Membership on the Medical Staff and clinical privileges be suspended or revoked; and/or
- k) Take such other corrective action as appropriate under the circumstances.

11.5-2 The term "recommend" as used in Section 11.5-1 above shall mean a recommendation to the Board. Any such recommendation by the MEC to the Board which, if taken, could adversely affect the Member's clinical privileges or Membership on the Medical Staff shall entitle the affected Member to the procedural rights provided herein.

11.5-3 Letters of admonition, warning or reprimand, imposition of required Consultations, assistance or probation shall not be considered an adverse action affecting a Member's clinical privileges; shall not be reported to the State Medical Licensing Board and shall not give rise to the procedural rights provided herein.

11.6 Summary Suspension

11.6-1 Criteria and Procedure

Whenever there is a good faith belief that the conduct or activities of a Member pose a threat to the life, health, or safety of any patient, employee, staff or other person present at the Hospital and that the failure to take prompt action may result in imminent danger to the life, health, or safety of any such person, any two (2) of the following persons shall have the authority to summarily suspend the appointment of such Member to the Medical Staff and/or to summarily suspend or restrict all or any portion of his or her clinical privileges:

- a) Director of Medical Staff Affairs (DMSA)
- b) Medical Staff President
- b) Chair of any Department with respect to Members assigned to that Department

- c) any member of the MEC
- d) CEO or any member of the Board.

Where there may be an overlap in individuals filling the above positions, it still requires two different individuals working together to summarily suspend a member. Unless otherwise stated, such summary suspension shall become effective immediately upon imposition and the persons or body responsible shall promptly give Special Notice of the reasons for the summary suspension to the Member, the MEC, and the CEO.

11.6-2 Duration and Investigation

Summary suspensions may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary suspension, the Member's patients shall be promptly assigned to another Member by the Department Chair or by the President, considering where feasible, the wishes of the patient in the choice of a substitute.

- a) During the summary suspension, the MEC shall conduct an investigation to determine the need for a recommendation for further adverse action. As soon as possible, but not more than fourteen (14) Days after such summary suspension has been imposed, a meeting of the MEC shall be convened to review and consider the action. During this time, the Member may meet with and make a statement concerning the issues under investigation, on such terms and conditions as the MEC may impose, though in no event shall any meeting of the MEC, with or without the Member, constitute a "hearing" within the meaning of this Plan, nor shall any procedural rules apply.
- b) During the summary suspension, the MEC may recommend continuance, modification, or termination of the summary suspension. If the summary suspension is terminated within fourteen (14) days of its imposition without further recommendation for adverse action there will be no report to the National Practitioner Data Bank.
- c) The MEC may modify, continue, or terminate the summary suspension. If the MEC determines to continue or fails to terminate the summary suspension beyond fourteen (14) days, or recommends other adverse action, the Member shall be given Special Notice with an explanation of such determination or recommendation.

11.6-3 Procedural Rights

In the event of a summary suspension lasting more than fourteen (14) days, the Member shall be entitled to those procedural rights specific to summary suspensions as contained herein.

11.7 Automatic Suspension

Membership on the Medical Staff as well as clinical privileges may be subject to automatic suspension in the discretion of any two of the following, the President, any member of the MEC, and the CEO. Events warranting such action include the following:

11.7-1 A Provider's patient charts shall be deemed incomplete if not completed by the Twenty-third (23rd) day following discharge of the patient. The medical records department shall issue an immediate warning to each Provider who has one or more incomplete charts. If a Provider fails to complete any incomplete charts within seven (7) days of receiving such warning, all charts are deemed delinquent. At that time all Hospital admitting privileges shall be automatically suspended until all delinquent charts of his or her patients are completed.

A Provider whose clinical privileges are suspended because of delinquent charts may not admit patients under the name of another Physician unless such other Physician has admitting privileges in good standing and such other Physician gives his or her prior approval.

The CEO or President will give the affected Provider written notice that his or her admitting privileges have been automatically suspended because of his or her delinquent records.

A Provider may request a written waiver of these requirements in advance of planned vacations or professional absences, provided any such waiver will not result in medical records in question being noncompliant with laws and accreditation standards applicable to the Hospital.

11.7-2 License to Practice Medicine and License to Prescribe or Dispense Drugs

Any limitation, revocation or suspension of a Provider's license to practice medicine and/or any limitation, revocation or suspension of a Provider's license to prescribe or dispense legend drugs or controlled substances shall automatically limit, revoke and/or suspend the Provider's clinical privileges for the same period of time.

The CEO shall notify the MEC of any automatic suspension triggered by limitation, revocation, or suspension of a license to practice medicine, dentistry, or podiatry, as applicable, and/or to prescribe or dispense legend drugs or controlled substances.

11.7-3 Failure to maintain Professional Liability Insurance

If Provider's professional liability insurance is canceled or is not renewed, Provider's clinical privileges shall be automatically suspended until such coverage is re-established and Provider provides a certificate of coverage or other reliable evidence of coverage to Hospital.

11.7-4 Failure to Complete Continuing Education or Attend Meetings.

If Provider fails to complete the required number of hours of continuing medical education or fails to attend required meetings of the Medical Staff, Departments, and/or Medical Staff Committees as required by the Medical Staff Bylaws and Related Manuals, Provider's clinical privileges are automatically suspended.

11.7-5 Procedural Rights

Automatic suspensions are not professional review actions based on professional competence or conduct, but are adverse actions imposed by Special Notice to the affected Provider by the CEO, MEC member(s), or President as appropriate.

ARTICLE XII

FAIR HEARING PLAN

12.1 Preamble

The Board, its Medical Staff and any committees thereof, in order to conduct professional peer review activity, hereby constitute themselves as peer review and professional review committees as defined by the Indiana Peer Review Act and the Health Care Quality Improvement Act of 1986. Such committees hereby claim all privileges and immunities afforded to them by said federal and state statutes. The purpose of this Fair Hearing Plan ("Plan") is to provide a mechanism through which a fair hearing and appeal might be provided to all Physicians having privileges or applying for privileges. Any action taken pursuant to this Plan shall be in the reasonable belief that such was in the furtherance of quality health care (including the provision of care in a manner that is not disruptive to the delivery of quality medical care in the Hospital), only after a reasonable effort has been made to obtain the true facts of the matter, after adequate notice and hearing procedures are afforded to any professional health care provider involved, and only in the reasonable belief that the action was warranted by the facts known after a reasonable effort has been made to obtain the facts.

12.2 Right to Hearing and to Appellate Review

12.2-1 When any Member receives notice of a recommendation of the MEC, or Board that, if ratified by decision of the Board of Directors, will adversely affect his or her appointment to or status as a Member of the Medical Staff or his or her exercise of clinical privileges, he or she shall be entitled to a hearing before an Ad Hoc Hearing Committee appointed by the President or Board Chairman. If the recommendation of the MEC or Board following such hearing is still adverse to the affected Provider, he or she shall then be entitled to an appellate review by the Board before the Board of Directors makes a final decision on the matter.

12.2-2 When any Member receives notice of a decision by the Board that will affect his or her appointment to or status as a Member of the Medical Staff or his or her exercise of clinical privileges, and such decision is not based on a prior adverse recommendation by the MEC of the Medical Staff with respect to which he or she was entitled to a hearing, then he or she shall be entitled to a hearing by a committee appointed by the Board, and if such hearing does not result in a

favorable recommendation, to an appellate review by the Board, before the Board makes a final decision on the matter.

12.2-3 All hearing and appellate reviews shall be in accordance with the procedural safeguards set forth in this Article.

12.3 Notice of Proposed Adverse Action

12.3-1 In all cases in which a Provider has been recommended by the Medical Executive Committee or the Board of Directors initially for adverse action, the Chief Executive Officer shall be responsible for giving prompt written notice to the affected Provider of the proposed adverse action and of the Provider's rights to a hearing or an appellate review, by certified mail, return receipt requested, or by personal delivery.

Such notice shall contain the following information:

- a) that a professional review action has been proposed to be taken concerning the Provider;
- b) the reasons for the proposed action including representative records and/or incident or committee reports if known at the time;
- c) that any hearing must be requested within thirty (30) days;
- d) that an expedited hearing date may be requested by a Provider under suspension; and
- e) summary of the Provider's rights as provided herein.

12.4 Request for Hearing

12.4-1 In all cases in which any Provider has been recommended for adverse action, the applicant may, within thirty (30) days of receipt of notice as provided under Section 12.2-1, request in writing a hearing before an Ad Hoc Committee .

12.4-2 The failure of a Provider to timely request a hearing to which he or she is entitled by these Bylaws within the time and in the manner wherein provided shall be deemed a waiver of his or her right to such hearing and to any appellate review to which he or she might otherwise have been entitled on the matter. The failure of a Provider to request an appellate review to which he or she is entitled by these Bylaws within the time and in the manner herein provided shall be deemed a waiver of his or her right to such appellate review on the matter.

12.4-3 When the waived hearing or appellate review relates to an adverse recommendation of the MEC or of a Hearing Committee appointed by the Board, the same shall thereupon become and remain effective against the Provider pending the Board's decision on the matter. When the waived hearing or appellate review relates to an adverse decision by the Board, the same shall thereupon

become and remain effective against the Provider in the same manner as a final decision of the Board provided in Section 12.9 of this Article. In either of such events, the CEO shall promptly notify the affected Provider of his or her status by certified mail, return receipt requested.

12.5 Notice of Hearing

- 12.5-1 Within ten (10) days after receipt of a request for hearing from a Provider entitled to the same, the CEO or the Chairman of the Board shall schedule and arrange for such a hearing and shall notify the Provider of the time, place and date so scheduled by certified mail, return receipt requested. The hearing date shall be not less than thirty (30) days from the date of receipt of the request for hearing; provided, however, that a hearing for a Provider who is under suspension which is then in effect and who requests an expedited hearing shall be held as soon as arrangements may reasonably be made, but not later than fifteen (15) days from the date of receipt of such Provider's request for hearing or as soon thereafter as reasonably possible.
- 12.5-2 The notice of hearing shall state in concise language the acts or omissions with which the Provider is charged, a list of specific or representative charts being questioned, and/or the other reasons or subject matter that was considered in making the adverse recommendation or decision, and a list of witnesses (if any known at the time) which are expected to testify at the hearing on behalf of the professional review committee or Hospital.
- 12.5-3 The hearing officer or presiding member of the Hearing Committee shall appoint a date, time and place for the exchange of witness lists and copies of exhibits by both sides. Any witness not then listed and any exhibit not provided may in the discretion of the committee or hearing officer be excluded from the hearing.
- 12.5-4 All material contained in a Provider's credentials and/or personal file shall be part of the hearing record, and the Provider shall have the right to have a copy of all such material in advance of the hearing.

12.6 Appointment of Hearing Committee or Hearing Officer

- 12.6-1 The Ad Hoc Committee shall be appointed by the President or Chairman of the Board and shall be comprised of not less than three (3) Physicians not in direct economic competition with the affected Member and who have had no prior involvement with the matter. One of the members so appointed shall be designated as Chairman.
- 12.6-2 When a hearing relates to an adverse decision of the, the CEO or Chairman of the Board may appoint a Hearing Committee to conduct such hearing and shall designate one of the members of this committee as Chairman. At least two (2) representatives of the Medical Staff shall be on such a Hearing Committee.
- 12.6-3 A Hearing Officer may also be appointed who is not in direct economic competition with the affected Provider, appointed by the CEO or Chairman of the

Board. The Hearing Officer shall conduct the hearing, receive evidence and any legal memoranda, hear argument, and make findings of fact and recommendations for any corrective action. The Hearing Officer shall also draft findings and recommendations voted by the members of the Committee.

12.7 Conduct of Hearing

- 12.7-1 There shall be at least a majority of the members of a Hearing Committee present when the hearing takes place, and no member may vote by proxy.
- 12.7-2 An accurate record of the hearing must be kept. The mechanism shall be established by the Ad Hoc Hearing Committee or Hearing Officer, and may be accomplished by use of a court reporter, or electronic recording unit and detailed transcription.
- 12.7-3 Personal presence of the Provider for whom the hearing has been scheduled shall be required unless he or she has waived such appearance and has been deemed to have accepted the adverse recommendation/ decision involved.
- 12.7-4 Postponement of hearing beyond the time set forth in these Bylaws shall be made only with the approval of the Chairman of an Ad Hoc Hearing Committee or Hearing Officer. Granting of such postponements shall only be for good cause shown and in the sole discretion of the Chairman or Hearing Officer.
- 12.7-5 The affected Member shall be entitled to be accompanied by and/or represented at the hearing by a member of the Medical Staff in good standing or by a member of his or her local professional society, or by an attorney at his or her own expense.
- 12.7-6 The Chairman of the Hearing Committee or his or her designee, or the Hearing Officer shall preside over the hearing to determine the order of procedure during the hearing, to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence and to maintain decorum.
- 12.7-7 The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless to the existence of any common law or statutory rule which might make evidence inadmissible over objection in a civil or criminal action. The Provider for whom the hearing is being held shall, prior to, during or after the hearing, be entitled to submit memoranda concerning any issue of procedure or of fact and such memoranda shall become a part of the hearing record.
- 12.7-8 The affected Member shall have the burden of demonstrating by a preponderance of the evidence that the recommended action is arbitrary, capricious or unsupported by the facts.

- 12.7-9 The affected Member shall have the following rights: to call and examine witnesses, to introduce written evidence, to cross-examine any witness on any matter relevant to the issue of the hearing, to challenge any witness and to rebut any evidence, to submit a written statement at the close of the evidence, to have a copy of the record of the proceedings upon payment of any reasonable charge associated with the preparation thereof, and to receive a copy of the written findings and recommendations of the Hearing Committee or Hearing Officer. If the Provider does not testify in his or her own behalf, he or she may be called and examined as if under cross-examination.
- 12.7-10 The hearings provided for in these Bylaws are for the purpose of resolving, on an intra-professional basis, matters bearing on professional competency and conduct. All members sitting on a Hearing Committee and all hearing Officers, representing the staff or Board, and their counsel shall be deemed to be agents of the Board in conducting peer review for the benefit of the Board. All persons participating in or communicating to such a Hearing Committee or Hearing Officer shall be immune from any cause of action for any actions done in good faith.
- 12.7-11 The Hearing Committee Chairman or Hearing Officer may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Hearing Committee may thereupon, at a time convenient to itself, conduct its deliberations outside of the presence of the Provider for whom the hearing was convened. The Hearing Committee Chairman or Hearing Officer may recess the hearing at its conclusion until a transcript can be provided.
- 12.7-12 Within fifteen (15) days after final adjournment of the hearing, the Hearing Committee or Hearing Officer shall make a written report and recommendation and shall forward the same together with the hearing record and all other documentation to the Medical Executive Committee or to the Board of Directors, whichever initiated the recommended adverse action. The report may recommend confirmation, modification, or rejection of the original adverse recommendation of the Medical Executive Committee or decision of the Board of Directors.
- 12.7-13 If the report recommends no adverse action for the Provider, the report shall be sent to the Board of Directors for action. If the report recommends adverse action for the Provider, the Chief Executive Officer shall be responsible for giving prompt written notice (within 10 days) to the affected Provider of the adverse decision and of the Provider's right to an appellate review, by certified mail, return receipt requested or by personal delivery. Such notice shall contain the following information:
- a) that an adverse recommendation has been made by the Ad Hoc Hearing Committee or Hearing Officer and the substance of that recommendation;
 - b) the reasons given by the Hearing Committee or Hearing Officer for the adverse recommendation;

- c) that an appellate review must be requested in writing within seven (7) days;
- d) that an expedited appellate review date may be requested by a Provider under suspension; and
- f) a summary of the Provider's rights as provided herein.
- g) The MEC or the Board of Directors receiving a recommendation for adverse action for a Provider shall facilitate immediate notification of the Provider by the CEO.

12.8 Appeal to Board of Directors

- 12.8-1 Within seven (7) days after an affected Provider receives notice of an adverse recommendation or decision made or adhered to after a hearing as above provided, he or she may, by written notice to the Board, delivered through the CEO by certified mail, return receipt requested, request an appellate review by held only on the record on which the adverse recommendation or decision is based, as supported by the Provider's written statement provided for below, or may also request that oral argument be permitted as part of the appellate review.
- 12.8-2 If such appellate review is not requested within seven (7) days, the affected Provider deemed to have waived his or her right to the same, and to have accepted such adverse recommendation or decision, and the same shall become effective immediately as provided in this Article.
- 12.8-3 Within ten (10) days after receipt of such notice of request for appellate review, the Board shall schedule a date for such review, including a time and place for oral argument if such has been requested and granted, and shall through the CEO, by written notice sent by certified mail, return receipt requested, or by personal delivery, notify the affected Provider of the same. The date of the appellate review shall not be more than thirty (30) days from the date of receipt of the notice of request for appellate review, except that when the Provider requesting the review is under a suspension which is then in effect, such review shall be scheduled as soon as the arrangements for it may reasonably be made, but not more that fifteen (15) days from the date of receipt of such notice.
- 12.8-4 The appellate review shall be conducted by the Board.
- 12.8-5 The affected Provider shall have access to the report and record (and transcription, if any) of the Ad Hoc Committee or Hearing Officer and all other material, favorable or unfavorable, that was considered in making the adverse recommendation or decision against him or her. An opportunity to submit a written statement in his or her own behalf, in which those factual and procedural matters with which he or she disagrees, and his or her reasons for such disagreement, shall be provided. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal council

may assist in its preparation. Such written statement shall be submitted to the Board through the CEO by certified mail, return receipt requested, at least three (3) days prior to the scheduled date for the appellate review. A similar statement may be submitted by the MEC or by the Chairman of the Hearing Committee or by the Hearing Officer appointed by the Board, and if submitted, the CEO shall provide a copy thereof to the Provider at least three (3) days prior to the date of such appellate review by certified mail, return receipt requested.

- 12.8-6 Board shall act as an appellate body. It shall review the record created in the proceedings, and shall consider the written statements submitted pursuant to subparagraph (e) of this Section 6, for the purpose of determining whether the adverse recommendation or decision against the affected Provider was justified and was not arbitrary or capricious. If oral argument is requested and granted as part of the review procedure, the affected Provider shall be present at such appellate review, shall be permitted to speak against the adverse recommendation or decision, and shall answer questions put to him or her by any member of the appellate review body. The MEC or the Board, whichever is appropriate, shall also be represented by an individual who shall be permitted to speak in favor of the adverse recommendation or decision and who shall answer questions put to him or her by any member of the appellate review body.
- 12.8-7 New or additional matters not raised during the original hearing or in the Hearing Committee report, nor otherwise reflected in the record, shall only be introduced at the appellate review under unusual circumstances, and the Board or the committee thereof appointed to conduct the appellate review shall in its sole discretion determine whether such new matters shall be accepted.
- 12.8-8 Appellate review is conducted by the Board, the Board shall, within ten (10) days after the scheduled or adjourned date of the appellate review, either make a written report recommending that the Board of Directors affirm, modify or reverse its prior decision, or refer the matter back to the Hearing Committee or Hearing Officer for further review and recommendation within fifteen (15) days. Such referral may include a request that the Hearing Committee or Hearing Officer arrange for a further hearing to resolve the disputed issues. Within ten (10) days after receipt of such recommendation after referral, the committee shall make its recommendation to the Board as above provided.
- 12.8-9 The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Article XII have been completed or waived. Where permitted by the Hospital Bylaws, all action required of the Board of Directors may be taken by a committee of the Board duly authorized to act.

12.9 Final Decision by Board of Directors

- 12.9-1 Within thirty (30) days after the conclusion of the appellate review, the Board shall make its final decision in the matter and shall send notice thereof to the MEC, and, through the CEO, to the affected Provider, by certified mail, return receipt requested. This decision shall be immediately effective and final, and shall not be subject to further hearing or appellate review.

12.9-2 Notwithstanding any other provision of these Bylaws, no Provider shall be entitled as a right to more than one hearing and one appellate review on any matter which shall have been the subject of action by the MEC or the Medical Staff, or by the Board, or by a duly authorized committee of the Board, or by both.

ARTICLE XIII CLINICAL DEPARTMENTS

13.1 Organization of Clinical Departments

The Medical Staff shall be divided into clinical departments. Each department shall be organized as a separate component of the Medical Staff and shall have a Department Chair selected and entrusted with the authority, duties, and responsibilities specified in Section 6.1-2.

13.2 Current Departments

The current departments are: Obstetrics, Surgery, Family Medicine, Emergency and Radiology.

13.3 Assignment to Departments

Each Member shall be assigned Membership in at least one department, but may be granted Membership and/or clinical privileges in other departments consistent with practice privileges granted.

13.4 Functions of Departments

Departments serve to provide specific support and feedback to the medical staff leadership regarding the activities of their members. They also serve to provide peer support to the Providers who are their members.

13.5 Departmental Leadership

A Department Chair will be appointed based on clinical qualification and Medical Staff approval.

ARTICLE XIV COMMITTEES

14.1 Designation

The committees described in this Article shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the Medical Staff to perform specified tasks. Unless otherwise specified, the chairman and members of all committees shall be appointed by and may be removed by the Medical Staff President, subject to consultation with and approval by the Medical Staff. Medical Staff committees shall be responsible to the Medical Staff. The President, Director of Medical Staff Affairs and the CEO shall serve as ex-officio members of all committees. No committee meeting shall

be considered closed and any Medical Staff member may attend any meeting. Attendance at committee meetings shall be required of active staff. Excused absences may be granted prior to the meeting time by the committee chairman. Regularly scheduled committee meetings shall meet as scheduled unless changed by majority consent of all Medical Staff members of the committee members. Unexcused absence from more than 50% of general medical staff subcommittees in any calendar year will be reported to the Medical Staff President for action as deemed necessary to encourage improved attendance. Minutes of all committee business will be recorded and retained.

14.2 General Provisions

14.2-1 Terms of Committee Members

Unless otherwise specified, committee members shall be appointed for a term of one year, and shall serve until the end of this period or until the member's successor is appointed, unless the member shall sooner resign or be removed from the committee.

14.2-2 Removal

If a member of a committee ceases to be a member in good standing of the Medical Staff, or loses employment or a contract relationship with the Hospital, suffers a loss or significant limitation of practice privileges, or if any other good cause exists, that member may be removed by the Medical Staff or President.

14.2-3 Vacancies

Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made; provided, however, that if an individual who obtains Membership by virtue of these Bylaws is removed for cause, a successor may be selected by the Medical Staff.

14.3 Medical Executive Committee

14.3-1 Composition

The MEC shall consist of the following persons:

- a) Medical Staff President and Vice President;
- b) One member of the Medical Staff serving as an At-Large member of the MEC;
- c) If the Director of Medical Staff Affairs is not serving as Medical Staff President, then the DMSA serves as an ex-officio member of the MEC along with the VP of nursing services, the VP of Quality, and the CEO;

- d) A member of the Quality Committee if not otherwise represented by members listed above.

14.3-2 Duties

The duties of the MEC shall include, but not be limited to:

- a) Representing and acting on behalf of the Medical Staff in the intervals between Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws;
- b) Coordinating and implementing the professional and organizational activities and policies of the Medical Staff.
- c) Receiving and acting upon reports and recommendations from Medical Staff departments, committees, and assigned activity groups.
- d) Recommending action to the Board on matters of a medical-administrative nature.
- e) Evaluating the medical care rendered to patients in the Hospital.
- f) Participating in the development of all Medical Staff and Hospital policy, practice, and planning.
- g) Reviewing the performance and professional competence of staff members and making recommendations to the Board for corrective action as needed.
- h) Taking reasonable steps to promote ethical conduct and competent clinical performance on the part of all members including the initiation of and participation in Medical Staff corrective or review measures when warranted.
- i) Designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Medical Staff and approving or rejecting appointments to those committees by the President.
- j) Reporting to the Medical Staff at each regular staff meeting.
- k) Assisting in the obtaining and maintaining of accreditation.
- l) Developing and maintaining methods for the protection and care of patients and others in the event of internal or external disaster.
- m) Appointing such special or ad hoc committees as may seem necessary or appropriate to assist the MEC in carrying out its functions and those of the Medical Staff.

- n) Reviewing the quality and appropriateness of services provided by contract Physicians.

14.3-3 Meetings

The MEC shall meet as often as necessary to accomplish its work and shall maintain a record of its proceedings and actions.

14.4 Quality Committee

14.4-1 Composition

The Quality Committee shall consist of at least three members of the Medical Staff. If the Director of Medical Staff Affairs is not a member of the Medical Staff, then the DMSA will serve ex-officio to this committee as well. When needed for proper oversight, special membership by appropriate department or committee chairs will be invited.

14.4-2 Duties

The Quality Committee shall:

- a) Review and evaluate the qualifications of each Provider applying for initial appointment, reappointment, or modification of and for clinical privileges, and, in connection therewith, obtain and consider the recommendations of the appropriate departments.
- b) Submit required reports and information on the qualifications of each Provider applying for Membership or particular clinical privileges including recommendations with respect to appointment, Membership category, department affiliation, clinical privileges and special conditions.
- c) Investigate, review and report on matters referred by the President or the Medical Staff regarding the qualifications, conduct, professional character or competence of any applicant.
- d) Submit periodic reports to the Medical Staff on its activities and the status of pending applications.

ARTICLE XV

OFFICERS OF THE MEDICAL STAFF

- 15.1** Officers of the Medical Staff shall be the President and Vice President. These shall each serve a two year term. Officers must be Members of the Active Medical Staff at the time of nomination and election and must remain Members in good standing during their term of office. Failure to remain in such status shall immediately create a vacancy in the office involved.

15.2 Election of Officers

15.2-1 Officers shall start their term on January 1 and shall be elected every two years at a Medical Staff Committee meeting held in the final quarter of the preceding year. All present Members of the Active and Associate Medical Staff attending that meeting shall be eligible to vote.

15.2-2 Officers may serve consecutive terms at the will of the Medical Staff.

15.2-3 Nomination may be made from the floor at the time of the meeting at which elections are held, or by petition signed by at least two Members of the Active or Associate Staff.

15.2-4 The Officers nominated and approved by the Medical Staff in the final quarter of the year shall be ratified by the Hospital Board of Directors at their next meeting following the meeting at which officers are approved by the Medical Staff.

15.3 Vacancies

Vacancies in office during the Medical Staff year shall be filled with a candidate nominated by the Medical Staff Committee. A special election to fill the vacant position shall be held at the next Medical Staff meeting after the vacancy occurs.

15.4 Duties of Officers

15.4-1 President. If the Director of Medical Staff Affairs is an Active Member of the Medical Staff, then he/she may serve as Medical Staff President. The President shall:

- a) Coordinate and cooperate with the CEO in all matters of mutual concern within the Hospital;
- b) Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;
- c) Serve as Chairman of the MEC;
- d) Serve as ex-officio Member of all other Medical Staff committees without vote;
- e) Be responsible for the enforcement of these Bylaws and Rules and Regulations, for implementation of sanctions where these are indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a Provider;
- f) Appoint committee Members of all standing, special, and multi-disciplinary Medical Staff committees, except the Medical Staff Committee;

- g) Represent the views, policies, needs, and grievance of the Medical Staff to the Board and the CEO;
- h) Receive and interpret the policies of the Board to the Medical Staff and report to the Board on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care;
- i) Assist in managing educational opportunities and activities of, by, and for the Medical Staff;
- j) Be a spokesman for the Medical Staff in its external professional and public relations.
- k) If the President is NOT the Director of Medical Staff Affairs, then the President will work with the DMSA to help achieve the goals set forth for the DMSA by the Hospital Board and the CEO.

15.4-2 Vice President. In the absence of the President, the Vice President shall assume the duties and have the authority of the President. He or she shall be an Active Member of the Medical Staff.

15.5 Removal of Elective Officers from Office

15.5-1 Removal of a Medical Staff officer for cause may be initiated by petition of an Active Staff Member in writing to the Medical Staff. An adverse recommendation must be approved by two-thirds (2/3) vote of the Active Medical Staff and with the approval of the Board.

15.5-2 Each of the following conditions in itself constitutes cause for removal of a Medical Staff Officer from office.

- a) Revocation of professional license by the authorizing state agency;
- b) Suspension from the Medical Staff (other than for delinquent medical records);
- c) Failure to perform the required duties of the office;
- d) Failure to adhere to professional ethics;
- e) Failure to comply with or support enforcement of the Hospital and Medical Staff Bylaws, rules and regulations, and policies;
- f) Failure to maintain adequate professional liability insurance; and
- g) Failure to maintain Active Staff status.

ARTICLE XVI

MEDICAL STAFF RULES AND REGULATIONS

The Medical Staff shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Board of Directors. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each Provider in the Hospital. Such Rules and Regulations shall be a part of these Bylaws, except they may be amended or repealed at any regular meeting with advance notice, by a two-thirds (2/3) vote of those Members present of the Active Medical Staff. Such changes shall become effective when approved by the Board.

ARTICLE XVII

AMENDMENTS

These Bylaws may be amended after submission of the proposed amendment at any regular or special meeting of the Medical Staff. A proposed amendment shall be referred to a special committee which shall report on it at the next regular meeting of the Medical Staff or at a special meeting called for such purpose. To be adopted, an amendment shall require a two-thirds (2/3) vote of the Active Medical Staff Members present. Amendments so made shall be effective when approved by the Board of Directors.

ARTICLE XVIII

ADOPTION OF BYLAWS/RULES AND REGULATIONS

These Bylaws together with the appended Rules and Regulations, shall be adopted at any regular or special meeting of the Medical Staff, shall replace any previous Bylaws and Rules and Regulations, and shall become effective when approved by the Board of Directors of the Hospital. They shall be reviewed every two years during the first six months of office of the newly appointed Medical Staff President, dated and signed by the Medical Staff President, President of the Board of Directors, and the Chief Executive Officer.

ARTICLE XIX

GOVERNING LAW

These Medical Staff Bylaws shall be governed by, and construed in accordance with the Health Care Quality Improvement Act of 1986 and, to the extent not inconsistent therewith, the Indiana Peer Review Act, and to the extent not so governed, with the other laws of the State of Indiana without giving effect to its conflict of laws principles.

Signed and approved:

6/09/2017

| ~~Jason E. Marker, MD, MPA, FAAFPL~~ Lindy Sergeant, M.D.
Date
Medical Staff President

| _____ 8/24/2017

Carol Hochstetler Date
President of the Board of Directors

| _____ 8/24/2017

David Bailey, FACHE Date
President/CEO