MAJOR HOSPITAL

MEDICAL STAFF BYLAWS:

Credentialing Manual

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The definitions set forth in the Medical Staff Governance and Organization Manual apply to all Medical Staff governing documents, unless otherwise indicated**.**

PREAMBLE

The Governing Board of Major Hospital, its Medical Staff, and any committees thereof, in order to conduct professional peer review activities, hereby constitute themselves as peer review and professional review bodies as these terms are defined by Indiana state and federal law, including but not necessarily limited to, the Indiana Peer Review Statute (See I.C. §34-30-15-1 *et. seq.*) and the Health Care Quality Improvement Act of 1986. These committees claim all privileges and immunities afforded to them by all applicable federal and state statutes. The purpose of this Credentialing Manual is to establish a peer review process to evaluate the qualifications of physicians and other health care providers who have applied for, or who have reapplied for, Medical Staff membership and/or clinical privileges at the Hospital. The peer review processes set forth in this Credentialing Manual are intended to reduce morbidity and mortality and to improve patient care. In order to ensure peer review participants are afforded all available privileges, protections and immunities, the Hospital intends for this Credentialing Manual to comply with all applicable laws and regulations, including the Indiana Peer Review Statute and the federal Health Care Quality Improvement Act of 1986.

DEFINITIONS

Unless otherwise indicated, the definitions set forth in the Medical Staff Governance and Organization Manual apply to this Credentialing Manual, as if set forth fully herein.

ARTICLE 1: PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT OF MEMBERSHIP AND/OR CLINICAL PRIVILEGES

Section 1.1 Application Procedure

1.1.1 Form Preparation

The MEC, with the assistance of the Hospital's Medical Staff Office and/or Medical Staff Coordinator, or their designee(s), (collectively referred to herein as "Medical Staff Office"), shall be responsible for developing, reviewing, and recommending any changes to application forms, including any appointment, reappointment, and updating forms. All forms and revisions thereto shall conform to any applicable Indiana state statutes and regulations that mandate the use of particular forms or specific content.

1.1.2 Request for Application

Any individual seeking Medical Staff membership and/or clinical privileges must request an application from Medical Staff Office or the Hospital's designated Credentialing Verification Organization ("CVO") (if a CVO is utilized). The pre-applicant shall be provided an application. Receipt of an application does not, however, preclude a subsequent finding of administrative ineligibility or otherwise in any fashion guarantee that medical staff membership and/or clinical privileges, as applicable, will be granted.

Section 1.2 Application for Initial Appointment and/or Clinical Privileges

1.2.1 Application Form

Each application for appointment to the Medical Staff and/or clinical privileges, as applicable, shall be in writing, submitted on the prescribed form, and signed by the pre-applicant. Once a signed and completed application form has been received and accepted by the Medical Staff Coordinator (or the Hospital's CVO if such function is delegated to a designated CVO), the pre-applicant shall be considered an applicant.

1.2.2 Content

The Hospital's form of application includes, at a minimum, the following requests for information. The Hospital may supplement its application form content by general or specific requests for information.

(a) Acknowledgment and Agreement

A statement that the applicant has received or has had access to the Hospital's Policies, has read and understands them, and agrees to be bound by the Hospital's Policies, including but not limited to all applicable provisions in all matters relating to consideration of his or her request for initial or continuing Medical Staff membership and/or clinical privileges.

(b) Qualifications and Professional History

Detailed information concerning the applicant's qualifications, demonstrated current competency and professional performance, including information regarding the qualifications specified in the Medical Staff Governance and Organization Manual and of any additional qualifications established by the Medical Staff or Governing Board for the particular Medical Staff category, Clinical Service, and/or clinical privileges being requested. Additionally, any faculty membership at any medical or other professional school; names and locations of past or current professional employment; and names and locations of any other past or current hospitals or other licensed health facilities where the applicant has applied or received medical staff membership and/or clinical privileges.

(c) Requests

A request stating the Medical Staff category, Clinical Service, and clinical privileges for which the applicant desires to be considered.

(d) References

The names of at least three (3) professional peers who have personal knowledge of applicant's current clinical skills, abilities, character, ethics, judgment, professional performance, and clinical competence or have otherwise been responsible for professional observation of applicant's professional services. For purposes of this section, a "peer" is defined as an individual in the same professional discipline as the applicant. (MD and DO are considered equivalent). A "peer" does not include a residency director, fellowship director, or personal relatives. At least one peer reference should be an individual that is within the same specialty as applicant. For purposes of this section, a physician (with at least equivalent clinical privileges as an applicant who is a Nurse Practitioner or Physician Assistant) shall be considered to be within the same discipline and specialty as the Nurse Practitioner or Physician Assistant.

(e) Professional Sanctions

Information regarding whether any of the following have ever been or are in the process of being denied, revoked, suspended, reduced, restricted, probationary, not renewed, or voluntarily relinquished or voluntarily not exercised shall be reported in detail:

(i) Medical Staff membership status and/or clinical privileges at any other hospital or health care facility;

(ii) Membership/Fellowship in local, state or national professional organizations;

(iii) Board Certification or related Board Certification status;

(iv) License to practice any profession in any jurisdiction; and

(v) Any state Controlled Substance License or Drug Enforcement Administration Controlled Substances Registration Certificate (DEA).

(f) Additional Disclosures

The applicant shall disclose:

(i) Any and all malpractice suits, settlements and judgments to which he or she is or has been a party during at least the past ten (10) years;

(ii) Any remedial, corrective or disciplinary action of any kind taken by any hospital, medical staff, professional organization, licensing body or governmental agency;

(iii) Any circumstance where employment, medical staff membership and/or clinical privileges were reduced, suspended, diminished, revoked, refused, voluntarily not exercised, or limited at any hospital or other health care facility, whether voluntarily or involuntarily;

(iv) Any circumstance where he or she withdrew an application for appointment/reappointment and/or clinical privileges, or resigned

from a medical staff or clinical privileges to avoid an investigation before action by a hospital's or health facility's medical staff or board;

(v) Any past or current investigations due to inappropriate conduct, disruptive behavior, or unprofessional conduct (e.g., sexual harassment);

(vi) Any past or current investigations, focused individual monitoring, review, or audits related to the quality of care or competency;

(vii) All other information residing in the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank;

(viii) All healthcare related employment/appointments (work history);

(ix) All information related to the investigation, arrest, indictment or conviction with regard to any felony or misdemeanor;

(x) Current criminal background check;

(xi) All information as to the applicant's medical education and post-graduate training; and

(xii) Any information requested on the supplemental form utilized as part of the Medical Staff membership and/or clinical privileges application process.

(g) Notification of Release of Immunity Provisions

Statement notifying the applicant of the scope and extent of the authorization, confidentiality, immunity and release provisions of Section 1.3 of this Credentialing Manual and Article 9 of the Medical Staff Governance and Organization Manual.

(h) Administrative Remedies

A statement that the applicant agrees that if an adverse decision is made with respect to his or her Medical Staff membership status and/or clinical privileges, the applicant will follow and exhaust, or otherwise voluntarily waive, the procedures and remedies afforded by this Plan as a prerequisite to the applicant pursuing any temporary or permanent injunctive relief, and/or any other type of litigation or legal action, if any, that may be available to the applicant. This obligation of applicant is in addition to any other rights, defenses, and immunities that the Hospital and its Medical Staff may have in relation to such requests, actions, or claims.

(i) Financial Responsibility

Evidence that the applicant has secured or currently maintains professional liability insurance in amounts or limits, and of a type, including status as a "qualified provider" pursuant to Indiana's Medical Malpractice Act, as prescribed by the Governing Board in consultation with the Medical Staff.

(j) Obligation to Update

The application form includes a statement that the applicant acknowledges that he or she has the burden of providing any and all information necessary to process the application as determined in the discretion of the MEC or Governing Board; that he or she is solely responsible for supplementing his or her application during the application process, in addition to the disclosure requirements set forth in this Credentialing Manual and the Medical Staff Governance and Organization Manual, to ensure the absolute accuracy of all statements and information contained therein as soon as this information becomes known but, in any event, before a final credentialing determination is made; and that any false or misleading information provided by a pre-applicant, applicant, Medical Staff member, or NPP during the pre-application, application, appointment, reappointment, or renewal process may be treated as a voluntary relinquishment or otherwise serve as grounds for corrective action or termination of the credentialing process, as applicable.

(k) Consent and Authorization to Share Information

As a condition of membership and/or clinical privileges, the applicant agrees that any quality, peer review, and other related information that is collected as part of the appointment/reappointment or privileging process, as well as any peer review activities, may be shared with other health care organizations and entities (whether or not affiliated with Hospital) and their designees, including without limitation those that are administratively and clinically affiliated with the Hospital and practitioner for purposes related to credentialing, privileging, managed care participation or any other quality review or service line activities, and any other health care facility or organizations at or for which the applicant seeks to practice. Each applicant and practitioner hereby agrees: (a) to execute and comply with any Authorization and Release documents that may be requested by the Hospital and/or Medical Staff to facilitate the sharing of such information, and (b) that such information, when shared or exchanged, may be evaluated and utilized as part of the appointment/reappointment or privileging process, may form the basis for a request for corrective action and/or an adverse action, and may also be exchanged as part of the preliminary review and/or investigation processes set forth in the Medical Staff Bylaws.

Section 1.3 Effect of Application

By applying for appointment to the Medical Staff and/or clinical privileges, and in addition to any other conditions, commitments or releases contained throughout the Medical Staff Bylaws, each applicant:

(a) Attests to the accuracy and completeness of all information on his or her application or accompanying documents and agreement that any inaccuracy, omission, or misrepresentation, whether intentional or not, may be grounds for termination of the application process without the right to a fair hearing or appeal. Each applicant acknowledges that if a material inaccuracy, omission or misstatement is discovered after an individual has been granted appointment and/or clinical privileges, the individual's appointment and clinical privileges shall lapse effective immediately upon notification of the individual without the right to a fair hearing or appeal. All determinations regarding whether an accuracy, omission or misrepresentation is material in nature shall be made by the MEC in its sole discretion;

(b) Signifies willingness to appear for interviews in regard to his or her application;

(c) Authorizes Hospital and Medical Staff representatives to consult with others who have been associated with him/her and/or who may have information bearing on the applicant's competence and qualifications;

(d) Consents to Hospital and Medical Staff representatives inspecting all records and documents that may be material to an evaluation of professional qualifications and competence to carry out the clinical privileges requested, of physical and mental health status and of professional ethical qualifications;

(e) Releases from liability, extends absolute immunity to, and agrees not to sue the Hospital, the Hospital's agents, the Governing Board, the Medical Staff, any member of the Medical Staff, and any Medical Staff Committee for their peer review activities, including the evaluation of the applicant, any determinations made or actions taken with respect to the applicant, and any use or communication of privileged or confidential information concerning the applicant's competence, professional ethics, character, physical and mental health, emotional stability, and other qualifications for Medical Staff appointment and clinical privileges (as applicable);

(f) Releases from any liability, extends absolute immunity to and agrees not to sue any individuals or organizations who provide information in good faith to Hospital and Medical Staff representatives concerning the applicant's competence, professional ethics, character, physical and mental health, emotional stability and other qualifications for Medical Staff appointment and clinical privileges; and

(g) Authorizes the Hospital and Medical Staff, and their designees to provide other hospitals, medical associations, the National Practitioner Data Bank, Healthcare Integrity and Protection Data Bank, licensing boards, affiliated entities of Hospital (or its successor), other health care facilities or organizations of health professionals with any information relevant to such matters that the Hospital may have concerning him or her, and releases Hospital and Medical Staff representatives from liability for so doing.

Section 1.4 Processing the Application

All requests for Medical Staff membership and/or clinical privileges by physicians, dentists, optometrists, oral surgeons, podiatrists, and Independent NPPs, as applicable, will be processed pursuant to the procedures set forth in this Credentialing Manual.

Unless Hospital policy and the practitioner's professional license and scope of practice permits the practitioner to exercise clinical privileges or provide patient care services without direction or supervision, all requests for clinical privileges or permission to provide patient care services by Dependent NPPs will be processed and evaluated by the Hospital through its Human Resources Department and/or Medical Staff Office in a manner consistent with the Hospital's pertinent policies and procedures. The Hospital may delegate credentialing verification functions pertinent to Dependent NPP's to a CVO.

1.4.1 Applicant's Burden

The applicant shall have the burden to produce adequate information for a proper evaluation of the applicant's licensure status, experience, education, background, training, current competence, demonstrated ability, physical and mental health status, emotional stability, character, and judgment, and of resolving any doubts about these or any of the other basic qualifications specified or referenced throughout the Medical Staff Bylaws. All information required to be provided or disclosed, including supplemental requests by the applicable Clinical Service, MEC, or Governing Board, must be submitted within forty-five (45) days of the request or when otherwise due by this Credentialing Manual, unless additional time is expressly permitted by the requesting party. If an applicant fails to meet this burden, the application will be deemed withdrawn, and unless waived by the MEC or Governing Board for good cause, the applicant will not be eligible to submit a new application for a period of one (1) year from the date the initial application was deemed to be withdrawn.

1.4.2 Complete Application/Verification of Information

(a) The applicant shall return an application that contains all requested information to the Medical Staff Office (or any designated credentialing verification organization ("CVO")) within sixty (60) days from the date the application was initially mailed, or otherwise provided, to the applicant, unless additional time is expressly permitted by the Credentials Committee for good cause. The applicant's failure to do so shall result in the administrative closure (and thus automatic withdrawal) of the application.

(b) Upon receipt of an application that contains all requested information, the Medical Staff Office (or any designated CVO), on behalf of the MEC, shall in a timely fashion seek to collect and obtain primary source verification of the applicant's licensure history, medical education and postgraduate training, malpractice insurance history, board certification status, sanctions and disciplinary actions, criminal history, employment/appointment history, professional references, and other qualification evidence submitted, including, but not limited to, National Practitioner Data Bank and Healthcare Integrity and Protection Data Bank information. The Medical Staff Office (or designated CVO) will also request from the Indiana Professional Licensing Agency all information concerning the licensure status and any disciplinary action taken against an applicant's license.

(c) An application will be deemed "complete" when the Medical Staff Office (or designated CVO) receives all information required by this Section 1.4.2. The Medical Staff Office will return an incomplete application to the applicant, along with notification of any problems or omissions in obtaining the information required. It shall then be the applicant's obligation/burden, as set forth above in Section 1.4.1, to obtain or provide the required information (as applicable) in order to achieve a complete application.

(d) Once an application is determined by the Medical Staff Office (or designated CVO) to be complete, the Medical Staff Office (or designated CVO) will provide or electronically transmit the application (including all supporting materials) to the Chief of the Clinical Service in which the applicant requests clinical privileges.

(e) In the event the Clinical Service, Clinical Service Chief, the MEC, and/or the Board thereafter determine at any point that any additional documentation or

information is necessary to fully evaluate the application, the applicant (as set forth in Section 1.4.1) shall have the burden to timely provide (or cause to be provided) such documentation/information. The application shall be deemed incomplete upon such a determination/request and until such time as the applicant has timely provided all requested documentation and information.

1.4.3 Clinical Service Action

The Clinical Service Chief or Medical Director, as applicable, shall initially review the complete application, and has the discretion to call a meeting with the MEC or other members of the Clinical Service to assist the Chief/Director in the credentialing and privileging process. The Clinical Service Chief/Director also has the discretion to conduct an interview with, or otherwise request additional information from, the applicant. As soon as practicable, but not more than fifteen (15) days after receiving the application, unless circumstances reasonably require additional time, the Clinical Service Chief/Director shall transmit a written recommendation on the prescribed form, including delineated clinical privileges, to the MEC. The Clinical Service Chief's/Director's written recommendation should include a statement that the requested appointment and/or clinical privileges be granted, denied, or modified, and should also contain reference to any additional information, including any Clinical Service-specific input, that is deemed relevant to the review. The Clinical Service Chief/Director shall conduct his or her review on behalf of the applicable Clinical Service, which itself is constituted as a peer review committee, and shall do so with the intent of reducing morbidity and mortality, and to improve the quality of patient care provided at the Hospital.

1.4.4 Medical Executive Committee Action

(a) Within thirty (30) days after receiving the complete application, all associated supporting materials, and the written recommendation from the Clinical Service Chief/Director, and unless additional time is reasonably required in the discretion of the MEC, the MEC shall review and consider all such documentation and information. The MEC may, as part of its review, conduct a personal interview with the applicant. Such an interview is not required and shall be requested/conducted in the MEC's sole discretion. The MEC may also request/conduct any other interviews, and/or request/review any other documentation or information that it deems necessary or appropriate under the circumstances as part of the review process.

(b) Once the MEC has (through its review and consideration of the complete application, including all supporting documentation and information) evaluated the licensure status, training/education, professional competence, character, judgment, experience, health status, ethical standing of the applicant, and other applicable qualifications of the applicant, as well as the Clinical Service Chief's/Director's recommendation, the MEC shall determine whether to:

(i) Recommend to the Governing Board that the applicant be appointed to the Medical Staff and/or that specific clinical privileges be granted;

(ii) Recommend to the Governing Board that the applicant be denied for Medical Staff membership and/or that specified clinical privileges be denied; or

(iii) Defer MEC action on the application for no more than sixty (60) days, unless circumstances reasonably require additional time, at which time a recommendation to the Governing Board must be made.

(c) The MEC shall conduct its review in its capacity as a peer review committee, and therefore shall do so with the intent of reducing morbidity and mortality, and to improve the quality of patient care provided at the Hospital.

1.4.5 Governing Board Action

Upon reviewing the application and all supporting material forwarded by the MEC, at its next regular meeting the Governing Board shall, in whole or in part, accept or decline to accept the recommendation of the MEC. Alternatively, it may refer the application back to the MEC for further consideration, stating the reasons for this action and setting a time limit within which any subsequent recommendation shall be made.

1.4.6 Notice of Final Decision

(a) If the Governing Board's action is favorable to the applicant, it shall become effective as a final determination. Notice of final determinations shall be communicated to the Chief of Staff, the applicable Clinical Service Chief/Director, and the Medical Staff Office, who shall notify the applicant in writing.

(b) If the decision of the Governing Board is adverse to the applicant with respect to appointment and/or clinical privileges, the CEO shall send a Special Notice of the adverse decision to the applicant. A copy shall be provided to the Chief of Staff and Medical Staff Office. The notice will explain the general reasons for the adverse decision. Initial applicants for appointment to the Medical Staff subject to an adverse determination are not entitled to a hearing or any other form of reconsideration, unless the decision is an adverse action, as that term is defined in the Corrective Action and Fair Hearing Manual. Adverse actions regarding the granting or renewal of clinical privileges for NPPs are addressed in Section 2.5, below.

(c) A decision and notice of appointment to the applicant shall be provided within sixty (60) days of the Governing Board's decision and shall include, as applicable, the Medical Staff category to which the applicant is appointed, the Clinical Service to which he or she is assigned, the clinical privileges he or she may exercise, and any special condition(s) attached to the appointment and/or clinical privileges.

1.4.7 Reapplication after Adverse Appointment or Privileges Decision

An applicant or practitioner who has received a final adverse decision regarding appointment, reappointment and/or clinical privileges, or has otherwise had his or her medical staff membership and/or clinical privileges at the Hospital revoked or terminated by way of an adverse action, shall not be eligible to reapply for appointment to the Medical Staff or for clinical privileges for a period of five (5) years from the date of the final action. When eligible to reapply, any such application shall be processed as an initial application, and the applicant shall submit such additional information as the Medical Staff or the Governing Board may require. Eligibility to apply, however, does not guarantee appointment to the Medical Staff or clinical privileges. The Medical Staff and Governing Board may consider the circumstances giving rise to the prior adverse action(s), if in their discretion they deem such circumstances relevant, when evaluating the application for Medical Staff membership and/or clinical privileges. Additionally, the Medical Staff and Governing Board, in their discretion, may rely upon the prior adverse action(s) and related findings in making recommendations and determinations with respect to the applicant.

Section 1.5 Reappointment/Renewal Process

1.5.1 Information Form for Reappointment

The Hospital's Medical Staff Office or a designated CVO shall, not less than one hundred twenty (120) days prior to the expiration date of a Medical Staff appointment and/or expiration of clinical privileges, provide the practitioner with an appropriate reappointment or renewal application form for use in considering reappointment and/or renewal of clinical privileges. Each practitioner who desires reappointment or renewal shall, not less than ninety (90) days prior to such expiration date, submit a fully completed reappointment/renewal application form to the Medical Staff Office or CVO, as applicable, an addition to any other requested information. In the event the Hospital is unable to fully process a request for reappointment or renewal (as applicable) prior to the expiration of a practitioner's then current term of appointment and/or clinical privileges (as applicable), the practitioner's Medical Staff membership and clinical privileges (as applicable) shall lapse, and thereafter, the practitioner must reapply for Medical Staff membership or clinical privileges pursuant to the initial appointment process.

1.5.2 Content of Reappointment Application Form

The content of the reappointment/renewal application form shall include, but not be limited to, the applicable information set forth in Section 1.2.2 of this Credentialing Manual. Notwithstanding the foregoing, the timeframe for such requests may be limited to the prior two-year period of appointment, and the results of OPPE conducted at the Hospital with respect to the practitioner over the two-year period of reappointment (if such results are complete and span the entire two-year period) may be utilized in lieu of the letters of reference required by Section 1.1.2(d).

Section 1.6 Processing of Reappointment and/or Renewal of Clinical Privileges

1.6.1 Reappointment Burden

The practitioner applying for reappointment and/or clinical privileges shall have the same burden of producing adequate information and resolving doubts as provided in Section 1.4.1 of this Credentialing Manual.

1.6.2 Complete Application/Verification of Information

The Hospital and Medical Staff shall in a timely fashion, in conjunction with any designated Verification Office, seek to collect and verify all information made available on each reappointment application form and to collect any other materials or information required or deemed pertinent, including, but not limited to information provided by or through the National Practitioner Data Bank and the Office of the Inspector General, and information regarding the practitioner's professional activities, performance and conduct in the Hospital and fulfillment of Medical Staff membership and/or clinical privileges obligations, including fulfillment of Medical Staff, Clinical Service, and Committee responsibilities, as applicable. The Hospital shall also request from the Indiana Professional Licensing Agency information concerning the licensure status and any disciplinary action taken against a practitioner's license.

The same provisions/obligations set forth in Section 1.4.2, above (regarding complete applications/verification of information), shall otherwise apply.

1.6.3 Clinical Service Action

The Clinical Service Chief/Director shall review the prescribed recredentialing/renewal form, all supporting materials furnished by the practitioner, and all other information and materials as deemed appropriate, including any OPPE and other quality or peer review reports pertaining to the practitioner. The Clinical Service Chief/Director may interview the practitioner and/or consult with other members of the Clinical Service and the MEC to assist the Chief/Director in this credentialing and privileging process. As soon as practicable, but not more than fifteen (15) days after receiving the prescribed recredentialing/renewal form, unless circumstances reasonably require additional time, the Clinical Service Chief/Director shall transmit (on the prescribed form(s)) the Clinical Service Chief's/Director's written recommendation to the MEC that the requested reappointment and/or clinical privileges be renewed, that the requested reappointment be renewed with modified Medical Staff category and/or Clinical Service affiliation and/or clinical privileges, or that the appointment and/or clinical privileges be denied/terminated. The Clinical Service Chief/Director shall conduct his or her review on behalf of the applicable Clinical Service, which is constituted as a peer review committee, and shall do so with the intent of reducing morbidity and mortality, and to improve the quality of patient care provided at the Hospital.

1.6.4 MEC and Governing Board Action

Once the Clinical Service Chief/Director has completed his or her review of the reapplication and submitted his or her recommendations to the MEC, the procedures set forth in Sections 1.4.4 through 1.4.7 of this Credentialing Manual shall be followed. For purposes of reappointment or renewal, the term "appointment" as used in those Sections shall be read as "reappointment."

1.6.5 Basis for Recommendations

Each recommendation concerning the reappointment of a Medical Staff member and the clinical privileges to be granted upon reappointment, including renewal of clinical privileges for an NPP, shall be based upon documented evidence of such practitioner's eligibility; professional ability and clinical judgment in the treatment of patients; professional ethics; discharge of Medical Staff, Clinical Service and clinical privileges obligations; compliance with Hospital Policies; cooperation with other practitioners and with patients; the practitioner's ability to safely practice; the practitioner's reasonable participation in continuing education activities relevant to his or her clinical privileges; and other matters bearing on ability and

willingness to contribute to quality patient care in the Hospital. A practitioner's eligibility for reappointment of membership and/or renewal of clinical privileges will also be based on compliance with the minimum number of patient contacts per each appointment/clinical privileges period as required by the applicable Medical Staff category qualifications and/or established by the practitioner's Clinical Service, MEC, and/or Governing Board for the purpose of verifying clinical activity, clinical competence, and/or engagement in Medical Staff Office. Relevant data generated through OPPE, FPPE, and other peer review processes at the Hospital shall also be considered. This data shall include, but certainly not be limited to, meeting attendance and compliance with other Medical Staff requirements and obligations required by Hospital Policies.

Section 1.7 Credentialing of Non-Physician Practitioners

NPPs shall be privileged through the Medical Staff credentialing procedures set forth in this Credentialing Manual. Additional special conditions applicable to NPPs are set forth in Section 2.5, below.

Section 1.8 Requests for Modification of Membership Status or Clinical Privileges

A practitioner may, either in connection with reappointment or renewal or at any other time, request modification of Medical Staff category, Clinical Service assignment, or clinical privileges. A requested change in Medical Staff category or Clinical Service assignment shall be sent to the Chief of Staff or designee, whereas a requested change in clinical privileges shall be sent to the appropriate Clinical Service Chief. All requests for additional clinical privileges must be accompanied by evidence of the practitioner's education, training, experience, board certification (if applicable), and competence to perform the specific clinical privileges requested. Such application shall be processed in substantially the same manner as provided in Section 1.6 of this Credentialing Manual for reappointment.

ARTICLE 2: CLINICAL PRIVILEGES

Section 2.1 Exercise of Privileges

Any practitioner providing direct clinical services at the Hospital shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted to him/her by the Governing Board. While only physicians, dentists, optometrists, oral surgeons, and podiatrists are eligible for Medical Staff membership, NPPs may also be granted clinical privileges in order to provide Clinical Services at the Hospital in accordance with this Article, the Medical Staff Governance and Organization Manual, and applicable Hospital Policies. All clinical privileges and services must be within the scope of the practitioner’s license, certificate or other legal authority authorizing him/her to practice in Indiana and consistent with any applicable restrictions. The care of all patients admitted by an NPP, if permitted by their clinical privileges, must be under the care of a physician member of the Medical Staff.

Section 2.2 General Delineation of Clinical Privileges

2.2.1 Requests

(a) Each application for appointment and reappointment to the Medical Staff and/or for clinical privileges must contain a request for the specific clinical privileges desired by the practitioner. A request for a modification of clinical privileges must be supported by documentation of appropriate training and/or experience supportive of the request and must be consistent with all criteria that have been delineated and established by the Governing Board and Clinical Service in which the practitioner is a member.

(b) Any request for clinical privileges for which there are no approved requirements may be held for a period of up to one hundred twenty (120) days, or for a longer period if determined to be necessary by the Governing Board. During this time, the Clinical Service(s) and the MEC may create requirements and formulate the necessary criteria for clinical privileges under which the request may be processed for approval by the Governing Board. All requirements for clinical privileges will consist of baseline criteria specifying the minimum education, training, experience, and evidence of competency required. All clinical privileges are subject to the reasonable resources and capabilities of the Hospital.

2.2.2 Basis for Clinical Privileges Determination

Requests for clinical privileges shall be evaluated based on the practitioner's education, training, certifications, experience, demonstrated ability, judgment, and compliance with Hospital Policies, and should take into consideration the resources and capabilities of the Hospital. If available, the basis for clinical privileges determinations shall also include clinical performance as observed or reviewed through the Hospital's quality improvement programs. In addition, other factors to be considered shall be the results of focused and ongoing professional practice monitoring and evaluation activities, other peer review activities, and whether the applicant meets applicable patient contacts requirements, all as may be required by Hospital Policies. A clinical privileges determination shall also be based on pertinent information concerning clinical performance obtained from other sources, such as peers of the practitioner, and/or from other institutions, especially from health care settings where the practitioner exercises the clinical privileges that are requested. This information shall be maintained in the quality file established for each practitioner.

Section 2.3 Special Conditions for Oral Surgery, Dental, Optometrist, and Podiatric Clinical Privileges

2.3.1 Oral Surgery and Dental Clinical Privileges

Requests for clinical privileges from oral surgeons and dentists shall be processed in the same manner as any other applicant or reapplicant. Procedures performed by oral surgeons and dentists shall be under the overall supervision of the Chairperson of the Clinical Service of Surgery or designee. Except with respect to oral surgeons who qualify for and receive clinical privileges to perform the medical portion of the history and physical, a medical history and physical examination will be made and recorded by a physician who is a member of the Medical Staff. The designated physician member shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization and shall determine the risk and effect of the proposed procedure on the total health status of the patient. The oral surgeon or dentist will be responsible for the dental care of the patient,

including the dental history and physical examination. Oral surgeons and dentists may issue orders within their licensed scope of practice and granted clinical privileges, and consistent with applicable Medical Staff policies.

2.3.2 Podiatric Clinical Privileges

Requests for clinical privileges from podiatrists shall be processed in the same manner as any other applicant or reapplicant. Procedures performed by podiatrists shall be under the overall supervision of the Chief of the Surgery Clinical Service or designee. A medical history and physical examination will be made and recorded by a physician who is a member of the Medical Staff. The designated physician member shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization and shall determine the risk and effect of the proposed procedure on the total health status of the patient. The podiatrist will be responsible for the podiatric care of the patient, including the complete history and physical examination. Podiatrists may issue orders within their licensed scope of practice and granted clinical privileges, and consistent with applicable Medical Staff policies.

2.3.3 Optometry Clinical Privileges

Requests for clinical privileges from optometrists shall be processed in the same manner as any other applicant or reapplicant. Procedures performed by optometrists shall be under the overall supervision of the Chief of the Surgery Clinical Service or designee. A medical history and physical examination will be made and recorded by a physician who is a member of the Medical Staff. The designated physician member shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization and shall determine the risk and effect of the proposed procedure on the total health status of the patient. The optometrist will be responsible for the optometric care of the patient, including the optometry history and physical examination. Optometrists may issue orders within their licensed scope of practice and granted clinical privileges, and consistent with applicable Medical Staff policies.

Section 2.4 Special Conditions for Residents and Fellows

Residents in training in the Hospital shall not normally hold membership on the Medical Staff and/or be granted specified clinical privileges. Residents and fellows in training shall be permitted to function clinically in accordance with the written training protocols developed by the MEC or program director in conjunction with the then current residency or fellowship training program (as applicable). All such residents and fellows shall be under the supervision of a physician member of the Medical Staff.

Residents and fellows with an Indiana medical license and who intend to practice beyond the scope of their training program (e.g., "moonlighting") in the Hospital, and who meet all other conditions/requirements for Medical Staff membership and clinical privileges, shall be required to apply for and receive appropriate Medical Staff membership and clinical privileges pursuant to the procedures set forth in this Credentialing Manual and the Medical Staff Bylaws.

Section 2.5 Special Conditions for Non-Physician Practitioners

(a) NPPs may only exercise clinical privileges on the condition that they are/remain employees of the Hospital, or alternatively, are supervised by or formally collaborate with a designated supervising or collaborative physician member of the Medical Staff (if such supervision or collaboration is required by the NPP's lawful scope of practice) who has (at least) equivalent clinical privileges, unless otherwise permitted by the practitioner's clinical privileges or Hospital Policies. All such practitioners must provide evidence, when required, of a current collaborative, supervisory, or employment agreement (as applicable) with a physician member of the Medical Staff.

NPP categories or professions approved by the Governing Board to provide services at the Hospital are eligible to apply for clinical privileges. NPPs may, subject to any licensure requirements or other limitations, exercise independent judgment only within the scope of practice, areas of professional competence, granted clinical privileges, and applicable Hospital Policies. The current list of NPP categories and professions approved by the Governing Board are as follows:

(i) Clinical Psychologists;

(ii) Nurse Practitioners;

(iii) Physician Assistants;

(iv) Clinical Nurse Specialists;

(v) Certified Registered Nurse Anesthetists;

(vi) Chiropractors

(vii) Physical Therapists;

(viii) Occupational Therapists; and

(ix) Speech Therapists.

(b) NPPs must either be (i) employed by the Hospital (or an authorized Hospital affiliate) or (ii) if expressly permitted by Hospital Policy by a physician member of the Medical Staff with clinical privileges (appropriate to meaningfully/appropriately supervise the NPP if and to the extent required by law) or by that physician's professional group or practice (collectively referred to in this Section 2.5 as the "Employing Physician").

2.5.2 Automatic Suspension/Termination

(a) The clinical privileges of an NPP shall administratively terminate, effective immediately and without recourse to any procedural rights set forth elsewhere in the Medical Staff Bylaws, in the event that the practitioner's employment by, or professional services contract (directly or through an affiliated entity) with, the Hospital or Employing Physician (as applicable) terminates for any reason.

(b) The clinical privileges of an NPP shall administratively suspend, effective immediately and without recourse to any procedural rights set forth elsewhere in the Medical Staff Bylaws, in the event that a required supervisory or collaborative agreement with a member of the Medical Staff is terminated for any reason. The NPP shall be permitted a period of thirty (30) days, commencing on the date the supervisory or collaborative agreement (as applicable) terminates, to enter into a new or alternate supervisory or collaborative agreement (as applicable and required by law) with another qualified member of the Medical Staff. If the NPP fails to enter into a new or alternate, legally valid, supervisory or collaborative agreement (as applicable and required by law) prior to the expiration of thirty (30) days, then the NPP's suspension shall be automatically/administratively converted to a termination of clinical privileges, without recourse to any procedural rights set forth elsewhere in the Medical Staff Bylaws.

2.5.3 Responsibilities of Employing or Collaborative/Supervising Member

(a) The number of NPPs acting as employees of and/or under the collaboration/supervision of one (1) member of the Medical Staff, as applicable, as well as the actions that the NPP(s) may undertake, shall be consistent with all applicable Hospital Policies.

(b) It shall be the responsibility of the collaborating or supervising member of the Medical Staff to countersign all medical record entries made by the NPP if required by applicable Hospital Policies.

(c) NPPs must maintain professional liability insurance, in the form and amounts required by the Governing Board, to cover any and all activities of the NPP at the Hospital and must furnish evidence of such coverage to the Hospital. An NPP shall exercise clinical privileges only while such coverage is in effect.

2.5.4 Hospital Employed NPPs

Except as provided below, the employment of an NPP by the Hospital shall be governed by the Hospital's employment policies and the terms of the individual's employment relationship. If the Hospital's employment policies, or the terms of any applicable employment relationship are more restrictive than, or conflict with, this Credentialing Manual, the employment policies or terms of the individual's employment relationship shall take priority.

(a) NPP Application. A request for clinical privileges, on an initial basis or for renewal, submitted by an NPP who is seeking employment or who is employed by the Hospital shall be processed in accordance with the medical staff credentialing process set forth in this Credentialing Manual. A report regarding each practitioner's qualifications shall be made to the CEO or the

Hospital's Human Resources Department, as appropriate for employment related decisions.

(b) Corrective Action. If concerns or complaints about a Hospital employed NPP's clinical competence or professional conduct originates with the Medical Staff, the concern may be reviewed and addressed in accordance with the pertinent provisions set forth in the Corrective Action and Fair Hearing Manual, and/or the concerns may also be reported to and addressed by the Hospital's Human Resources Clinical Service.

Section 2.6 Review following Denial of Clinical Privileges

(a) Excluding NPPs employed by the Hospital, in the event that an NPP is denied, in full or in part, clinical privileges requested pursuant to the procedures set forth in this Credentialing Manual, the NPP (and when applicable his or her Employing Physician member of the Medical Staff) shall have the right to appear personally before the MEC (or other designated Medical Staff Committee) to discuss the decision.

(b) If the NPP desires to appear before the MEC, he or she must make a written request to the MEC Chairperson within ten (10) days of receiving the notice of denial.

(c) If the NPP timely and appropriately requests a meeting, the NPP will be informed of the general nature of the information supporting the denial prior to the scheduled meeting.

(d) At the meeting, the NPP (and when applicable his or her employing or supervising physician member of the Medical Staff) shall be invited to discuss the decision.

(e) Within ten (10) days following the meeting, unless additional time is reasonably required, the MEC shall notify the Governing Board of its recommendation to uphold, reverse, or modify the denial.

(f) At its next regularly scheduled meeting, unless additional time is reasonably required, the Governing Board shall determine whether to uphold, reverse, or modify the denial. The NPP will be notified in writing of the Governing Board's determination.

Section 2.7 Telemedicine Clinical Privileges

2.7.1 Appointment to Medical Staff

Applicants seeking appointment to the Medical Staff and/or clinical privileges to perform telemedicine services may, but need not, be processed pursuant to the complete appointment and privileging procedures described in Section 1.4 above. Further, such applicants may be exempted by the MEC from particular Medical Staff requirements/obligations that are not applicable by virtue of the applicant's distant site practice (including but not limited to vaccination requirements, meeting attendance requirements, and other such requirements/obligations). Alternatively, in the case of applicants who intend to provide telemedicine services under a written agreement between the Hospital and a distant-site hospital or entity, the MEC may make recommendations to the Governing Board regarding

such applicants in reliance upon the credentialing and privileging decision of the distant-site hospital or entity with whom the Hospital has an agreement for telemedicine services.

2.7.2 Applicants from Distant-Site Hospitals or Entities

Applicants based at distant-site hospitals or entities who intend to provide telemedicine services under a written agreement with the Hospital may apply for such telemedicine clinical privileges and appointment to the Auxiliary Staff provided each applicant meets the basic qualifications for appointment set forth in Section 1.2 of the Medical Staff Organization and Governance Manual and by submission of the same application or application with equivalent content as specified in this Credentialing Manual. All determinations regarding equivalent content will be made by the MEC and Governing Board.

2.7.3 Credentialing of Applicants from Distant-Site Hospitals or Entities

Upon confirmation by the Medical Staff Office that an applicant's request for appointment and telemedicine privileges complies with the terms of the written agreement between the Hospital and the distant-site hospital or entity, including clinical privileges criteria adopted by the Medical Staff, the MEC may rely upon the credentialing and privileging decisions made by a distant-site hospital or telemedicine entity when making its recommendation for appointment and clinical privileges provided the agreement between the Hospital and distant-site hospital or entity (minimally) ensures the following:

(a) The distant-site hospital is a Medicare participating hospital or the distant-site telemedicine entity provides written assurances that its credentialing and privileging process and standards meet the Medicare Conditions of Participation for Hospitals;

(b) The distant-site hospital or distant-site telemedicine entity, as applicable, meets all other pertinent accreditation requirements to which the Hospital may be subject;

(c) The practitioner is privileged at the distant-site hospital or distant-site telemedicine entity and a current list of equivalent privileges is provided;

(d) The distant-site practitioner holds a current license issued or recognized by the State of Indiana, and complies with any Indiana-specific certification/registration requirements;

(e) The practitioner meets the professional liability insurance requirements established by the Governing Board; and

(f) That upon being granted membership and/or clinical privileges, the Hospital provides the distant-site hospital or entity evidence of an internal review of the practitioner's clinical performance for use in the practitioner's periodic appraisal and, at a minimum, the information must include all adverse events resulting from the telemedicine services provided by the distant-site practitioner as well as any registered complaints.

2.7.4 Failure to Utilize Clinical Privileges

If a practitioner who has been granted clinical privileges to provide telemedicine services at the Hospital fails to utilize such clinical privileges or otherwise provide telemedicine services to Hospital patients at a satisfactory volume as determined by the practitioner's assigned

Clinical Service for the purpose of reliably assessing the quality and performance of the practitioner's telemedicine services, the member shall be deemed to have voluntarily withdrawn his or her Medical Staff membership and clinical privileges, without right of appeal or hearing, effective either six (6) months following the date practitioner last provided telemedicine services at the Hospital or when otherwise acknowledged by the Medical Staff**.**

2.7.5 Temporary Clinical Privileges for Telemedicine Applicants

If the Hospital has not entered into a written agreement for telemedicine services with a distant-site hospital or entity but has a pressing clinical need for telemedicine services and a distant-site practitioner can supply such services via a telemedicine link, the Hospital may evaluate the use of temporary clinical privileges for a distant-site practitioner as addressed in Section 2.8, below. In such cases, the distant-site practitioner must be credentialed and privileged to provide telemedicine services in accordance with Hospital standards and procedures applicable to the approved telemedicine services.

Section 2.8 Temporary Clinical Privileges

2.8.1 Circumstances

The CEO (or the CEO's authorized designee), acting on behalf of the Governing Board, may grant specific temporary clinical privileges as set forth in this Section. Temporary clinical privileges may be made contingent upon, in the discretion of the CEO, successful completion of any Hospital sponsored training programs related to electronic medical record (EMR) and related clinical system implementation, and/or submission of required program documentation prior to review of the request for temporary admitting and clinical privileges by the applicable Medical Director or Clinical Service Chief.

(a) Pendency of Application

Upon receipt of a complete application for Medical Staff appointment and request for specific clinical privileges that has been received, reviewed, and recommended for approval by the applicable Clinical Service Director or Chief of Service, as applicable (or authorized designee), and the Chief of Staff (or authorized designee), an appropriately licensed physician, dentist, optometrist, oral surgeon, podiatrist, or NPP may be granted temporary clinical privileges for a period of up to sixty (60) days. In exercising such temporary clinical privileges, the applicant shall act under the supervision of the Medical Director or Chief of Service, as applicable (or authorized designee), to which he or she is assigned and in accordance with the conditions specified in Section 2.8 of this Credentialing Manual.

(b) Care of Specific Patients/Important Patient Care Need

Upon the recommendation of the applicable Clinical Service Director or Chief of Service, as applicable (or authorized designee), and the Chief of Staff (or authorized designee), a duly licensed physician, dentist, optometrist, oral surgeon, podiatrist, or NPP of documented competence may be granted temporary clinical privileges for the care of one or more specific patients. Such temporary clinical privileges shall only be granted under extraordinary circumstances, may be limited by the CEO to a specified number of patients, and shall be exercised in accordance with the conditions specified in Section 2.8 of this Credentialing Manual. The granting of temporary privileges for this purpose is not precipitous, and occurs only after (minimally):

(i) Verification of licensure, Drug Enforcement Administration (DEA) registration, Indiana CSR, professional liability insurance in such amounts that are required by the Governing Board, and

(ii) At least one recent reference from a previous hospital, chief of staff, or department chair.

(c) Locum Tenens

Upon the recommendation of the applicable Clinical Service Director or Chief of Service, as applicable (or authorized designee), and the Chief of Staff (or authorized designee), a duly licensed physician, dentist, optometrist, oral surgeon, podiatrist, or NPP of documented competence who will serve as a locum tenens may (without applying for Medical Staff membership) be granted locum tenens clinical privileges for an initial period of up to sixty (60) days in accordance with the conditions specified in Section 2.8.2 of this Credentialing Manual. The granting of temporary privileges for this purpose is not precipitous, and occurs only after (minimally):

(i) Verification of licensure, Drug Enforcement Administration (DEA) registration, Indiana CSR, professional liability insurance in such amounts that are required by the Governing Board, and

(ii) At least one recent reference from a previous hospital, chief of staff, or department chair.

Temporary clinical privileges for purposes of locum tenens are not intended to be sequential such that they bypass the standard credentialing process. Accordingly, such temporary clinical privileges may only be renewed for one (1) period of up to sixty (60) days (but not to exceed his or her period of service as locum tenens), shall be limited to treatment of the patients of the practitioner for whom he or she is serving as locum tenens, and shall be exercised in accordance with the conditions specified in Section 2.8 of this Credentialing Manual.

2.8.2 Conditions

Temporary clinical privileges may be granted by the CEO only when the individual requesting temporary clinical privileges meets the basic qualifications set forth in the Medical Staff Governance and Organization Manual. Any practitioner seeking temporary clinical privileges must have his or her qualifications appropriately verified, as set forth above. Special requirements of consultation and reporting may be imposed by the Chief of Staff and/or the Clinical Service Chief or Clinical Service Director who is responsible for supervision of a practitioner granted temporary clinical privileges. Before temporary clinical privileges are granted, the practitioner must acknowledge in writing that he or she has received, or been given access to, all applicable Hospital Policies (including but not limited to the Medical Staff Bylaws and the Hospital Corporate Compliance Plan) and that he or she agrees to be bound by the terms thereof in all matters relating to temporary clinical privileges.

2.8.3 Suspension

On the discovery of any information or the occurrence of any event of a nature which raises questions about a practitioner's professional qualifications, professional conduct, or ability to appropriately or safely exercise any or all of the temporary clinical privileges granted, temporary clinical privileges may be summarily suspended by any of the individuals identified in Section 1.2 of the Corrective Action and Fair Hearing Manual. In the event of such suspension, the practitioner's patients then in the Hospital shall be assigned to a Medical Staff member(s) by the applicable Clinical Service Chief(s). The wishes of patients shall be considered, where feasible, in choosing a substitute practitioner. The substitute practitioner(s) shall have the right to refuse to accept such patient assignments, in which case the Chairperson shall assign the patients to another substitute practitioner(s).

2.8.4 Rights of a Practitioner with Temporary Clinical Privileges

By applying for temporary clinical privileges, all practitioners acknowledge the expected short-term nature of such status and that such status does not confirm appointment, or an expectation of appointment, to the Medical Staff. Accordingly, all such practitioners expressly agree that the practitioner shall **not** be entitled to the procedural rights afforded by the Corrective Action and Fair Hearing Manual in the event: a request for temporary clinical privileges is refused or denied, or (if such temporary privileges are granted) all or any portion of the temporary clinical privileges are summarily suspended, restricted in any fashion, and/or terminated.

Section 2.9 Emergency Clinical Privileges

For the purpose of this Section, an "emergency" is defined as a condition in which serious or permanent harm would result to a patient or bystander or in which the life of a patient or bystander is in immediate danger and any delay in administering treatment would add to that danger. In the case of an emergency, any practitioner (within the scope of his/her license) 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 of any consultation necessary or desirable, regardless of his or her Clinical Service assignment, Medical Staff status, or clinical privileges. The practitioner shall make every reasonable effort to communicate promptly with the appropriate individuals concerning the need for emergency care and assistance by members of the Medical Staff with appropriate clinical privileges, shall promptly yield such care to qualified members of the Medical Staff when it becomes reasonably available, and once the emergency has passed or assistance has been made available, shall defer to the

appropriate Clinical Service Chief and/or Section Chief (as applicable) with respect to further care of the patient.

Section 2.10 Disaster Clinical Privileges

Any individual intending to provide professional services during a disaster event must be granted clinical privileges prior to providing patient care. Disaster clinical privileges are considered temporary in nature and may be granted following verification of the volunteer's identity and evidence of state professional license. The procedure for granting disaster clinical privileges, including the applicable time requirements, is set forth in the Medical Staff Policy: "Granting Practitioners 'Emergency' Privileges," which is incorporated herein by reference.

Section 2.11 History and Physical Examination Requirements

A medical history and physical examination, which is signed or cosigned by a physician, must be completed and documented for each patient in accordance with Hospital Policies. In all instances, a history and physical exam must be performed and documented within thirty (30) days prior to date of admission or registration, or within twenty-four (24) hours after an admission or registration, but prior to surgery or a procedure requiring anesthesia services. If a history and physical is performed and documented within 30 days prior to the date of admission, then a thorough updating entry must be provided within twenty-four (24) hours after the admission, which documents/addresses vital signs, systems stability, any systems or other relevant change, and any other information pertinent to the admission. If the report has been dictated, but not yet recorded in the patient's chart, there shall be a statement to that effect and an admission note in the chart by the admitting physician, which includes vital signs, allergies, and appropriate data.

Section 2.12 Impaired Member or NPP

(a) An impaired member or NPP is one who is unable to practice their health profession with reasonable skill and safety to patients due to a physical or mental illness or condition, whether caused by aging, loss of motor skills, the excessive use or abuse of drugs, including alcohol or other problems affecting his or her ability to practice effectively and safely. The Medical Staff mandates that all practitioners who are granted clinical privileges, exercise such clinical privileges without impairment while in the Hospital, or at any of its satellites or at any Hospital sponsored event. All practitioners agree, as a condition of their appointment to the Medical Staff or granting of clinical privileges, to abide by the MEC's authority and policies regarding impairment within the Hospital. If a practitioner notifies the Medical Staff of an impairment or is suspected of being impaired, the MEC will address the matter under its authority in these Bylaws, and at the discretion of the CEO, the matter may be addressed pursuant to the Hospital's human resources policies for individuals employed by the Hospital and individuals who work for a group under contract with the Hospital.

(b) The MEC will address all Member and NPP impairment matters in a confidential, unbiased manner while striving to protect patient safety and the rights of the applicable practitioner. The MEC is under no obligation to evaluate or treat an impaired practitioner, as this is an obligation of the practitioner's personal physician or other health care providers. The MEC, in its discretion, may rely upon evaluations and assessments by the practitioner's providers and/or independent practitioners to determine whether a practitioner is safe to practice. This determination may involve

establishing conditions that the Member or NPP must meet to continue practicing, which may include, but are not limited to: random drug screens, regular appointments with a psychologist, psychiatrist or other appropriate provider; imaging, laboratory or other diagnostic studies; proof of attendance at treatment related meetings; and/or a conditional leave of absence. If there is sufficient evidence supporting impairment and if a practitioner fails to satisfy any conditions imposed by the MEC, or if quality of care or patient safety are at risk, a practitioner's membership and/or clinical privileges (as applicable) may be suspended pending further investigation in accordance with the Corrective Action and Fair Hearing Plan. In addition, the Chief of Staff may appoint an interim practitioner, as appropriate, to assume care for any Hospital patients under the care of the impaired practitioner.

Section 2.13 Outpatient Diagnostic Services

Physicians, dentists, optometrists, oral surgeons, podiatrists, or NPPs who are not members of the Medical Staff and/or who do not have clinical privileges at the Hospital may order outpatient diagnostic services and outpatient therapeutic services as set forth in the Medical Staff Policy: "Outpatient Services Orders by Physician/Non-Physician Practitioners," which is incorporated herein by reference.

Section 2.14 Medical Staff Delegation

The Medical Staff delegates to the Physical Therapists and Speech Therapists evaluation, development and initiation of the plan of care in their respective disciplines upon the order or referral of a M.D., D.O., podiatrist, psychologist, optometrist, chiropractor, dentist, nurse practitioner, or physician assistant holding an unlimited license to practice medicine, surgery, optometry, osteopathic medicine, podiatric medicine, psychology, optometry, chiropractic, dentistry, nursing or as a physician assistant, respectively. Occupational Therapists are not permitted to accept orders from a dentist.

Evaluations and treatment without a referral; exceptions:

(i) In the outpatient setting, a physical therapist may evaluate and treat an individual during a period not to exceed forty-two (42) calendar days beginning with the date of initiation of treatment without a referral from a provider as listed above.

(ii) If the individual needs additional treatment from the physical therapist after forty-two (42) calendar days, the physical therapist shall obtain a referral from the individual's provider.

A physical therapist may not perform spinal manipulation of the spinal column or the vertebral column unless: (1) the physical therapist is acting on the order or referral of a physician, osteopathic physician, or a chiropractor has examined the patient before issuing the order or referral.

The Medical Staff delegates to the dietitians the evaluation and ordering diets and nutrition supplements per Medical Staff policy and procedure.

Section 2.15 Focused and Ongoing Professional Practice Evaluation

As part of its ongoing quality improvement activities, and in compliance with Indiana state and federal law requirements and accreditation standards, the Hospital engages in both Focused and Ongoing Professional Practice Evaluation.

(a) Focused Professional Practice Evaluation ("FPPE") at the Hospital is intended to serve two purposes:

(i) The "peer review" evaluation, for privilege-specific competency, of (a) new practitioners at the Hospital seeking clinical privileges and of (b) current practitioners at the Hospital that have requested to receive new or additional clinical privileges; and

(ii) The "peer review" evaluation of practitioners at the Hospital where specific performance related concerns implicating patient safety and/or quality of care are identified.

The Hospital's process for FPPE is set forth in SPP MS-19 Medical Staff Professional Practice Evaluation

(b) Ongoing Professional Practice Evaluation ("OPPE") is a systematic and ongoing "peer review" process used to evaluate and confirm the current competency of those practitioners with clinical privileges at the Hospital.

(i) OPPE is intended to assist the Medical Staff with identifying and resolving practitioner related performance concerns or trends that may adversely impact patient safety or quality of care. OPPE is intended to foster an efficient, evidence-based privilege monitoring and renewal process. Information generated through OPPE will be used to evaluate the qualifications of practitioners, including determinations to continue, limit, or revoke any existing privileges(s). Information generated through OPPE, within the requirements of peer review confidentiality, will also be utilized for more systematic performance improvement activities intended to maintain or improve patient safety and quality of care.

(ii) All practitioners subject to OPPE are required to maintain a sufficient degree of volume/activity at the Hospital so as to permit meaningful evaluation of their performance through OPPE. In the event a Clinical Service Chief, MEC, or the Governing Board determines that a practitioner has not demonstrated sufficient volume/activity at the Hospital to permit meaningful OPPE, the practitioner may be requested to promptly provide, or cause to be provided, (authenticated) information/data from the practitioner's primary practice location(s). A practitioner's failure to timely comply with such a request, or a practitioner's failure to demonstrate any volume/clinical activity at the Hospital, may result in administrative action, including the automatic/administrative resignation of that practitioner's Medical Staff membership and/or clinical privileges at the Hospital (as applicable), as more fully described in the Corrective Action and Fair Hearing Manual.

The Hospital's process for OPPE is set forth in SPP MS-19 Medical Staff Professional Practice Evaluation.

Section 2.16 Substantial Compliance/Bylaws not a Contract

(a) As set forth in Section 11.2 of the Governance and Organization Manual, the Medical Staff Bylaws are intended to create a framework to ensure compliance with pertinent Indiana state and federal law, and accreditation requirements, and to ensure entitlement to all immunities and protections set forth in the pertinent Indiana state peer review statutes and the Federal Health Care Quality Improvement Act. Therefore, strict compliance by the MEC, other Medical Staff committees, and Governing Board with the procedures and timelines set forth in these Bylaws is not required. Rather, the MEC, Medical Staff committees, and Governing Board, as applicable, should endeavor to substantially comply with the provisions set forth in this Credentialing Manual and elsewhere in the Medical Staff Bylaws. These Bylaws are not intended in any fashion to create a legal contract.

Nothing in this provision, however, negates a provider's strict obligation to comply with the deadlines set forth in the Bylaws, including the timing requirements regarding submission of applications and reapplications, as well as information requested by the MEC and/or Governing Board pertinent to the evaluation of the application or reapplication.

ARTICLE 3: AMENDMENT AND ADOPTION

Section 3.1 Amendment

This Credentialing Manual may be amended or repealed, in whole or in part, pursuant to the process and procedures set forth in the Governance and Organization Manual.

Section 3.2 Medical Staff

This Credentialing Manual was recommended to the Governing Board by the Medical Staff and adopted by the Governing Board in accordance with and subject to the Medical Staff Bylaws.

By:_____
Chief of Staff

Date:_____

Section 3.3 Governing Board

This Credentialing Manual was approved and adopted by consent of resolution of the Governing Board after considering the Medical Staff's recommendation and in accordance with and subject to the Hospital's Bylaws.

By:_____
Chairperson, Governing Board

Date:_____

Section 3.4 Record of Revisions

Date	Article/Section Modified