ODESSA REGIONAL MEDICAL CENTER
A STEWARD FAMILY HOSPITAL

MEDICAL STAFF BYLAWS

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DEFINITIONS

"Act" means the Health Care Quality Improvement Act of 1986.

"Administration" means the executive members of the Hospital's leadership team.

"Advanced Practice Professional" or **"APP"** means an individual, not including a Physician, Dentist, Oral Surgeon or Podiatrist, who is licensed and/or certified to render health care services independently or under the supervision of a Medical Staff Member, and is credentialed and privileged in accordance with these Medical Staff Bylaws.

"Advanced Practice Professionals Staff" means all Advanced Practice Professionals approved by the Governing Body to exercise Clinical Privileges at the Hospital.

"Adverse Action" means an action taken or recommended by the Medical Executive Committee or the Governing Body that entitles the affected Practitioner to hearing and appellate review rights as set forth in Article 5 of these Bylaws.

"Adverse Action Notice" means a Written Notice informing a Practitioner of an Adverse Action.

"Affiliates" means those entities owned, operated, or controlled, directly or indirectly, by Steward Health Care System LLC.

"Appellate Review Request" means a written request for an appellate review submitted in the manner set forth in these Bylaws by a Medical Staff Member who is entitled to an appellate review under these Bylaws.

"**Applicant**" means a Practitioner who completes and submits an Application for or has been granted the following at the Hospital:

1. Appointment
2. Reappointment
3. Clinical Privileges (including initial, renewed, modified, temporary or disaster Privileges)
4. Modification of Medical Staff Category

"**Application**" means a written request for appointment or reappointment to the Staff, modification of Medical Staff category, and/or Clinical Privileges (including initial, renewed, modified, and/or temporary Clinical Privileges) on a form approved by the Governing Body.

"Certificate of Insurance" means a current certificate of insurance or other evidence of professional liability insurance coverage acceptable to the Governing Body and with limits not less than those specified by the Hospital.

"Clinical Privileges" or **"Privileges"** means permission granted by the Governing Body to appropriately licensed individuals to render specifically delineated professional, diagnostic, therapeutic, medical, surgical, dental, or podiatry services at the Hospital.

"CFR" means the United States Code of Federal Regulations.

"Collaborative Practice Agreement" means a written and signed agreement between an individual in one of several Advanced Practice Professional disciplines and one or more supervising Medical Staff Members that describes the collaborative relationship in which the Advanced Practice Professional and the supervising Medical Staff Member(s) will practice, if required by law or pursuant to these Bylaws or Medical Staff or Hospital Policies.

"Collaborative Relationship" means the relationship in which individuals in certain Advanced Practice Professional disciplines work with one or more Medical Staff Members to deliver health care within the scope of the Advanced Practice Professionals' expertise and lawful practice, and may include requirements for medical direction and supervision. A Collaborative Practice Relationship shall, if required by applicable law, these Bylaws, Medical Staff or Hospital Policies, or the Governing Body, be memorialized in a Collaborative Practice Agreement.

"Credentials Verification Organization" or **"CVO"** means a qualified organization with which the Hospital has contracted to perform certain credentials verification services.

"Delivery Date" means the date upon which any Written Notice is deemed to have been delivered to a Practitioner. The Delivery Date for Written Notices shall be as follows:

Method of Delivery	Delivery Date
Personal/Hand Delivery	Date of Delivery
Certified Mail, return receipt requested	Seventy-two (72) hours after deposit with the U. S. Postal Service, certified or registered with return receipt requested
Overnight Courier	Twenty-four (24) hours after deposit with a reputable overnight courier
Email	Date email sent to last address on file

"Dentist" means an individual who has received a doctorate in dental surgery or doctorate in dental medicine degree and has a current license to practice dentistry in the State of Texas.

"Department" means a clinical grouping of Staff Members in accordance with their specialty or major practice interest, as specified in these Bylaws.

"Department Chair" means the Chair of a Medical Staff Department, and may also be known as the "Department Director."

"Distant Site Telemedicine Entity" or **"DSTE"** means a provider of telemedicine services that is not a Medicare-participating hospital and that provides contracted telemedicine services in a manner that enables the Hospital (if using the DSTE's services) to meet applicable Medicare Conditions of Participation and NIAHO accreditation requirements relating to the credentialing and privileging of practitioners providing telemedicine services to patients of the Hospital from a distant site.

"Division" means a clinical sub-grouping, within a Department of Staff Members, in accordance with their subspecialty or major practice interest.

"Division Chief" means the Chief of a Medical Staff Division, and may also be known as the "Service Chief."

"Ex Officio" means service as a member of a committee or other body by virtue of an office or a position held. Unless otherwise specified in these Bylaws, an Ex Officio member shall serve as a non-voting member.

"Focused Professional Practice Evaluation" or "FPPE" means a time-limited study, review, evaluation, or assessment of the training, experience, skill, professional conduct, qualifications, current competence, and/or clinical judgment or expertise of a particular Staff Member. Relevant information obtained from a FPPE shall be integrated into performance improvement activities and credentialing reviews. The FPPE process is designed and intended to address opportunities for improvement, and although the process is considered a medical peer review activity, it is NOT intended as an investigation or discipline, and is NOT part of the corrective action process. If corrective action is indicated as a result of the FPPE process, the corrective action procedures outlined in these Bylaws shall be followed.

"Governing Body" means the Board of Trustees or Board of Directors of the Hospital. As appropriate to the context, and consistent with applicable law, the Hospital's corporate bylaws, and delegations of authority made by the Governing Body, Governing Body may also mean any Governing Body committee or any individual authorized by the Governing Body to act on its behalf in certain matters.

"Hearing Request" means a written request for a hearing submitted in the manner set forth in these Bylaws by a Medical Staff Member who is entitled to a hearing under these Bylaws.

"Health Care Provider" means any Medical Staff Member, any Advanced Practice Professionals Staff member; any intern, resident, fellow, or medical officer; and any employee or agent of the Hospital providing patient care.

"History and Physical" or **"H&P"** means a medical history and physical examination that is performed, in part, to determine whether any aspect of the patient's condition or medical history would or should affect the planned course of the patient's treatment (e.g., a medication allergy or a new or existing condition that requires additional interventions to reduce risk to the patient). A H&P must be performed or approved by an individual who has been privileged to perform or approve a H&P in accordance with these Bylaws and Medical Staff policy. [1]

"Hospital" means **Odessa Regional Medical Center**. The Hospital is a "health care entity" as defined in 42 U.S.C. § 11151(4)(A) and a "hospital" as defined in 42 U.S.C. § 11151(5).

"Hospital Policies" means policies approved by the Governing Body or Hospital President that are not Medical Staff Policies.

"Hospital President" means the individual appointed by the Governing Body to act on its behalf in the overall management of the Hospital.

"Hospital Representative" means, without limitation, the Hospital's and its Affiliates' Staff members, Medical Staff members and officers, Governing Bodies, Governing Body members, officers, directors, Medical Executive Committees, medical executive committee members, Department and Division members, Chairs and Chiefs, employees, agents, attorneys, and any outside reviewers who, on behalf of the Hospital or Affiliate, provide or evaluate information concerning any Applicant's qualifications, clinical competency, character, professional conduct, mental or emotional stability, health, ethics or any other matter that might have an effect on Staff Membership, Clinical Privileges, or patient care.

"Licensed Health Care Professional" means any person with employment, practice, association for the purpose of providing patient care, or privileges at the Hospital who has been issued any type of license, certificate or registration by an agency of the State of Texas authorizing the person to render or assist in rendering health care services.

"Licensee" means a person licensed by the Medical Board.

"Medical Board" means the Texas Medical Board.

"Medical Director" means a physician under contract with the Hospital to assume overall responsibility for medical direction at the Hospital.

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

"**Medical peer review committee**" means any Medical Staff Committee, Department or Division, the Governing Body, any committee of the Governing Body, and their respective members and agents (including Medical Staff Services) when responsible for, or conducting any activities related to: (1) the evaluation or improvement of the quality of health care rendered by Practitioners (including, but not limited to credentialing and privileging review, recommendation, and monitoring activities); (2) the determination of whether health care services were performed in compliance with the applicable standards of care (both on an ongoing basis and an incident or pattern specific basis); (3) the determination of whether the cost of health care services rendered was considered reasonable; (4) the determination of whether a Practitioner's actions call into question such Practitioner's fitness to provide health care services; or (5) the evaluation and assistance of Practitioners impaired or allegedly impaired by reason of alcohol, drugs, physical disability, mental instability or otherwise. Medical peer review committees include, but are not limited to: the Medical Executive Committee, the Credentials Committee, any Practitioner Health Committee as described in Article 10, any subcommittee or member of the foregoing, any Department or Division or committee thereof, any Professional Review Body, and any other committee or entity which, or individual who, conducts or assists the Medical Staff and/or the Hospital and/or medical peer review committee in the performance of any medical peer review or Professional Review Activity, and/or otherwise participates in a Professional Review Action.

"Medical Staff" means all Physicians, Podiatrists, Dentists, and Oral Surgeons appointed to the Active, Courtesy, Telemedicine, or Honorary categories of the Medical Staff by the Governing Body. The Medical Staff is a "medical peer review committee" and a "Professional Review Body" as those terms are defined in these Medical Staff Bylaws.

"**Medical Staff Bylaws**" or "**Bylaws**" means, as appropriate, these Medical Staff bylaws.

"Medical Staff Policies" means the rules and regulations of the Medical Staff and those policies of the Medical Staff that elaborate upon or explain elements of performance which are required, by applicable law or accreditation standards, to be included in the Bylaws. Medical Staff Policies are approved by the Medical Staff or Medical Executive Committee and the Governing Body in accordance with these Bylaws.

"Medical Staff President" means the individual elected by the Medical Staff as its chief administrative officer.

"Medical Staff Services" means the Hospital's administrative support personnel who are tasked by the Hospital with Staff support functions, either alone or in conjunction with a CVO.

"Medical Staff Year" means the calendar year.

"Modification Request" means a written request for modification of an individual's Medical Staff Category and/or Clinical Privileges.

"National Integrated Accreditation for Healthcare Organizations" or **"NIAHO"** (sometimes referred to as "DNV" or "DNV-GL") means the accreditation entity that accredits the Hospital.

"National Practitioner Data Bank" or **"NPDB"** means the data bank established under the Act.

"Ongoing Professional Practice Evaluation" or "OPPE" means a continuous process in which certain data is evaluated to identify professional practice trends that impact quality of care and patient safety. OPPE activities may be assigned to a particular Department, Division or committee under the direction of the Medical Executive Committee or another appropriate committee as designated herein or by the Medical Executive Committee. Relevant information obtained from the OPPE process shall be integrated into credentialing reviews. The OPPE process is designed and intended to identify and address opportunities for improvement, and although the process is considered a medical peer review activity, it is NOT intended as an investigation or discipline, and is NOT part of the corrective action process. If corrective action is indicated as a result of the OPPE process, the corrective action procedures outlined in these Bylaws shall be followed.

"Oral Surgeon" means a Dentist who has successfully completed a postgraduate program in oral and maxillofacial surgery accredited by a nationally recognized accrediting body approved by the U.S. Department of Education.

"Patient Encounter" means: (a) an inpatient or outpatient admission of a patient during which the subject Medical Staff Member has direct, in-person contact with the patient; (b) the performance of a procedure at the Hospital or a Hospital-licensed facility; or (c) the provision of diagnostic or therapeutic services for a patient at the Hospital or a Hospital-licensed facility.

"Physician" means an appropriately licensed medical doctor (M.D.) or osteopathic physician (D.O.) who possesses an unlimited license to practice medicine in the State of Texas.

"Podiatrist" means an individual who has received a Doctorate of Podiatric Medicine (PM) and has a current license to practice podiatry in the State of Texas.

"Practitioner" means a Physician, Podiatrist, Dentist, Oral Surgeon or Advanced Practice Professional.

"Professional Review Action" means any action or recommendation of a Professional Review Body which is taken or made in the conduct of Professional Review Activity, which is based on the competence or professional conduct of a Health Care Provider and which affects, or may affect such individual's Staff Membership and/or Clinical Privileges.[2]

"Professional Review Activity" means any activity which is undertaken to determine whether (a) a Health Care Provider is eligible for Staff Membership or Clinical Privileges; (b) the scope or conditions of such Staff Membership or Clinical Privileges; or (c) if such Staff Membership or Clinical Privileges should be modified or terminated.[3]

"Professional Review Body" means a medical peer review committee, including but not limited to the Governing Body, Medical Executive Committee, Credentials Committee, a Department, a Division, any Hearing or Appellate Review Committee, any subcommittee or member of the foregoing, and any other

committee or entity which, or individual who, conducts or assists the Medical Staff and/or the Hospital in the performance of any Professional Review Activity and/or otherwise participates in a Professional Review Action.

"Staff" means the Medical Staff and the Advanced Practice Professionals Staff. Members of the Medical Staff are not members of the Advanced Practice Professionals Staff; and members of the Advanced Practice Professionals Staff are not members of the Medical Staff.

"Staff Member" means a current appointee to (i) the Medical Staff, including the Active, Courtesy, Telemedicine, and Honorary categories of the Medical Staff, or (ii) the Advanced Practice Professionals Staff.

"Staff Membership" means appointment to the Medical Staff (including the Active, Courtesy, Telemedicine or Honorary categories of the Medical Staff), or the Advanced Practice Professionals Staff.

"Written Notice" means a written notice that is delivered to the Practitioner via personal/hand delivery, certified mail, return receipt requested, or overnight courier to the Practitioner's last known residential or office address. Notwithstanding the above, for purposes of Medical Staff meetings, Department meetings, and Medical Staff committee meetings, the term "Written Notice" shall also include notice via email to the Practitioner's last known email address on file with Medical Staff Services.

ARTICLE 1. NAME, PURPOSES & RESPONSIBILITIES

1.1 NAME

The name of this medical staff organization shall be:

"Medical Staff of ODESSA REGIONAL MEDICAL CENTER"

1.2 BYLAWS

The purposes of these Bylaws are to: (1) describe the organization and structure of the Medical Staff and its relationship to the Governing Body; (2) create a system of rights and responsibilities within the organized Medical Staff and between the organized Medical Staff and both the Governing Body and the Medical Staff's members; (3) establish a mechanism for the organized Medical Staff to carry out its responsibilities and govern the professional activities of its members and other individuals with Clinical Privileges, subject to the ultimate responsibility of the Governing Body;[4] and (4) authorize the development and implementation of a quality improvement program.

1.3 ORGANIZED MEDICAL STAFF

The purposes and responsibilities of the Organized Medical Staff are set forth in Section 6.2.

1.4 GOVERNING BODY

The purposes and responsibilities of the Governing Body with regard to the Medical Staff are described in the Hospital bylaws, these Medical Staff Bylaws, the Medical Staff Policies and the Hospital Policies.[5]

1.4.1 Bylaws and Policies

The Governing Body reviews, approves and upholds these Bylaws, the Medical Staff Polices and the Hospital Policies.[6]

1.4.2 Staff Membership and Clinical Privileges

The Governing Body determines, in accordance with applicable law, which categories of providers are eligible candidates for Staff Membership;[7] makes final decisions with respect to requests for appointment and reappointment to the Staff after considering the recommendations of the Medical Executive Committee;[8] ensures that the criteria for Staff Membership and/or Clinical Privileges include individual character, competence, training, experience, professional conduct, and judgment;[9] and ensures that under no circumstances is the approval of Staff Membership or Clinical Privileges in the Hospital dependent solely upon certification, fellowship, or membership in a specialty body or society.[10] For purposes of this section, "professional conduct" means actions and/or behavior of a Practitioner in the course of his or her professional activities.

1.4.3 Communication with the Medical Staff

The Governing Body: (a) works with the Medical Staff to evaluate the Medical Staff's performance in relation to its mission, vision, and goals; (b) ensures that the Medical Staff is accountable to the Governing Body for the quality of care provided to patients[11] and for the performance of its responsibilities pursuant to these Bylaws; and (c) provides the organized Medical Staff with the opportunity to participate in Hospital governance, and the opportunity to be represented at Governing Body meetings, by the Medical Staff President.

ARTICLE 2. STAFF MEMBERSHIP & CLINICAL PRIVILEGES

2.1 Generally

2.1.1 No Entitlement

An Applicant shall not be entitled to Staff Membership or to the exercise of Clinical Privileges at the Hospital merely by virtue of the fact that the Applicant: (a) is licensed to practice medicine, podiatry, dentistry or another applicable profession in this or in any other state; (b) is board certified or a member of any professional organization; or (c) had or currently has such privileges at this or any other hospital.[12]

2.1.2 No Discrimination

No Applicant who is otherwise qualified shall be denied Staff Membership and/or Clinical Privileges by reason of race, color, creed, age, sexual orientation, disability, gender, military status, national origin, or any other class protected by law, except as may be permitted by law. The criteria utilized to determine whether an Applicant is qualified to perform requested Clinical Privileges shall be consistently applied to all Applicants seeking such Clinical Privileges.[13]

2.1.3 Exercise of Clinical Privileges; Certain Restrictions

Each Practitioner providing direct clinical services at the Hospital, by virtue of Staff Membership or otherwise, shall, in connection with such practice and except as provided in Section 2.9, be entitled to exercise only those Clinical Privileges that are within the scope of such Practitioner's licensure, certification, education, training and experience, and specifically granted to the Practitioner upon approval by the Governing Body. A Practitioner's authorization to exercise Clinical Privileges may be limited in accordance with applicable Medical Staff and Department practice and policies, or as specified by the Governing Body. The recommendation or implementation of restrictions on an individual Medical Staff Member's Clinical Privileges may entitle the Medical Staff Member to hearing and appeal rights in accordance with Article 5.

2.1.4 Admitting and Prescribing Privileges

The privilege to admit patients to the Hospital shall be specifically delineated. All prescribing practices and prescribing privileges must be in accordance with the Applicant's licensure and scope of practice, current clinical competence, accepted standards of good medical practice, applicable DEA and Texas controlled substances registration, and, if required by law, written prescriptive practice guidelines. Prescribing privileges may be further limited by the Governing Body through the delineation of medication prescribing privileges based on an Applicant's scope of practice and current competence.

2.1.5 Exclusive Contracts

The Governing Body may, in the interest of quality patient care and as a matter of policy, authorize the Hospital's entry into exclusive contracts with qualified Practitioners/entities to manage and/or staff certain Hospital facilities and/or services, and/or perform certain coverage responsibilities. Such contracts may include provisions wherein the parties waive certain rights under these Bylaws; but such contracts shall not alter the Qualifications for Staff Membership and Clinical Privileges (set forth in Section 2.3, below) that must be satisfied by Practitioners seeking Staff Membership, or alter the right or obligation of the Hospital or the Medical Staff to consider and take action on the applications for Privileges of the Practitioners who wish to exercise Clinical Privileges at the Hospital pursuant to such contracts. In the event of any conflict

between the terms of any such contract and these Bylaws, the contract terms shall prevail and supersede.

2.1.6 Duration of Appointment, Reappointment and Clinical Privileges

Initial appointment and reappointment to the Medical Staff and Clinical Privileges shall be granted for a specific period not to exceed two (2) years following final approval of the Governing Body.[14] Honorary Medical Staff Members are not eligible for Clinical Privileges, may be appointed for an indefinite term, and are not required to complete the reappointment process.

2.1.7 Ongoing Evaluation of Qualifications and Competence

Each Applicant's competence to perform Clinical Privileges (other than Applicants for Honorary Staff status) shall be assessed and evaluated on an ongoing basis through, among other things, the Hospital's OPPE and FPPE processes (as further described in Medical Staff Policies). In addition, each Applicant must report any changes in the Applicant's qualifications in accordance with Section 2.4 of these Bylaws. If at any time, such information indicates that the Applicant is no longer competent to perform any or all of the Applicant's previously granted Clinical Privileges, such Clinical Privileges may be modified or terminated by the Governing Body in accordance with the terms of these Bylaws, following the recommendation of the Medical Executive Committee.

2.2 Health Care Providers Eligible for Staff Membership & Clinical Privileges

2.2.1 Eligible Health Care Providers

The following categories of Health Care Providers are eligible for Staff Membership and/or Clinical Privileges:[15]

Medical Staff

- Medical Doctors
- Doctors of Osteopathic Medicine
- Dentists
- Oral Surgeons
- Doctors of Podiatry

Advanced Practice Professional Staff

- Advanced Practice Registered Nurses (APRNs)
  - Certified Registered Nurse Anesthetists
  - Certified Nurse Midwives
  - Nurse Practitioners
  - Psychiatric Mental Health Clinical Nurse Specialists
- Physician Assistants
- Licensed Independent Clinical Social Workers
- Licensed Mental Health Counselors
- Psychologists (Ph.Ds or Psy.Ds)

2.2.2 Available Clinical Privileges

The Governing Body, in consultation with the Medical Staff, shall determine which Clinical Privileges it has the space, equipment, personnel, and other necessary resources to support. No Applicant shall be granted Clinical Privileges if the Hospital does not have the necessary resources to support such Clinical Privileges. Lists of the specific Clinical Privileges available to each category of provider listed above are maintained by Medical Staff Services.

2.3 Qualifications for Staff Membership and Clinical Privileges

Only those Applicants who, at the time of and following appointment to the Staff, continuously meet the qualifications, standards and requirements set forth in these Bylaws and associated Medical Staff and Hospital Policies (and provide documentation of the same as/when required in accordance with these Bylaws) shall be eligible for initial and ongoing Staff Membership and Clinical Privileges.[16]

Each Applicant shall have the burden of establishing that he or she is eligible for Staff Membership and Clinical Privileges and for resolving any doubts about such eligibility; and it is the sole responsibility of each Applicant to submit all of the information and supporting documentation requested by the Medical Staff on the forms and in the manner requested by the Medical Staff. Except as set forth in Section 2.9 (Temporary, Emergency and Disaster Privileges), Section 2.6.8 (Honorary Medical Staff), and Section 2.7 (Telemedicine Staff), such information and supporting documentation shall include the items listed below.

2.3.1 Current Competence

Each Applicant must possess the individual character, current competence, training, skills, experience, judgment, background, and physical ability (with reasonable accommodation) needed to perform requested Clinical Privileges and provide quality patient care. Each Applicant must be able to demonstrate proficiency in the following six areas of general competencies:

(a) Patient Care. Each Applicant is expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life.

(b) Medical/Clinical Knowledge. Each Applicant is expected to demonstrate knowledge of established and evolving biomedical, clinical, and social sciences, and the application of such knowledge to patient care and the education of others.

(c) Practice-Based Learning and Improvement. Each Applicant is expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.

(d) Interpersonal and Communication Skills. Each Applicant is expected to demonstrate interpersonal and communication skills that enable the Applicant to establish and maintain, and each Applicant shall establish and maintain, professional relationships with patients, families, other members of the health care teams, and members of Hospital administration.

(e) Professionalism. Each Applicant is expected to demonstrate behavior, and to act in a manner, that reflect(s) a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward the Applicant's patients, profession, colleagues (both clinical and administrative), and society.

(f) Systems-Based Practice. As recommended by ACGME (Accreditation Council for Graduate Medical Education), each Applicant is expected to demonstrate both an

understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

2.3.2 Complete Application and Fee

Each Applicant must submit a complete, legible, signed Application and any applicable Application fee (such Application fee, which is separate from the Medical Staff Dues referenced in Section 2.4.16, shall be established and may be modified by the Hospital President in consultation with the Medical Executive Committee). Except for Applicants to the Honorary Medical Staff, who by virtue of Medical Staff category are not eligible for Clinical Privileges, each Application must be accompanied by a request for specific Clinical Privileges.

2.3.3 License/Registration [17]

Each Applicant must: (a) possess a current license to practice his/her profession in the State of Texas; (b) if applicable, provide a copy of his/her most recent application for initial or renewal registration to practice medicine in the State, including all attachments and other explanatory materials submitted with the application; (c) provide a list of all current and past licenses and certifications (in any state); and (d) provide a list of any current or previous challenges to licensure or certification (including resolution), or voluntary relinquishment of licensure or certification (in any state). Medical Staff Services shall confirm the status of each Applicant's license/registration through primary source verification prior to appointment, reappointment, modification of Clinical Privileges, and at the time of license expiration. The foregoing notwithstanding, Applicants who are completing or who recently completed post-graduate training or who are relocating to or recently relocated to Texas, need not be licensed in Texas at the time of submitting an Application, but must have applied for licensure in Texas prior to submitting an Application and must possess a Texas license and satisfy all other pre-requisites for Staff Membership before being appointed to the Staff.

2.3.4 Residency/Training Program

Medical Staff Services shall confirm each Applicant's residency and training history through primary source verification prior to initial appointment and whenever the Applicant provides information regarding training programs completed after initial appointment. If requested by Medical Staff Services, each Applicant must provide copies of certificates or letters confirming completion of an approved residency/training program or other educational curriculum, as applicable. If the Applicant is a foreign medical graduate, Medical Staff Services shall verify graduation through the Educational Commission for Foreign Medical Graduates.

(a) Physicians. A Physician must have successfully completed a residency program accredited by either: (i) the Accreditation Council for Graduate Medical Education (ACGME); (ii) the American Osteopathic Association; (iii) the Royal College of Physicians and Surgeons of Canada; or (iv) a program approved by the Medical Executive Committee and the Governing Body.

(b) Podiatrists. A Podiatrist must have successfully completed a training program accredited by the Council on Podiatric Medical Education or approved by the Medical Executive Committee and the Governing Body.

(c) Dentists. A Dentist must:

(i) have successfully completed a training program at a school of dentistry that is either: (1) accredited by the American Dental Association; or (2) approved by the Medical Executive Committee and the Governing Body;

(ii) have successfully completed at least one year of a post-graduate program that is approved by either: (1) the Commission on Dental Accreditation of the American Dental Association; or (2) the Medical Executive Committee and the Governing Body; and

(iii) demonstrate the performance of at least 10 inpatient procedures in a hospital setting during such post-graduate training (which training occurred in the last two years) or during the last two years of practice.

(d) Oral and Maxillofacial Surgeons. An Oral Surgeon must have successfully completed a post-graduate residency program accredited by the Commission on Dental Accreditation of the American Dental Association, or an equivalent program approved by the Medical Executive Committee and the Governing Body.

(e) Advanced Practice Professionals. Advanced Practice Professionals must have successfully completed a training program required for licensure or certification, or an equivalent program approved by the Medical Executive Committee and the Governing Body.

2.3.5 Board Certification

Medical Staff Services shall confirm each Applicant's board status (i.e., board certification or evidence of board eligibility) through primary source verification prior to initial appointment and reappointment. If requested by Medical Staff Services, each Applicant must provide: (a) copies of certificates or letters from the appropriate specialty board confirming board status; and (b) information regarding the Applicant's previous voluntary or involuntary termination of board certification, if any.

(a) Physicians. A Physician must either:

(i) be board certified by one of the following: (1) the American Board of Medical Specialties; (2) the American Osteopathic Association; or (3) a specialty board approved by the Medical Executive Committee and the Governing Body; or

(ii) be qualified to pursue board certification, pursue board certification in good faith in accordance with the standards and guidelines of the relevant board, and achieve board certification by the time of the Physician's first reappointment Application following five (5) years of Staff Membership.

Once board certified, Physicians must continue to be board certified for the duration of their Staff Membership in a specialty within their primary area of practice.

(b) Podiatrists. A Podiatrist must either:

(i) be board certified by one of the following: (1) the American Board of Podiatric Surgery; or (2) a specialty board approved by the Medical Executive Committee and the Governing Body; or

(ii) be board eligible and receive board certification by the time of the Podiatrist's first reappointment Application following five (5) years of Staff Membership.

Once board certified, Podiatrists must maintain board certification for the duration of their Staff Membership.

(c) Oral and Maxillofacial Surgeons. An Oral Surgeon must either:

(i) be board certified by one of the following: (1) the American Board of Oral and Maxillofacial Surgery; or (2) a specialty board approved by the Medical Executive Committee and the Governing Body; or

(ii) be board eligible and receive board certification by the time of the Oral Surgeon's first reappointment Application following five (5) years of Staff Membership.

Once board certified, Oral Surgeons must maintain board certification for the duration of their Staff Membership.

(d) Advanced Practice Professionals. Advanced Practice Professionals must have successfully obtained certification from the appropriate professional organization, as applicable.

(e) Exception. An Applicant is not subject to the board certification requirements above if such Applicant was not required to obtain or maintain board certification while serving as a medical staff member at the Hospital prior to the date of the initial adoption of these Bylaws. Such exception shall continue to apply following an interruption in such Applicant's Staff Membership or Clinical Privileges.

(f) Waiver. The Governing Body, following recommendation of the applicable Department Chair, the Credentials Committee and the Medical Executive Committee, may waive the board certification requirements described above for an individual Practitioner. The refusal of the Department Chair, Credentials Committee, Medical Executive Committee, or Governing Body to recommend or approve waiver of board certification requirements shall not entitle the Practitioner to any hearing or appeal rights under these Bylaws.

2.3.6 Peer Recommendations

Written peer recommendations from at least two (2) peers are required for all Applicants seeking: (a) initial appointment and/or Clinical Privileges; (b) renewed Clinical Privileges if there is insufficient professional practice review data generated at the Hospital to evaluate the Applicant's competence; and (c) modified Clinical Privileges if there is insufficient professional practice review data generated at the Hospital to evaluate the Applicant's competence for the privileges being requested. Such Applicants must provide the names and addresses of peers (individuals in the same professional discipline practicing in the same or similar field as the Applicant) who currently work with the Applicant, directly observe the Applicant's professional performance over a reasonable period of time, and can and will provide reliable written information regarding the Applicant's proficiency in the six areas of general competencies described in Section 2.3.1; provided, however, that if the Applicant cannot provide the names and addresses of peers who currently work with the Applicant, the Applicant shall provide a written explanation as to why such names and addresses cannot be provided, and shall provide the names and addresses of peers who have worked with the Applicant within the preceding two (2) years, unless a longer period is explicitly approved by the Credentials Committee. Determinations that there is insufficient professional practice review data generated at the Hospital to evaluate an Applicant's competence shall be made by the Credentials Committee with input from the appropriate Department Chair.

2.3.7 Professional Practice Evaluation Data

Each Applicant seeking Clinical Privileges must provide or permit access to professional practice evaluation data (including morbidity and mortality data) about the Applicant generated at the Hospital and any other facility, entity or clinical practice that currently privileges the Applicant or reviews or evaluates the Applicant's professional practice, if available.

2.3.8 No Sanctions or Exclusion

Each Applicant must be eligible for participation in the Medicare and Medicaid programs and may not be currently excluded, suspended, debarred, or ineligible to participate in any health care program funded in whole or in part by the federal or state government, including as a result of a conviction of a criminal offense related to the provision of health care services. Medical Staff

Services shall confirm each Applicant's status through primary source verification prior to appointment and reappointment.

2.3.9 DEA Registration

If the Applicant's practice will involve the prescription of controlled substances, the Applicant must possess a current, unrestricted Drug Enforcement Agency (DEA) registration in each state in which the Applicant will prescribe medications.[18] Medical Staff Services shall confirm each Applicant's DEA registration through primary source verification prior to appointment and reappointment. If requested by Medical Staff Services, an Applicant must provide a copy of his/her current DEA and (if applicable) Texas registration certificate, as well as previously successful or currently pending challenges to registration, or voluntary or involuntary relinquishment of either registration, if any.

2.3.10 Executed Acknowledgement, Authorization and Release

Each Application must include the Applicant's specific, written acknowledgement that the Applicant agrees to the provisions set forth in Section 2.4.9 (Acknowledgment, Authorization and Release).

2.3.11 Current and Past Employment and Affiliations

Each Applicant for initial appointment must provide contact names and addresses of all of the Institutions, organizations and entities (including clinical practices) with which the Applicant is currently, or during the ten (10) years (three (3) years for an Applicant for reappointment or additional Clinical Privileges) prior to the Application date was employed, affiliated, had staff membership, or held privileges. In addition, each applicant must provide any information regarding: (1) the voluntary or involuntary termination of the Applicant's employment, affiliation, or staff membership, at any other institution, organization, or entity (including clinical practices); and (2) any investigation or disciplinary action by the Applicant's employer or other institution, organization, or entity, if such investigation or disciplinary action is ongoing, or resulted in the limitation, reduction, denial, loss or relinquishment of clinical privileges or employment, including information about any voluntary or involuntary course of counseling, treatment or testing for drug or alcohol abuse.

Medical Staff Services shall contact each entity with which the Applicant had employment, practice, association for the purpose of providing patient care, or clinical privileges during the past ten years to request: (a) an assessment of the Applicant's clinical skills; and (b) information regarding any pending or final disciplinary action, malpractice litigation, and any other information relevant to the Applicant's character, competence or professional behavior, including information about any voluntary or involuntary course of counseling, treatment or testing for drug or alcohol abuse.[19] For Applicants seeking reappointment or additional Clinical Privileges, Medical Staff Services shall contact each entity at which the Applicant had employment, practice, association for the purpose of providing patient care, or clinical privileges during the past three years to request: (a) an assessment of the Applicant's clinical skills; and (b) information regarding any pending or final disciplinary action, malpractice litigation, and any other information relevant to the Applicant's character or competence or professional behavior, including information about any voluntary or involuntary course of counseling, treatment or testing for drug or alcohol abuse.

2.3.12 Absence of Criminal Background

By applying for Medical Staff Membership, each Applicant consents to, and agrees to cooperate with, the performance of a background check, including a criminal background check. Information obtained from the criminal background check will be utilized, as appropriate, in connection with the review of the Applicant's Application for Staff Membership and Clinical Privileges. Medical Staff Services will complete the criminal background check. Thereafter, Medical Staff Services will conduct an electronic background search for all reappointment Applicants at least every five (5) years.[20]

2.3.13 National Practitioner Data Bank (NPDB) Report

Medical Staff Services will obtain an NPDB report for all Physicians who submit initial and reappointment/renewal applications, and all current Physician Staff Members seeking modified Clinical Privileges. Such NPDB report must not contain information that, in the Governing Body's discretion, would disqualify the Applicant for Staff Membership or Clinical Privileges.

2.3.14 Proximity

Each Applicant seeking Clinical Privileges (other than distant site Telemedicine Applicants) must demonstrate that he/she will practice and reside closely enough to the Hospital, or that, when responsible for providing services at the Hospital (including call), he/she will be sufficiently proximate to the Hospital to ensure timely and continuous care of his/her patients and to ensure fulfillment of his/her responsibilities as a Staff Member.

2.3.15 Telemedicine Services Agreement

Each Medical Staff Applicant who seeks to provide Telemedicine services at the Hospital from a distant site location must, if applying to the Staff pursuant to the process outlined in Section 2.7, be affiliated with a Distant Site Telemedicine Entity *(*DSTE) or a distant site hospital (DSH) that has entered into a Telemedicine Services Agreement with the Hospital as outlined in Section 2.7.1(b). If the Applicant is affiliated with and has been granted privileges by a DSTE or a DSH as provided in these Bylaws, the Applicant must be in good standing with such DSTE or DSH and provide (or have provided on his/her behalf) written documentation of his/her current privileges.

2.3.16 Collaborative Practice Agreement; Written Practice Guidelines

When required by law, regulation, these Bylaws, Medical Staff or Hospital Policy, or the Governing Body in connection with the delineation of Clinical Privileges, an Advanced Practice Professional must maintain a Collaborative Relationship with a Medical Staff Member and/or provide a copy of a written Collaborative Practice Agreement to Medical Staff Services. Collaborative Practice Agreements must be in a form acceptable to the Governing Body. Collaborative Practice Agreements include, but are not limited to, prescriptive practice guidelines when required by applicable law, regulations, Medical Staff and/or Hospital Policies, or the Governing Body. Advanced Practice Professionals must practice in accordance with any written practice guidelines that have been approved by the Medical Executive Committee in consultation with the Hospital's senior nursing leadership.

2.3.17 TB and Immunization Status

Each Applicant (other than Telemedicine Medical Staff Applicants physically located at distant sites and Honorary Medical Staff Applicants) must provide documentation of the Applicant's TB and immunization status as requested by Medical Staff Services.

2.3.18 Certification of Fitness; Physical and Psychological Examination

Each Applicant must submit a statement that no health problems exist that would adversely affect the Applicant's ability to perform the essential functions of the requested Clinical Privileges, including but not limited to the ability to render proper patient care, with or without reasonable accommodations. Applicants shall also have the ability to request reasonable accommodations they believe are necessary. Each Applicant agrees, if requested to do so by the Credentials Committee, Medical Executive Committee or Governing Body, to undergo mental or physical examinations, tests and/or other evaluations deemed appropriate to evaluate the Applicant's ability to perform the essential functions of the requested Clinical Privileges. The Medical Executive Committee and Governing Body will, as appropriate, determine whether requested accommodations are necessary and reasonable.

2.3.19 Professional Liability Insurance

Each Applicant, other than Honorary Medical Staff Applicants, must submit a current Certificate of Insurance evidencing professional liability insurance coverage with limits of not less than two hundred thousand dollars ($200,000) per occurrence/six hundred thousand dollars ($600,000) annual aggregate or such higher limits as may be specified by the Governing Body, and the Applicant must maintain such insurance coverage for all periods of Staff Membership.

2.3.20 Claims and Settlements

Each Applicant must provide a listing and description of all malpractice claims and lawsuits, pending or closed, which have been filed against the Applicant during the past ten (10) years. Each Applicant shall also authorize his/her malpractice insurance carrier(s) to release the following information relating to any claims or actions for damages against the Applicant (pending or closed within the previous ten years), regardless of whether there has been a final disposition: (a) Applicant's policy number; (b) name, address and age of the claimant or plaintiff; (c) nature and substance of the claim; (d) date and place at which the claim arose; (e) amounts paid (if any) and the date and manner of disposition, judgment, settlement, or otherwise; (f) the date and reason for final disposition, if no judgment or settlement; and (g) any additional information requested by the Credentials Committee, Medical Executive Committee, or Governing Body.

2.3.21 Confirmation of Identity

Each initial Applicant must provide:

(a) Current Photograph. A head shot photograph of the Applicant, with a minimum size of 2" x 2" taken within the immediately preceding two (2) years, showing the Applicant's current appearance and full face with a light background, either in color or black and white. The photograph must be on photograph quality paper, not a copy. Note: The Applicant's photograph is exclusively used to confirm the Applicant's identity and the Applicant's appearance on the photograph, and is not otherwise considered during the credentialing and privileging process.

(b) Government-Issued Photograph Identification. A copy of the Applicant's driver's license, passport or other U.S. government-issued photograph identification. The copy must be clear enough to compare it with the head shot photograph described above.

Medical Staff Services shall compare each initial Applicant's current photograph to the copy of the Applicant's government-issued photograph identification. A copy of the current photograph may also be sent to the Applicant's peer references to confirm the Applicant's identity.

2.3.22 Continuing Education

Each Applicant, other than Applicants for Honorary Medical Staff status, must attest in writing that the Applicant has completed the number of qualifying continuing education program hours required for Texas licensure purposes and that he/she will provide additional information about his/her participation in continuing education programs upon request.

2.3.23 Alternative Coverage

Each Applicant must have alternate coverage available as required by Medical Staff Policies and applicable Department policies.

2.3.24 Current Curriculum Vitae

Each Applicant must submit a current curriculum vitae with his/her application to the Staff.

2.3.25 Citizenship or Immigration Status

Each Applicant must be a United States citizen or resident alien, or have been issued a visa by the United States Immigration and Naturalization Service or other equivalent documentation that permits such Applicant to exercise Clinical Privileges at the Hospital.

2.3.26 Other Information

Each Applicant must provide other information requested and deemed by the applicable Department Chair, Medical Executive Committee, and/or Governing Body to be relevant to the evaluation of the Applicant's ability to exercise Clinical Privileges.

2.4 ONGOING OBLIGATIONS

By signing and submitting an Application, or requesting temporary or disaster Clinical Privileges, each Practitioner affirms his/her agreement to the ongoing obligations set forth below, which obligations shall remain in effect as long as the Practitioner is an Applicant or a Staff Member, or exercises temporary or disaster Clinical Privileges at the Hospital. For purposes of this Section 2.4 the term "Practitioner" includes all Applicants and Staff Members, including those requesting and/or obtaining temporary or disaster Clinical Privileges and, as applicable, Honorary and Telemedicine Staff Members.

2.4.1 Maintain Qualifications

Each Practitioner agrees to maintain all necessary qualifications for Staff Membership and/or Clinical Privileges as set forth in Section 2.3 of these Bylaws.

2.4.2 Provide Notice of Change in Qualifications

Each Practitioner agrees (including but not limited to when applying for reappointment and/or modification of current Clinical Privileges) to inform Medical Staff Services of, and describe in writing, any changes to the Applicant's qualifications for Staff Membership and/or Clinical Privileges (including, but not limited to, disciplinary action investigations and proceedings, and disciplinary actions taken).

2.4.3 Appear for Interview

Each Practitioner agrees to appear for any requested interviews regarding his/her Application/request, and, subsequent to appointment or the granting of Clinical Privileges, to appear for any requested interviews related to questions regarding the Practitioner's qualifications, conduct or competence. Interviews may be in person or by electronic means, at the discretion of the requester, but during at least one of the interviews conducted as part of the Application process, the interviewer(s) must be able to see the Applicant/Practitioner.

2.4.4 Provide Continuous Care

Upon the granting of Staff Membership and Clinical Privileges, each Practitioner agrees to: (a) provide or arrange for continuous care to his/her patients at the appropriate professional level of quality and efficiency; (b) delegate in his/her absence the responsibility for diagnosis and care of his/her patients to a qualified Staff Member who possesses the Clinical Privileges necessary to assume care of such patients; and (c) seek consultation with another Staff Member who possesses appropriate Clinical Privileges in any case when the clinical needs of the patient require the input of a Practitioner with different Clinical Privileges than the Practitioner(s) currently attending the patient, or seek consultation as otherwise required by the Medical Staff and Hospital policies regarding consultation.

2.4.5 Participation in Call Coverage Programs

In order to meet the needs of Hospital inpatients and outpatients and ensure compliance with applicable regulatory requirements, the Medical Executive Committee and the Hospital President will determine which programs and specialty services require on-call coverage; provided, however, that if the Medical Executive Committee and the Hospital President disagree on whether on-call coverage is needed in a specialty, or the extent of such needed coverage, then the matter shall be determined by the Governing Body. For those Departments and specialty services for which on-call coverage is required, Active Medical Staff Members, Medical Staff Members who maintain admitting privileges (including Practitioners with Temporary privileges), and Advanced Practice Professionals Staff Members are obligated (but not entitled) to participate in such coverage if assigned to do so by the applicable Department Chair as provided herein (unless waived by the Hospital). Individual Staff Members may request a waiver from call coverage participation requirements pursuant to Section 2.4.17. Call schedules shall be prepared by the applicable Department Chair. If the Department Chair fails to set the call schedule in the manner and to the extent determined by the Medical Executive Committee, the Hospital President and/or the Governing Body, then the Medical Executive Committee shall have the authority to set the call schedule in the manner and to the extent so determined. If the Medical Executive Committee fails to set the call schedule in the manner and to the extent determined by the Hospital President and/or the Governing Body, then the Governing Body shall have the authority to set the call schedule in the manner and to the extent so determined.

2.4.6 Authorize Consultation and Review

Each Practitioner authorizes Hospital Representatives to consult with others (including others outside the Hospital) who are or have been associated with the Practitioner and/or who have information regarding the Practitioner's competence and qualifications, and consents to the Hospital's Representatives' inspection of all records and documents evaluating the Practitioner's professional qualifications and competence to serve as a member of the Staff and carry out the Clinical Privileges requested by Practitioner, including the Practitioner's moral and ethical qualifications. The Practitioner also agrees that the Medical Staff may obtain an evaluation of the Practitioner's performance or conduct by one or more outside consultants selected by the Medical Staff or the Hospital if the Medical Staff or the Hospital considers it appropriate. The Practitioner will cooperate with and receive a copy of any such evaluations.

2.4.7 Participate in Staff Functions; Meeting Attendance

As may be required by the Medical Executive Committee or the Governing Body, each Practitioner must actively participate in recognized functions of the Staff category, administrative position, and office to which he/she is appointed, elected or assigned. This includes, but is not limited to, participating in quality improvement and other clinical and/or behavior monitoring activities. In accordance with applicable Medical Staff Policies, Active Medical Staff Members

are expected to attend Medical Staff and Departmental Meetings and such attendance may be considered in evaluating Active Medical Staff Members' qualifications at the time of reappointment. All other Staff Members are strongly encouraged to attend Medical Staff and Departmental meetings.

2.4.8 Participate in Quality Improvement and Other Initiatives

The Practitioner agrees to participate in peer review (including OPPE and FPPE), quality assessment, performance improvement, risk management, case management/resource management, initiatives to promote high quality care, the appropriate utilization of Hospital resources, and other Hospital and Medical Staff review and improvement initiatives.

2.4.9 Acknowledgement, Authorization and Release

Each Practitioner:

(a) Acknowledges that the Practitioner has been provided access to the Medical Staff Bylaws, Medical Staff Policies, and associated Hospital Policies, and agrees to be bound by and comply with the same, as they may be modified from time to time;

(b) Authorizes the Hospital, its Affiliates and Hospital Representatives to release and exchange, and/or obtain all information necessary for the review and evaluation of the credentials of the Practitioner, and/or the services provided by and/or conduct of the Practitioner, including any and all information related to the Practitioner's competence to practice his or her profession and any pending or final disciplinary action as defined by the Medical Board, including but not limited to information regarding any voluntary or involuntary course of counseling, treatment or testing for drug or alcohol abuse;

(c) Authorizes the Hospital, its Affiliates and Hospital Representatives to release and exchange all information necessary to facilitate credentialing of the Practitioner by third party payors, and/or other hospitals or entities at which the Practitioner has or is seeking privileges or employment, including any and all information related to the Practitioner's competence to practice his or her profession;

(d) Authorizes the release of information from any other health care facility, medical practice or practice setting (including their personnel) where the Practitioner is or was affiliated or employed to Hospital, its Affiliates and Hospital Representatives;

(e) Authorizes the release of the following information from the Practitioner's medical malpractice carrier as to claims or actions for damages in the previous ten years: (1) policy number; (2) name, address and age of claimant/plaintiff; (3) nature and substance of the claim; (4) date and place at which the claim arose; (5) amounts paid, if any and the date and manner of disposition, judgment, or settlement; and (6) the date and reason for the final disposition, if no judgment or settlement;

(f) Releases the Hospital, Hospital Representatives, and Hospital's Affiliates from liability related to acts reasonably undertaken and performed in good faith in furtherance of the foregoing and in furtherance of quality health care, including in connection with the Application and the Practitioner's ongoing Staff Membership and Clinical Privileges;

(g) Acknowledges the Practitioner's responsibility to promptly notify and provide information to the Hospital President regarding any changes to the Practitioner's qualifications;

(h) Authorizes the posting of the Practitioner's affiliation with the Hospital, including on the Hospital's website; and

(i) Acknowledges that if the Practitioner participates in research activities that involve Hospital patients or the use of Hospital facilities, equipment or supplies, the Practitioner must perform such activities in accordance with applicable laws and regulations and Hospital and Medical Staff Policies, and must provide prior written notification of any research activities to the Hospital's IRB.

2.4.10 Comply with Ethical Guidelines

Each Practitioner agrees to abide, as applicable, by the Principles of Medical Ethics of the American Medical Association, the American Osteopathic Association, the American Podiatric Medical Association, Inc., the Code of Ethics of the American Dental Association, or other ethical principles or codes for the appropriate professional association of the Practitioner, as if the same were appended to and made a part of these Bylaws.

2.4.11 Comply with Laws and Policies

Each Practitioner agrees to strictly abide by: (a) all local, state and federal laws and regulations, NIAHO and other applicable accreditation standards, and professional review regulations and standards, as applicable to the Practitioner's professional practice; and (b) these Bylaws, Medical Staff Policies, Hospital Policies, and all other rules, policies and procedures, guidelines, and other requirements of the Medical Staff and the Hospital, including but not limited to the Hospital's compliance plan and Code of Conduct. Each Practitioner who serves as a Medical Staff Officer, Medical Executive Committee Member, Department Chair, Division Chief, Medical Staff Committee Chair, or Medical Staff Committee member (each a "leader"), agrees to comply with the Medical Staff's and Hospital's conflict of interest policies, including all applicable disclosure and recusal requirements. The Governing Body will determine whether a particular leader's conflict(s) of interests are incompatible with the leadership position and, if so, whether the Practitioner must step down from that position or take other action. A determination that a Practitioner must step down from a leadership position or take other action shall not be considered corrective or Disciplinary Action and shall not entitle the Practitioner to hearing or appeals rights under these Bylaws.

2.4.12 Mandatory Self-Disclosure

(a) Notification to the Practitioner Health Committee. Each Practitioner agrees to notify the Hospital Chief Medical Officer and Practitioner Health Committee in writing immediately after he/she becomes aware (in no event later than the end of the next business day, except, in connection with (iii), below, no later than the end of the third business day) of any of the circumstances listed below:

(i) The Practitioner enters, participates in, or, against medical advice, leaves or refuses any program of treatment prescribed or required by the Medical Board or pursuant to these Bylaws or Hospital or Medical Staff policy.

(ii) The Practitioner is admitted for, seeks, or is undergoing treatment for substance or alcohol abuse or a behavioral health problem. "Substance abuse" shall include but not be limited to, use or ingestion of illegal drugs, or use or ingestion of prescription medications not prescribed in the ordinary course of treatment of injury or disease. "Behavioral health problem" shall mean any condition or disease of a psychiatric or psychological nature which, in the opinion of a qualified psychiatrist, impairs the Practitioner's ability to perform with reasonable accommodation the essential functions of his or her position, including but not limited to his or her ability to care for patients or practice his or her profession in accordance with the applicable prevailing standard of care.

(iii) The Practitioner has a physical illness or injury or mental health illness that impairs the Practitioner's ability to perform with reasonable accommodation the essential functions of his or her position, including but not limited to care for patients or practice his or her profession in accordance with the applicable prevailing standard of care.

(b) Notification to the Medical Staff President. Each Practitioner agrees to notify the Medical Staff President in writing immediately after he/she becomes aware (in no event later than the end of the next business day) of any of the circumstances listed below (unless, where applicable, the circumstance is appropriately reported to the Practitioner Health Committee as set forth above). The Medical Staff President will immediately notify the Hospital Chief Medical Officer of the occurrence of any of the circumstances listed below:

(i) Any circumstance or condition which would affect or result in a change in status of any of the Practitioner's qualifications for Staff Membership and/or Clinical Privileges as set forth in these Bylaws;

(ii) Any disciplinary action or restriction, or relinquishment of privileges, related to the Practitioner's professional practice by any entity (including but not limited to the Practitioner's employer or any other hospital, health facility, medical practice, health plan, or agency);

(iii) Criminal proceedings against the Practitioner, including arrest, arraignment, or indictment, even if the charges against the Practitioner were dropped, filed, dismissed or otherwise discharged. The Practitioner must also report: convictions for felonies and misdemeanors; nolo contendere pleas; matters where sufficient facts of guilt were pled or found; matters that were continued without a finding even if they were ultimately dismissed; and any other plea bargain. A charge of Driving Under the Influence is not a "minor traffic offense" and must also be reported; and

(iv) The investigation of allegations (or a finding) related to the Practitioner's professional practice or conduct by any governmental or regulatory agency, including but not limited to an investigation or finding related to the to the abuse or neglect of any person, or misappropriation (improperly taking or using) of the property of a patient or other person.

2.4.13 Immunity from Liability

The Practitioner agrees and acknowledges that the Hospital, its Affiliates, and Hospital Representatives (including any medical peer review committee and its/their members, agents and representatives) shall have absolute immunity from civil liability for actions performed in good faith in connection with providing, obtaining or reviewing information, and evaluating or making recommendations or decisions concerning the following: (a) any activity or action of a medical peer review committee (including any medical peer review or credentialing activity); (b) any Professional Review Action; (b) any Adverse Action, corrective action, hearing or appellate review; (c) any FPPE, OPPE, or other evaluation of patient care services or qualifications; (d) any utilization review; and/or (e) any other Hospital, Department, Division or Committee activities related to patient care services and/or professional conduct. In furtherance of the foregoing, each Practitioner shall, upon request of the Hospital, execute releases in favor of the Hospital, Hospital Representatives and third parties from whom information has been requested, or who have provided, requested or been provided, or who have evaluated or acted upon, information in connection with the above activities.

2.4.14 Cooperate with Hospital

The Practitioner agrees to cooperate with the Hospital in matters involving its fiscal responsibilities and policies, including matters relating to payment or reimbursement by governmental and third party payers (to the extent such policies are consistent with applicable standards of care or operations and consistent with applicable laws and professional ethics).

2.4.15 Exhaustion of Remedies

The Practitioner agrees that if an Adverse Action is taken or recommended against him or her, the Practitioner will exhaust the remedies afforded by these Bylaws before resorting to legal action.

2.4.16 Pay Medical Staff Dues

The Practitioner agrees to pay Annual Medical Staff or Advanced Practice Professionals Staff dues, if any, upon request. Applicable Medical Staff and Advanced Practice Professionals Staff dues shall be set forth in a Medical Staff Policy. Failure to pay dues shall be addressed in accordance with the terms of Section 4.4.7, below. Medical Staff Dues are separate from, and in addition to, any application fee that is payable hereunder in connection with an Application.

2.4.17 Waiver of Certain Staff Obligations

An individual Staff Member may request to be exempted from certain obligations of Medical Staff or Advanced Practice Professionals Staff Membership, including the obligation to participate in call coverage programs. An individual Staff Member seeking such an exemption must submit a request to the applicable Department Chair. The Department Chair will submit the request and his/her recommendation regarding the request to the Medical Executive Committee, which may approve the waiver effective not less than thirty (30) days after the date of such approval, subject to the following review process. The Medical Executive Committee shall promptly notify the Hospital President and the applicable Department Chair of any waiver it has approved. If another member of the Medical Staff who would be aggrieved by the waiver objects to the waiver, or if the Hospital President objects to the waiver, then during the thirty day period following submission of the request for waiver, the aggrieved Medical Staff member or Hospital President may request review of the waiver by the Medical Executive Committee. Following the Medical Executive Committee review and determination, either the Medical Staff Member seeking the waiver or the aggrieved Member or the Hospital President may, within five (5) days, request review by the Governing Body, in which case the Governing Body or a designated committee thereof will make the final decision on the waiver request at its next meeting. Such review relating to a waiver shall not constitute a hearing, and the hearing and appellate review procedure and rights described in Article 5 do not apply. The waiver will not go into effect during the pendency of the Governing Body review of the waiver request.

2.4.18 Training and Utilization of Electronic Medical Records Systems and Technology

The Practitioner agrees to participate in required training for, and to utilize, the electronic medical record systems and other technology in use by the Hospital in connection with the care of Hospital patients and the conduct of Medical Staff and Hospital functions for which such systems and technology are relevant.

2.5 OBTAINING AND SUBMITTING AN APPLICATION

2.5.1 Obtaining an Application

Except as provided below, individuals seeking appointment, reappointment, Clinical Privileges (including initial or modified Clinical Privileges), and/or modification of Medical Staff category must submit a complete written Application.

(a) Initial Appointment and Clinical Privileges. A prospective Applicant for initial Staff Membership and/or Clinical Privileges must contact Medical Staff Services to obtain an Application. Unless the Applicant is seeking Honorary Staff Membership, Medical Staff Services personnel may contact the prospective Applicant to confirm that the prospective Applicant meets the following basic criteria:

(i) Possesses a current license to practice his/her profession in Texas or has submitted an application for such license;

(ii) Can provide peer recommendations as described in Section 2.3 of these Bylaws;

(iii) Is eligible for participation in state and federal reimbursement programs as provided in Section 2.3;

(iv) Can provide a current certificate of insurance evidencing professional liability coverage with limits not less than those specified by the Governing Body or these Bylaws;

(v) Practices in a specialty (or would be assigned to a Department or Division) that is open to new Applicants (certain Departments and/or Divisions, such as anesthesiology and radiology, may be closed to new Applicants if the Hospital enters or has entered into an exclusive contractual arrangement to secure such specialty services in accordance with Section 2.1.5).

(vi) Satisfies the board certification or board eligibility requirements of Section 2.3.5.

If the prospective Applicant confirms that he/she meets the foregoing criteria, Medical Staff Services personnel shall provide the Applicant with an Application. Medical Staff Services shall send the appropriate Application to the potential Applicant, or make the Application available to the potential Applicant electronically. If a CVO or DSTE will participate in the credentials verification process, the Application or a portion of the Application may be sent to the Applicant by the CVO or DSTE, and the CVO or DSTE may request and/or confirm additional information from the Applicant and/or other third parties. (Those individuals who wish to be considered for Honorary Medical Staff status will not submit an Application, but must submit to the Medical Staff Office a request for Honorary Medical Staff status, or have a request submitted on their behalf as described in Section 2.6.8.) If the prospective Applicant does not meet the basic qualifications above, Medical Staff Services personnel shall inform the Applicant that the Hospital will not provide or process an Application unless all such criteria are met. The failure to meet the criteria above and refusal of Medical Staff Services to provide an Application on that basis shall not be considered corrective or Disciplinary Action and shall not entitle a prospective Applicant to hearing or appeals rights under these Bylaws. The foregoing notwithstanding, Applicants who are completing or who recently completed post-graduate training, or who are relocating to or recently relocated to Texas, need not (as stated in Section 2.3.3 above) be licensed in Texas at the time of submitting an Application, but must have applied for licensure in Texas prior to submitting an Application and must possess a Texas license and satisfy all other pre-requisites for Staff Membership before being appointed to the Staff.

(b) Reappointment and Renewal of Clinical Privileges. Medical Staff Services will send to each Applicant for reappointment/renewal the appropriate Application at least twelve (12) weeks prior to the Applicant's reappointment/renewal date. If a CVO or a DSTE will participate in the credentials verification process, the Application or a portion of the

Application may be sent by the CVO or DSTE, and the CVO or DSTE may request and/or confirm additional information from the Applicant and/or other third parties. Honorary Medical Staff Members do not need to complete the reappointment application/review process.

(c) Modification of Medical Staff Category or Clinical Privileges. An individual seeking to modify his/her Medical Staff category or his/her current Clinical Privileges must request the appropriate Application from Medical Staff Services. Medical Staff Services shall send the appropriate Application to the prospective Applicant, or make the Application available to the prospective Applicant electronically, unless the particular Clinical Privileges sought are not available to the Applicant.

(d) Previously Denied or Terminated Applicants. An individual whose Application for Staff Membership and/or Clinical Privileges has been denied or whose Staff Membership and Clinical Privileges have been terminated, shall not be permitted to submit the same or a similar Application for at least two (2) years after notice of such Adverse Action, unless the notice of Adverse Action or the Governing Body provides otherwise. Applications submitted during this two (2) year period shall be returned to the Applicant, and no right of hearing or appellate review shall be available in connection with the return of such Application. An Application submitted subsequent to the two year period shall be processed as an initial Application.

2.5.2 Application Submission

(a) Initial Appointment. Initial Applicants must submit a complete Application (including required supporting documentation specified in the Application and the applicable Application fee) to Medical Staff Services within ninety (90) days of the Applicant's receipt of the Application. If a complete Application is not submitted within ninety (90) days of the Applicant's receipt of the initial Application, then, absent a showing of good cause in the sole discretion of Medical Staff Services, no further processing of the Application will take place, and the Applicant shall not be entitled to hearing and appellate review rights in connection with such action.

(b) Reappointment/Renewal. In order to allow for an adequate amount of time to process the Application, reappointment/renewal Applicants must submit a complete Application (including required supporting documentation specified in the Application and the applicable Application fee) to Medical Staff Services at least sixty (60) days prior to the expiration of the Applicant's then current term of appointment. If an Applicant fails to timely submit a reappointment/renewal Application, such Application will not be processed and the Applicant will be deemed to have voluntarily relinquished his/her Staff Membership and all Clinical Privileges upon expiration of the Applicant's then current term, unless good cause is shown for the late submission. Refusal to process an Application that is not submitted in a timely manner shall not be considered corrective or Disciplinary Action and shall not entitle the reappointment/renewal Applicant to hearing or appellate review rights. If an Applicant fails to timely submit a reappointment/renewal Application and the processing of the application is refused, the Applicant must, if he/she desires appointment and Clinical Privileges, complete an initial Application, meet all of the requirements for initial appointment and Clinical Privileges, and pay any applicable initial appointment Application fee.

(c) Modification of Medical Staff Category or Clinical Privileges. Requests for modification of Medical Staff category or current Clinical Privileges may be submitted to Medical Staff

Services at any time; except that such requests will not be accepted or considered within the twelve (12) month period following a denial of a similar request, unless the notification of denial or the Governing Body provides otherwise.

2.5.3 Applicant's Burden

Each Applicant, at the time of an Application and, thereafter, if applicable, as a Staff Member, shall have the burden of producing complete, accurate and adequate information to allow a proper evaluation of and resolve any doubts related to his/her qualifications for Staff Membership and/or Clinical Privileges. This burden may include completion of a medical, psychiatric, or psychological examination, at the Applicant's expense, if deemed appropriate by the Credentials Committee, Medical Executive Committee or Governing Body, which entity shall also designate two eligible physicians (or psychologists, or one of each), either of whom may serve as the examining practitioner. The Applicant may then select one of the two eligible practitioners to serve as the examining practitioner; or the Applicant may request an evaluation from a duly qualified practitioner acceptable to the Governing Body. In any event, the examining practitioner will not be either a Hospital employee, or person in economic competition with the Applicant, or person with a personal, familial, or business relationship or conflict with the Applicant. The Applicant's failure to sustain his/her burden hereunder, or the Applicant's submission of information which is either inaccurate or incomplete, may be grounds for denial of an Application.

2.6 REVIEW AND EVALUATION PROCESS

2.6.1 Generally

Prior to making a recommendation or decision regarding an Application for Active, Courtesy or Advanced Practice Professionals Staff Membership, Medical Staff Services, the appropriate Department Chair, the Credentials Committee, the Medical Executive Committee, and the Governing Body will review all relevant information regarding the Applicant (including, if applicable, OPPE and/or FPPE data and documentation relating to the Applicant) and verify that the Applicant meets the qualifications for Staff Membership and Clinical Privileges set forth in these Bylaws. A Hospital Representative(s) may contact any of the Applicant's peer references, educational institution references or clinical settings where the Applicant had or has employment or privileges for additional information, and/or may request an interview with the Applicant. Applications for Honorary Medical Staff Membership shall be reviewed and approved as set forth in Section 2.6.8, and applications from distant site telemedicine providers seeking review pursuant to privileging by proxy procedures shall be reviewed, in the first instance, pursuant to Section 2.7.1.

2.6.2 Anticipated Time Periods for Application Processing

All individuals and groups required to act on an Application shall do so in a timely and good faith manner and, except for good cause (including but not limited to a delay on the part of the Applicant), each Application should be processed within the time periods set forth below, measured from the receipt of a completed Application as determined by Medical Staff Services. The foregoing notwithstanding, these time periods are deemed guidelines, not requirements, and do not create any right to have an Application processed within these precise periods. If the provisions of the hearing and appellate review processes specified in these Medical Staff Bylaws are initiated, the time requirements provided therein, also as guidelines, shall apply, as applicable, in connection with the continued processing of the Application.

Individual/Group	Time Period
Medical Staff Services (and CVO or DSTE)	90 days
Department Chair	Prior to next Credentials Committee Meeting
Credentials Committee	Next Scheduled Meeting
Medical Executive Committee	Next Scheduled Meeting
Governing Body	Next Scheduled Meeting

2.6.3 Initial Review by Medical Staff Services

(a) Initial Review. Medical Staff Services shall maintain a separate credentials file for each individual Applicant.[21] Medical Staff Services will perform an initial review of each Applicant's credentials file to ensure that it includes: (a) a complete Application; (b) verification of the Applicant's credentials (including primary source verification of certain qualifications as set forth in Section 2.3); and (c) all other required documentation. If the Applicant's credentials file is deemed complete, it will be forwarded to the appropriate Department Chair for review.

(b) Incomplete Application. It is the sole responsibility of each Applicant to submit all of the required information and supporting documentation described in these Bylaws, or as otherwise requested by Medical Staff Services and the Medical Staff, on the approved forms and in the manner requested. The Hospital is under no obligation to act on an Application until all such information and supporting documentation have been received (even if the missing information is to be provided by a third party). If the required or requested information and documentation have not been submitted, the Applicant's file will be deemed incomplete. Medical Staff Services will notify the Applicant of any information and/or documentation that is required to complete the Applicant's credentials file, and that if the information and/or documentation is not provided within thirty (30) days, the Application will not be further processed. The Applicant shall not be entitled to hearing or appellate review rights in connection with such action.

2.6.4 Department Chair Review and Recommendation

The Department Chair shall determine whether the Applicant's peer recommendations and professional practice review data is sufficient to assess the Applicant's competence to perform the requested Clinical Privileges. If not, the Department Chair shall refer the Applicant's credentials file back to Medical Staff Services and Medical Staff Services shall request that the Applicant provide additional information or peer recommendations. If, within thirty (30) days of such request, the Applicant has failed to provide additional information and/or peer recommendations which the Department Chair reasonably deems sufficient to assess the Applicant's competence to perform the requested Clinical Privileges, the Applicant will be notified that his/her Application will not be further processed. If, however, the Department Chair determines that the Applicant's peer recommendations and professional practice review data are sufficient, the Department Chair shall complete the evaluation described in Section 2.6.1 and submit a written recommendation to the Credentials Committee that includes the following:

(a) Staff Membership. When applicable, whether the Applicant's application for Staff membership should be approved or disapproved, the appropriate Medical Staff category (as applicable), and the appropriate Department to which the Applicant should be assigned. If the recommendation regarding Staff membership or Medical Staff category is adverse to the Applicant, the written recommendation shall clearly state the reason(s) for such adverse recommendation.

(b) Clinical Privileges. Whether the Applicant's request should be approved or disapproved, in whole or in part, and whether there are any recommended conditions or restrictions. If the Applicant seeks initial or modified Clinical Privileges, the written recommendation shall include a focused professional practice evaluation method to be instituted in accordance with the Hospital's peer review policy. If the recommendation regarding Clinical Privileges is adverse to the Applicant, in whole or in part, the written recommendation shall state the reason(s) for such adverse recommendation.

(c) Written Guidelines. For Advanced Practice Professionals, whether written practice guidelines have been submitted as part of the Application and/or should be required, and if so, what those guidelines are, and any other recommended conditions or restrictions, including in connection with the scope of practice requested.

2.6.5 Credentials Committee Review and Recommendation

Upon completion of the evaluation described in Section 2.6.1 and review of the Department Chair's written recommendation, the Credentials Committee will submit a written recommendation to the Medical Executive Committee that includes the information set forth in Section 2.6.4. If the Credentials Committee disagrees with the recommendation of the Department Chair or the recommendation is adverse to the Applicant, in whole or in part, the Credentials Committee's written recommendation shall include the reason(s) for the disagreement or the adverse recommendation.

2.6.6 Medical Executive Committee Review and Recommendation

Upon completion of the evaluation described in Section 2.6.1, and review of the written recommendations of the Department Chair and the Credentials Committee, the Medical Executive Committee will draft a written recommendation that includes the information set forth in Section 2.6.4.[22]

(a) Favorable Recommendation. If the Medical Executive Committee disagrees with the recommendations of the Department Chair or the Credentials Committee, in whole or in part, the Medical Executive Committee's proposed recommendation shall include the reason(s) for the disagreement. If the proposed recommendation is favorable to the Applicant, the Medical Executive Committee will submit its recommendation to the Governing Body.

(b) Unfavorable Recommendation. If the recommendation is adverse to the Applicant, but not an Adverse Action as defined in Section 5.2.1, the Medical Executive Committee will submit its recommendation to the Governing Body, including the reason for the adverse recommendation. If the recommendation is deemed an Adverse Action in accordance with these Medical Staff Bylaws, the Hospital President will provide the Applicant with Written Notice of the Adverse Action (including the reasons for such recommendation) and advise the Applicant of his/her hearing rights (if any) in accordance with Article 5. The Governing Body shall not consider an Adverse Action recommendation until the Applicant has had an opportunity to exercise his/her hearing rights (if any) in accordance with these Medical Staff Bylaws.

2.6.7 Governing Body Review and Decision[23]

If, following a favorable recommendation of the Medical Executive Committee as described in Section 2.6.6(a), or following an unfavorable recommendation that is not an Adverse Action, the Governing Body's initial action with respect to the Applicant is deemed an Adverse Action in accordance with these Medical Staff Bylaws, the Hospital President will provide the Applicant

with Written Notice of the Adverse Action (including the reasons for such action) and advise the Applicant of his/her hearing rights (if any) in accordance with Article 5. The Governing Body shall not further consider the matter until the Applicant has had an opportunity to exercise his/her hearing rights (if any) in accordance with these Medical Staff Bylaws.

Upon completion of the evaluation described in Section 2.6.1, and review of the written recommendations of the Department Chair, the Credentials Committee, and the Medical Executive Committee, and following the Applicant's exercise of hearing rights, if applicable, the Governing Body will act on the matter. If the Governing Body's action is favorable to the Applicant, its action shall be final, and it will notify the Applicant by issuing a written decision that includes the information set forth in Section 2.6.4. If the Governing Body determines that its action will be an Adverse Action, the Hospital President will provide the Applicant with a Written Notice of Appeal Right, as described in Section 5.7 of these Bylaws. The Governing Body shall not further consider the matter until the Applicant has had an opportunity to exercise his/her appeal rights in accordance with these Medical Staff Bylaws.

If the Applicant fails to avail him/herself of his/her appeal rights, the Governing Body's action shall be final and the Applicant shall be notified of said action as provided in Sections 2.6.4 and 2.8.1(b). if the Applicant avails him/herself of his/her appeal rights, then, at its next meeting after receipt of the Appellate Review Committee Report and the other documentation described in Section 5.8 of these Bylaws, the Governing Body shall make a decision in the matter and shall send notice thereof to the Medical Executive Committee and the Hospital President. If the Governing Body's decision would be contrary to an Adverse Action/rrecommendation of the Medical Executive Committee, the matter will be submitted to a committee of an equal number of (a) medical staff members of the Medical Executive Committee and (b) Governing Body members for review and recommendation before the Governing Body takes final action. The Medical Staff/Medical Executive Committee members of the committee will be appointed by the Medical Executive Committee, and the Governing Body members of the committee will be appointed by the Governing Body. The committee will deliberate and provide its recommendation to the Governing Body within thirty (30) days of a request for review submitted to the Medical Executive Committee from the Governing Body. Following receipt of the recommendation of the committee, if applicable, the Governing Body will take action on the matter, and following final Governing Body action, the Governing Body will issue a written decision that includes the information set forth in Section 2.6.4. The written decision, if favorable, may precondition appointment or reappointment, and granting or continued exercise of Clinical Privileges, upon the Applicant undergoing mental or physical examinations and/or such other evaluations or conditions as it may deem appropriate at that time or at any intervening time, to evaluate the Applicant's ability to exercise Clinical Privileges.

2.6.8 Applicants for Honorary Medical Staff Status

Honorary Medical Staff Members are not eligible for Clinical Privileges. A physician who has retired from the practice of medicine or no longer wishes to exercise clinical privileges at the Hospital may request Honorary Medical Staff status either by submitting a written request for such status, or by having such a request submitted on his/her behalf, to the Medical Executive Committee. An Honorary Medical Staff Member need not meet the qualifications set forth in Section 2.3, nor complete the submission and review process set forth above. An Honorary Medical Staff Member must generally: (a) be recognized for his/her reputation and contributions to the health and medical sciences, and/or his/her contributions to the Hospital; (b) be recommended for Honorary Staff status; and (c) be approved for membership on the Honorary Medical Staff by the Medical Executive Committee and the Governing Body. Honorary Medical

Staff Members are required to inform the Medical Staff Office immediately of any adverse action taken against them by any health care facility, payor or licensing body, including any resignation or relinquishment of privileges or status while an investigation is ongoing. Efforts will be made to contact Members of the Honorary Medical Staff every two (2) years to confirm that they wish to retain Honorary Medical Staff status and to determine whether they continue to reside in the Hospital's service area. A physician's Honorary Medical Staff status may be terminated by the Governing Body at any time and for any reason; and Honorary Medical Staff status shall terminate if the individual having such status is found to no longer reside in the Hospital's service area.

2.7 PRIVILEGING–DISTANT SITE TELEMEDICINE PRIVILEGES

2.7.1 Minimum Qualifications for Privileging for Distant Site Telemedicine Practitioners

In lieu of utilizing the full privileging process set forth elsewhere in these Bylaws, and provided that doing so then comports with applicable Texas and federal law, the Medical Staff and the Hospital may, in their discretion, elect to utilize the privileging by proxy process set forth in this Section 2.7 to approve an Application for Telemedicine Medical Staff Membership and Telemedicine Clinical Privileges from an Applicant who wishes to provide services to Hospital patients from a distant site. An Applicant for telemedicine services who does not satisfy the requirements set forth in this Section must, in order to obtain such privileges, apply for privileges in accordance with Sections 2.5 and 2.6 of these Bylaws.

(a) Telemedicine Services Agreement. The Applicant is affiliated with a Distant Site Hospital (DSH) or a Distant Site Telemedicine Entity (DSTE). Such DSH or DSTE must have a current, written Telemedicine Service Agreement with the Hospital. If the Applicant is affiliated with and has been granted privileges by a DSH or DSTE, the Applicant must be in good standing with such DSH or DSTE, and must provide, or arrange for provision to Medical Staff Services of, written documentation of the Privileges he/she is requesting at the Hospital and his/her current privileges with the DSH or DSTE (which must include the requested Privileges). If granted privileges at the Hospital, the Applicant agrees to and shall provide those services in accordance with the terms of the Telemedicine Services Agreement between the Hospital and the DSH or DSTE with which the Applicant is affiliated and from which the Applicant has obtained Clinical Privileges. A copy of the Telemedicine Services Agreement shall be submitted to Medical Staff Services and shall include at least the following:

(i) If the Telemedicine Services Agreement is between the Hospital and a DSH:

a. a statement that the DSH is a contractor of services to the Hospital;

b. a statement that the DSH is a Medicare-participating hospital;

c. a statement that the DSH will cooperate with the Hospital and perform services in a manner that will permit the Hospital to comply with all applicable Medicare Conditions of participation for the services described in the Telemedicine Services Agreement;

d. a statement that it is the responsibility of the DSH's governing body to, and that the DSH's governing body shall, meet all of the requirements set forth in 42 CFR § 482.12 (a)(1)-(a)(9) and 42 CFR § 482.22 (a)(1)-(a)(4) with regard to the Applicant;

e. a statement that the DSH's governing body will ensure that the Applicant meets the qualifications for staff membership and clinical privileges at the DSH, that the Applicant is privileged at the DSH to provide the Privileges he/she has requested at the Hospital, and that the Hospital will be notified promptly of any changes to the Applicant's qualifications, membership or clinical privileges;

f. a statement that the DSH will provide the Hospital a current list of the Applicant's privileges at the DSH, as well as timely updates to that list, as applicable;

g. a statement that the DSH will, or will cause the Applicant to, provide the Hospital with electronic copies of credentialing and privileging materials for the Applicant if requested, and such other material as may reasonably be required by the Hospital to satisfy its credentialing standards;

h. a statement that the Applicant holds a professional license issued or recognized by the State of Texas; and

i. a statement that the Hospital will perform periodic reviews of the Applicant's performance of any Privileges granted at the Hospital and send to the DSH information that is useful to assess the Applicant's quality of care, treatment, and services for use in privileging and performance improvement, including, at a minimum, all adverse events that result from the telemedicine services provided by the Applicant to the Hospital's patients, all complaints the Hospital receives about the Applicant, and all adverse outcomes related to sentinel events that result from telemedicine services provided by the Applicant

(ii) If the Telemedicine Services Agreement is with a DSTE:

a. a statement that the DSTE is a contractor of services to the Hospital;

b. a statement that the DSTE will cooperate with the Hospital and perform services in a manner that will permit the Hospital to comply with all applicable Medicare Conditions of participation and NIAHO standards for the services described in the Telemedicine Services Agreement;

c. a statement that the DSTE's credentialing and privileging process meets all of the requirements set forth in 42 CFR § 482.12 (a)(1)-(a)(7), NIAHO standards, and 42 CFR § 482.22(a)(1)-(2) with regard to the Applicant;

d. a statement that the DSTE will ensure that the Applicant meets the qualifications for staff membership and clinical privileges at the DSTE, that the Applicant is privileged at the DSTE to provide the Privileges he/she has requested at the Hospital, and that the Hospital will be notified promptly of any changes to the Applicant's qualifications, membership or clinical privileges;

e. a statement that the DSTE will provide the Hospital a current list of the Applicant's Privileges at the DSTE, as well as timely updates to that list, as applicable;

f. a statement that the DSTE will, or will require the Applicant to, provide the Hospital with electronic copies of credentialing and privileging materials for the Applicant if requested, and such other material as may reasonably be required by the Hospital to satisfy its credentialing standards;

g. a statement that the Applicant holds a professional license issued or recognized by the State of Texas; and

h. a statement that the Hospital will perform periodic reviews of the Applicant's performance of any Privileges granted at the Hospital and send to the DSTE information that is useful to assess the Applicant's quality of care, treatment, and services for use in privileging and performance improvement, including, at a minimum, all adverse events that result from the telemedicine services provided by the Applicant to the Hospital's patients, all complaints the Hospital receives about the Applicant, and all adverse outcomes related to sentinel events that result from telemedicine services provided by the Applicant.

(b) Credentialing and Privileging Information. The DSH or DSTE provides Medical Staff Services with a current list of the Applicant's clinical privileges at the DSH or DSTE, which includes at least those Clinical Privileges which the Applicant is seeking at the Hospital.

(c) License/Registration. The Applicant possesses a current unrestricted professional license/registration as described in Section 2.3.3 of these Bylaws. A Practitioner whose licensure or registration is or has been denied, limited, or challenged in any way, is not eligible for Telemedicine Clinical Privileges using this alternative credentialing process.

(d) Additional Qualifications for Staff Membership and Clinical Privileges. The Applicant satisfies the following qualifications for Staff Membership, as set forth in Section 2.3 of these Bylaws: (i) No Sanctions or Exclusions (Section 2.3.8); (ii) Signed Acknowledgement (Section 2.3.10); (iii) National Practitioner Data Bank Report (Section 2.3.13); and (iv) Professional Liability Insurance (Section 2.3.19).

2.7.2 Review by Medical Staff Services

(a) Initial Review. Medical Staff Services shall maintain a separate credentials record for each distant site Telemedicine Applicant. Medical Staff Services will perform an initial review of each distant site Telemedicine Applicant's credentials record to verify the presence of required documentation in accordance with Section 2.7.1, including: (a) a copy of the applicable Telemedicine Services Agreement; (b) a copy of the lists of the Applicant's requested Privileges and his/her current privileges from the DSH or DSTE; (c) primary source verification of the Applicant's license and registration; and (d) evidence of the "Additional Qualifications" set forth above and such other documentation as may be required to enable the Hospital to satisfy applicable regulatory requirements. If the Applicant's credentials record is deemed complete, it will be forwarded to the appropriate Department Chair for review who, following review, will forward the file to the Medical Executive Committee.

(b) Incomplete Credentials Record. It is the sole responsibility of each Applicant to submit, or ensure the submission of, all of the required information and supporting

documentation described in this Section of the Bylaws, or as otherwise requested by the Medical Staff, on the approved forms and in the manner requested. The Hospital is under no obligation to act on an Application until all such information and supporting documentation have been received (even if the missing information is to be provided by a third party). If the required information and documentation have not been submitted, or if additional information is requested by Medical Staff Services or another Hospital Representative and not provided, the Applicant's record/application will be deemed incomplete. Medical Staff Services will notify the Applicant of the information and documentation required to complete the credentials record and that the Applicant's failure to provide such information and/or documentation within thirty (30) days following the notification will result in the Application not being further processed. The Applicant shall not be entitled to hearing or appellate review rights in connection with such action.

2.7.3 Medical Executive Committee Review and Recommendation

The Medical Executive Committee, in consultation with the applicable Department Chair, shall confirm that the Applicant meets the qualifications set forth in this Section 2.7 and that the Applicant is requesting only such privileges as he or she has the right to exercise at the DSH or DSTE. The Medical Executive Committee may request additional information relating to the Applicant and may defer action on the Application pending receipt of such information. Following its review, the Medical Executive Committee shall prepare a written recommendation regarding the application.

(a) Favorable Recommendation. If the Medical Executive Committee recommendation is favorable to the Applicant, the Medical Executive Committee will submit its recommendation to the Governing Body. If the Applicant is seeking initial or modified clinical privileges, the Medical Executive Committee's recommendation shall include a focused professional practice evaluation method to be instituted in accordance with the Hospital's peer review policy.

(b) Unfavorable Recommendation. If the Medical Executive Committee recommends that the Applicant's application must be processed in the same manner as Applications submitted by other Practitioners seeking privileges at the Hospital (i.e., pursuant to Sections 2.5 and 2.6 of these Bylaws), if the Medical Executive Committee makes an unfavorable recommendation based on the Applicant's failure to satisfy the qualifications for Telemedicine Staff membership, or if the Medical Executive Committee recommendation is deemed an Adverse Action in accordance with these Bylaws, the Hospital President will so notify the Applicant (including the reasons for the Medical Executive Committee recommendation) and advise the Applicant of his/her hearing rights (if any) in accordance with these Medical Staff Bylaws. (Neither a recommendation that the Applicant's application be processed in accordance with the terms of Section 2.5 and 2.6, nor a determination that the Applicant fails to satisfy the qualifications for Telemedicine Staff membership, shall be deemed an Adverse Action.) The Medical Executive Committee shall not submit to the Governing Body an Application that is recommended for review pursuant to Sections 2.5 and 2.6, or that does not satisfy the qualifications described in this Section 2.7. The Medical Executive Committee shall not submit to the Governing Body an Application that is the subject of an Adverse Action until the Applicant has had an opportunity to exercise his/her hearing rights (if any) in accordance with these Medical Staff Bylaws.

2.7.4 Governing Body Review and Decision

Upon receipt and review of the Applicant's file, including the written recommendations of the Medical Executive Committee, and following the Applicant's exercise of hearing and/or appeal rights, if applicable, the Governing Body will act on the matter. The Governing Body may approve the application, may determine that the Applicant's application be processed in accordance with the terms of Section 2.5 and 2.6 (which shall not be deemed an Adverse Action), or may deny the application in whole or in part. The Applicant shall be notified of the Governing Body's action in the manner set forth in Section 2.8 of these Bylaws.

2.8 NOTIFICATION OF STAFF MEMBERSHIP AND CLINICAL PRIVILEGING DECISIONS

2.8.1 Notification of Applicant

(a) Favorable Decision. If the Governing Body's decision regarding an Application is favorable to the Applicant, the Hospital President shall notify the Applicant in writing of the Governing Body's final decision. The written notification will include, as applicable:

(i) that the Governing Body has approved the Applicant's request for appointment/reappointment or change in Medical Staff category;

(ii) the Medical Staff Category to which the Applicant is appointed or reappointed;

(iii) the Department assignment;

(iv) the delineation of Clinical Privileges granted;

(v) any special conditions or restrictions that apply; and

(vi) for all Applicants seeking initial or additional Clinical Privileges, a description of the focused professional practice evaluation method that will be used to evaluate the Applicant's ability to perform the privileges.

(b) Unfavorable Decision. If the Governing Body's decision is deemed an Adverse Action or unfavorable, the Hospital President will provide the Applicant with Written Notice of the decision.

2.8.2 Communication with Hospital Departments

Medical Staff Services will ensure that the appropriate Departments and other Hospital patient care areas are informed of the Clinical Privileges granted to an Applicant, as well as of any conditions, revisions, restrictions or revocations of an Applicant's Clinical Privileges.

2.9 TEMPORARY, EMERGENCY, AND DISASTER PRIVILEGES

2.9.1 Minimum Qualifications for Temporary Clinical Privileges

An individual may be granted temporary Clinical Privileges if (i) the individual has submitted a complete application for Medical Staff membership and/or Clinical Privileges that is the subject of an affirmative recommendation by the Credential Committee, with no concerns noted, or (ii) to fulfill an important and pressing clinical need, as follows:

(a) Minimum Qualifications—Applicants with Complete Applications. All Applicants for temporary Clinical Privileges based on a complete Application, as described in these Bylaws, must meet the minimum qualifications set forth below:

i. The Application must be complete, with an affirmative recommendation from the Credentials Committee with no concerns raised, and must be awaiting approval by the Medical Executive Committee and/or Governing Body.

ii. The Applicant's license or registration to practice his or her profession, DEA registration, if applicable, malpractice insurance coverage as required herein, and relevant training experience must be verified.

iii. The Applicant must provide at least two Peer Recommendations, and other evidence, as deemed appropriate, of current competence and ability to perform the Privileges requested.

iv. A query to the National Practitioner Data Bank must be made, and the information received in response thereto evaluated, with results satisfactory to the Credentials Committee.

v. The Applicant cannot be, or have been, the subject of (A) a current or previous successful challenge to licensure or registration in any state; (B) involuntary termination of medical staff membership at another facility; or (C) involuntary limitation, reduction, denial or loss of clinical privileges at another facility.

(b) Minimum Qualifications—Applicants to Fill an Important Need. In instances in which, based on identified patient care needs, a Department Chair or designee requests the granting of temporary privileges for a Practitioner (including a locum tenens Practitioner) who (i) has not submitted a complete Application for Staff membership and (ii) is not seeking Staff membership, but who can fulfill the identified needs, the Practitioner may be asked to submit a request for temporary privileges on a form that has been approved by the Governing Body. Any such Applicant must meet the following minimum qualifications: a current, unrestricted Texas professional license or registration, malpractice insurance coverage as required by these Bylaws, current DEA and Texas controlled substances certificate (for Practitioners who will be prescribing controlled substances), and letters of recommendation or references as deemed appropriate by the Medical Staff President (or designee) or the Hospital President.

2.9.2 Granting of Temporary Clinical Privileges

(a) Credentials Verification. Medical Staff Services (or a qualified CVO or DSTE) will verify the Practitioner's credentials and forward the Clinical Privileges request and the credentials file to the Medical Staff President.

(b) Review by Medical Staff President. The Medical Staff President or his/her designee, in consultation with the applicable Department Chair, shall review the Clinical Privileges request and the credentials file. If the Medical Staff President or designee approves the request, he/she shall submit a written recommendation to the Hospital President. If the Medical Staff President or designee disapproves the request, Medical Staff Services shall notify the Practitioner or Department Chair (as applicable) of the denial.

(c) Review by Hospital President. Upon receipt of a recommendation from the Medical Staff President or designee, the Hospital President shall review the Clinical Privileges request, the credentials file, and the Medical Staff President's recommendation. The Hospital President may grant temporary Clinical Privileges for a specified period not to exceed one hundred-twenty (120) days in any one year period for Practitioners referenced in Section 2.9.1(a) and for a period not to exceed thirty (30) days in any one year period for Practitioners referenced in Section 2.9.1(b). If the Hospital President disapproves the request, Medical Staff Services shall notify the Practitioner or Department Chair (as applicable) of the denial.

2.9.3 Emergency Privileges

In an emergency situation (defined as a circumstance in which immediate action is necessary to prevent serious harm or death), any Staff Member with Clinical Privileges may provide any type of patient care, treatment, or services necessary to prevent serious harm or death, regardless of the Staff Member's Staff category or designated Clinical Privileges, as long as such care, treatment or services is within the scope of the Staff Member's license. If time permits, such Staff Member, or other Hospital staff members in attendance, shall attempt to locate an appropriately privileged Practitioner.

2.9.4 Disaster Privileges

Disaster privileges may be granted to volunteer Practitioners only when the Hospital's Emergency Operations Plan has been activated in response to a disaster and the Hospital is unable to meet immediate patient needs. Such disaster privileges may only be granted by the Hospital President or the Medical Staff President in accordance with the Hospital's policy regarding disaster privileges. A Practitioner's request for disaster privileges will not be accepted or considered within the twelve (12) month period following the denial or termination of a similar request from that Practitioner, unless the denial or termination decision provides otherwise.

2.9.5 Monitoring and Review

Individuals exercising temporary or disaster Clinical Privileges shall act under the supervision and observation of the Department Chair of the Department to which he/she is assigned. The Medical Staff President or the Hospital President may impose special requirements in order to monitor and assess the quality of care rendered by the Practitioner exercising temporary or disaster Clinical Privileges.

2.9.6 Termination of Temporary and Disaster Privileges

Temporary and disaster privileges shall automatically terminate at the end of the specific period for which they were granted. In addition, temporary and disaster privileges may be denied, or may be immediately terminated by the Hospital President upon notice of any failure by the Practitioner to comply with any special requirements imposed on the Practitioner in connection with the exercise of such Privileges at the Hospital. The Hospital President may also, at any time,

upon the recommendation of the Medical Staff President or his or her designee, terminate a Practitioner's temporary or disaster privileges, effective upon the discharge of the Practitioner's patient(s) from the Hospital. However, if the life or health of such patient(s) would be endangered by continued treatment by the Practitioner, any person authorized to impose a summary suspension in accordance with Section 4.3 of these Bylaws may terminate the Practitioner's temporary privileges, effective immediately. The Medical Staff President shall assign a Medical Staff appointee to assume responsibility for the care of such terminated Practitioner's patient(s) until discharged from the Hospital. The wishes of the patient(s) shall be considered where feasible in the selection of an alternative Practitioner.

2.9.7 Hearing and Appellate Review Rights

An individual who requests temporary or disaster Clinical Privileges shall not be entitled to the hearing and appellate review rights afforded by these Bylaws as the result of denial of temporary or disaster Clinical Privileges and/or the limitation, restriction or termination of such temporary or disaster Clinical Privileges.

2.10 LEAVE OF ABSENCE; VOLUNTARY RESIGNATION

2.10.1 Leave of Absence

(a) Request for Leave. A Staff Member may obtain a leave of absence from the Medical Staff for a period not to exceed one (1) year by submitting a written request to the Medical Executive Committee which explains the reason for the requested leave. The requirement to submit a written request may be waived by the Medical Staff President if conditions warrant. A leave shall be granted if approved by the Medical Executive Committee and the Governing Body, provided, however, that the Staff member retains in effect professional liability coverage for the period covered by the requested leave. The Medical Executive Committee and Governing Body may, in their discretion, extend a Staff Member's leave of absence for a period not to exceed one (1) additional year.

(b) Scheduled Reappointment. During the leave of absence, the Staff Member will, if applicable, be required to complete the reappointment process as scheduled. If the Staff Member fails to do so, the Staff Member will be required to submit a new initial appointment application upon return.

(c) Reinstatement.

(i) *Request for Reinstatement*. At least thirty (30) days prior to the termination of the leave of absence, or at any earlier time, the Staff Member may request reinstatement of Staff Membership and Clinical Privileges by submitting a written request to the Medical Staff President. The written request for reinstatement shall include an attestation that no adverse changes have occurred in the status of any of the Practitioner's qualifications for Staff Membership or Clinical Privileges since the Practitioner's last Application, or, if changes have occurred, a detailed description of the nature of the changes and any additional information requested by the Medical Staff President, Hospital President, Department Chair, Credentials Committee, Medical Executive Committee, and/or the Governing Body.

(ii) *Review Process*. The Medical Staff President will forward the request for reinstatement to the member's Department Chair for a recommendation. The Department Chair shall forward his/her recommendation to the Medical Executive Committee, which may seek a review and recommendation from the Credentials Committee before acting on the request. The Medical Executive Committee shall

make a recommendation and forward it to the Governing Body for approval, which approval may include reasonable conditions intended to promote health care quality and safety. The refusal of the Governing Body to reinstate a Practitioner following an approved leave of absence, or a determination by the Governing Body to restrict the Practitioner's Clinical Privileges that constitutes an Adverse Action, shall entitle the Practitioner to hearing and appellate review rights as provided in these Bylaws.

(d) Failure to Request Reinstatement. If a Practitioner fails to complete the reappointment process during his/her leave of absence, the Practitioner shall be deemed to have voluntarily resigned from the Medical or Advanced Practice Professionals Staff at the end of the Practitioner's then current term and such resignation shall not entitle the Practitioner to hearing or appellate review rights under these Bylaws. If a Practitioner fails to submit a request for reinstatement prior to the end of his/her approved leave of absence, the Practitioner shall be deemed to have voluntarily resigned from the Medical or Advanced Practice Professionals Staff at the end of the approved leave and such resignation shall not entitle the Practitioner to hearing or appellate review rights. A Practitioner who seeks to regain his/her Staff Membership or Clinical Privileges following such voluntary resignation must complete an Application for Reappointment to the Staff, meet all of the requirements for reappointment and Clinical Privileges, and pay any applicable Application fee.

2.10.2 Voluntary Resignation

Resignations from the Medical Staff must be submitted in writing to Medical Staff Services and must state the date the resignation becomes effective. The Practitioner's Department Chair, the Hospital President, the Medical Executive Committee, and the Governing Body shall be informed of all resignations.

2.11 MEDICO-ADMINISTRATIVE APPOINTMENTS

2.11.1 Appointment

A Staff Member who is appointed, employed, or under contractual arrangements to perform administrative duties at the Hospital and who also renders clinical care at the Hospital must meet the qualifications for Staff Membership and necessary Clinical Privileges.

2.11.2 Termination of Administrative Functions

The administrative functions of a Practitioner who is appointed or employed by the Hospital or under contract with the Hospital or a Hospital contractor to perform administrative duties may be terminated in accordance with the terms of the contract or appointment, or employment arrangement, as applicable. Such termination shall not affect such Practitioner's Staff Membership or Clinical Privileges except as provided in these Bylaws and/or in any contract with the Practitioner (or with the entity with which the Hospital contracts to provide such Practitioner's administrative services). Unless otherwise provided in these Bylaws or by contract, if the termination is deemed an Adverse Action, the Hospital President will provide the Practitioner with Written Notice of the Adverse Action in accordance with these Medical Staff Bylaws. A Practitioner may waive any right or privilege under these Bylaws, or pursuant to the terms of a contract between the Practitioner and the Hospital, or pursuant to the terms of a contract between the Practitioner and an entity with which the Hospital has a contract and by which the Practitioner is bound. In the event of any conflict or inconsistency between the terms of any such contract and these Bylaws, the terms of the contract shall supersede and prevail.

ARTICLE 3. STAFF CATEGORIES

3.1 GENERALLY

3.1.1 Designation; Modification

Each approved Applicant shall be designated as a member of one of the Staffs and/or Staff categories set forth below. At the time of appointment and each reappointment, each Staff Member's staff category shall be recommended by the Medical Executive Committee and approved by the Governing Body.[24] A Medical Staff Member seeking to change his/her current Medical Staff category must submit the appropriate Application to Medical Staff Services. Such Applications shall be reviewed and approved or denied using the same process as is set forth herein for Staff appointment/ reappointment.

3.2 CATEGORIES

3.2.1 Medical Staff

Each approved Applicant shall be designated as a member, as applicable, of one of the Medical Staff categories set forth below, or of the Advanced Practice Professionals Staff, as set forth in Section 3.2.2. The composition, duties and privileges related to each Medical Staff category and to the Advanced Practice Professionals Staff are described in Section 3.3.

Active:	Medical Staff Members with admitting privileges; and all Hospital-Based Medical Staff Members (e.g., Anesthesiologists, Pathologists, Radiologists, Emergency Department Physicians). Appointees to the Active Staff shall not be entitled to vote for Medical Staff officers or Department chairs until they have served on the Active Staff for a period of twelve (12) months, unless otherwise approved by the Medical Executive Committee and Governing Body.
Courtesy:	Non-voting Medical Staff Members with admitting privileges, including some Consultants, Locum tenens and moonlighting[1] Staff Members, including those credentialed in accordance with Section 2.9.2.
Telemedicine	Distant site Staff Members who possess telemedicine Privileges only
Honorary:	No Patient Encounter requirements; not eligible for admitting or Clinical Privileges

3.2.2 Advanced Practice Professionals Staff

Each Advanced Practice Professional shall be designated as a member of the Advanced Practice Professionals Staff.

[1] Moonlighters" are fully licensed physicians who are engaged by the Hospital to work episodically to cover shifts or services that are not or cannot be covered by full time Staff. Moonlighters generally work in a full-time capacity for entities other than the Hospital; and their engagement by the Hospital is ordinarily limited to specified time periods.

3.3 RIGHTS AND OBLIGATIONS OF STAFF MEMBERS

Rights/Obligations	Active	Courtesy[3]	Honorary	Telemed.	APP
Must meet the qualifications set forth in §:	2.3	2.3	2.6.8	2.3 or 2.7	2.3
Eligible for admission privileges	YES	YES	NO	NO	NO
Eligible for Clinical Privileges	YES	YES	NO	YES*[4]	YES
Subject to FPPE/OPPE	YES	YES	NO	YES	YES
Eligible for privileges to enter patient orders	YES	YES	NO	YES	YES
Eligible for access to Medical Records	YES	YES	NO	YES	YES
Supervise APPs	YES	YES	NO	YES	NO
Serve as Medical Staff Officer	YES	NO	NO	NO	NO
Serve on the MEC	YES	NO	NO	NO	NO
Serve on other Medical Staff Committees	YES	NO	YES	YES	YES
Serve as a Medical Staff Committee Chair	YES	NO	NO	NO	NO
Serve on a Departmental Committee	YES	NO	If Invited	YES	YES
Serve as a Department Chair	YES	NO	NO	NO	NO
Serve as a Division Chief	YES	NO	NO	NO	NO
Attendance at Medical Staff meetings	Expected	If invited	Encouraged	Encouraged	If Invited
Attendance at Department meetings	Expected	Encouraged	Encouraged	Encouraged	Encouraged
Vote in Med. Staff Officer & Dept. Chair elections	YES[2]	NO	NO	NO	NO
Vote in other medical staff matters	YES	NO	NO	NO	NO
Vote in medical staff Departmental matters	YES	NO	NO	NO	Per Dept.[5]
Must participate in call coverage programs [1]	YES	YES	NO	NO	YES
May attend CME	YES	YES[3]	YES	YES	YES
Must pay annual dues					

[1] In order to meet the needs of Hospital inpatients and outpatients and ensure compliance with applicable regulatory requirements, the Medical Executive Committee and the Hospital President (or, if they disagree, the Governing Body) will determine whether certain programs and specialty services require on-call coverage, in accordance with Section 2.4.5. Active Medical Staff Members, Courtesy Staff Members, and Advanced Practice Professionals are obligated (but not entitled) to participate in call coverage programs, if applicable to their Department and/or specialty service (see Section 2.4.5), as assigned by the Department Chair. Individual Staff members may request a waiver of on-call program participation requirements. (Refer to Section 2.4.17 of these Medical Staff Bylaws re waiver requests.)

[2] Initial appointees to the Active Staff shall not be entitled to vote for Medical Staff officers or Department Chairs until they have served on the Active Staff for a period of twelve (12) months, unless otherwise authorized by the Medical Executive Committee and Governing Body.

[3] Courtesy Medical Staff Members may attend CME, but at their own expense.

[4] Telemedicine practitioners may write orders to the extent authorized in their delineated privileges as approved in accordance with these Bylaws.

[5] The Department Chair may permit Advanced Practice Professionals to vote on Department Matters.

ARTICLE 4. CORRECTIVE ACTION

4.1 COMMUNICATION OF PRACTICE AND CONDUCT CONCERNS

The Medical Staff actively encourages any individual (including a Staff Member, Hospital employee, patient, visitor, vendor or other person) who has or becomes aware of any question or concern related to the professional practice or conduct of any individual Staff Member, to promptly communicate such question or concern in accordance with the applicable Medical Staff and/or Hospital Policy(ies). In the event the Medical Executive Committee (or other Hospital committee functioning as a medical peer review committee) determines that a Staff Member should be subject to corrective action, the chair of such committee shall initiate the corrective action process set forth in Section 4.2.

4.2 CORRECTIVE ACTION PROCESS

4.2.1 Application

The procedures set forth in this Article 4 are applicable to all Medical Staff and Advanced Practice Professionals Staff Members.

4.2.2 Written Request for Corrective Action

Whenever information indicates that a Staff Member's acts, omissions, conduct or professional performance inside or outside of the Hospital may be:

(a) Below the standards of the Medical Staff, including applicable professional standards of care;

(b) Detrimental to patient safety or to the delivery of quality care;

(c) Unethical, disruptive or harassing; and/or

(d) In violation of these Bylaws, Medical Staff Policies, Hospital Policies, or applicable laws, regulations, or accreditation standards,

the Governing Body Chair, the Hospital President, a Department Chair, the Medical Staff President, the Chair of a medical peer review committee, or the Hospital Chief Medical Officer may submit a written request for corrective action ("Corrective Action Request") to the Medical Executive Committee. A Corrective Action Request must be based on a reasonable belief that the action is in furtherance of quality health care and/or to limit or stop unprofessional or disruptive conduct,[25] and such action shall be supported by reference to the specific acts or omissions which constitute the grounds for the Corrective Action Request. The Medical Staff President shall notify the Hospital President and the applicable Department Chair in writing within seven (7) business days of the Medical Executive Committee's receipt of a Corrective Action Request, and will continue to keep the Hospital President and the Department Chair fully informed of all action taken in connection therewith. The foregoing notwithstanding, if the request for Corrective Action is in the nature of a request for Summary Suspension, the procedures outlined in Section 4.3 shall be followed.

4.2.3 Written Notice of Corrective Action Request

Within fourteen (14) days of the receipt of a Corrective Action Request, the Hospital President shall provide the affected Staff Member with Written Notice of the Corrective Action Request. The Written Notice shall:

(a) Advise the Staff Member of the Corrective Action Request and the underlying basis for the request, including the acts or omissions underlying the request; and

(b) Advise the Staff Member that he/she may request a preliminary interview with the Medical Executive Committee by submitting a written interview request ("Interview Request") to the Medical Staff President via personal/hand delivery or certified mail, return receipt requested within five (5) business days of the Delivery Date of the Notice of Corrective Action Request.

4.2.4 Preliminary Interview

In the event that a Staff Member who is the subject of a Corrective Action Request requests a preliminary interview in accordance with the terms of Section 4.2.3(b), the Hospital President shall be informed and the interview shall be held within fifteen (15) business days following the receipt of the preliminary interview request by the Medical Staff President. The informal preliminary interview shall include at least: (a) a review of the Corrective Action Request, and (b) an opportunity for the Staff Member to discuss the matter with the Medical Executive Committee. During such interview, the Staff Member shall be invited to discuss, explain or refute the allegations against the Staff Member. The Medical Executive Committee may request further information as required to make a recommendation regarding the Corrective Action Request. This informal interview shall be preliminary in nature and none of the procedural rules provided in Article 5 with respect to hearings shall apply, except that a record of the interview shall be made in the minutes of the Medical Executive Committee. The Staff Member shall not be entitled to representation by legal counsel at the informal preliminary interview.

4.2.5 Medical Executive Committee Review and Action

The Medical Executive Committee shall evaluate the acts or omissions described in the Corrective Action Request and any other concerns or issues that arise during the course of its review, and shall make a reasonable attempt to obtain the facts related to such acts or omissions, including by conducting such further inquiries as it deems appropriate.[26] The Medical Executive Committee may request the assistance of Hospital administration or Department or Division peer review or ad hoc committees. Following such review, including the informal interview with the Staff Member, if requested, the Medical Executive Committee's action on the Corrective Action Request may include, but is not limited to, one or more of the following:

(a) Rejection or modification of the Corrective Action Request;

(b) Issuance of a warning;

(c) Issuance of an oral or written reprimand;

(d) Requirement to complete specific education;

(e) Imposition of a term of monitoring;

(f) Requirement to seek consultations;

(g) Recommendation for reduction, limitation, suspension or revocation of Clinical Privileges;

(h) Recommendation that the Staff Member's Staff Membership be revoked; and/or

(i) Any other action that may be appropriate under the circumstances, including summary suspension, in which case the procedures set forth in Section 4.3 of these Bylaws shall be followed.

4.2.6 Written Notice of Adverse Action

Before any action of the Medical Executive Committee that may be deemed an Adverse Action (defined in Section 5.2.1) is forwarded to the Governing Body, the Hospital President shall notify the Staff Member of the Adverse Action in accordance with the terms of Article 5 and the Staff Member shall be provided an opportunity to exercise his or her hearing rights (if any), as set forth in Article 5. The Medical Executive Committee action shall otherwise be forwarded to the Governing Body, which may, following its review, request that the Medical Executive Committee reconsider its action, or the Governing Body shall act on the matter, subject to the terms of Article 5 of these Bylaws.

4.3 SUMMARY SUSPENSION [27]

4.3.1 Authority and Indications

A Staff Member's Clinical Privileges may be summarily suspended if such action is taken in the reasonable belief that the suspension is warranted by the facts known and that the failure to take such action is reasonably likely to result in imminent danger to the health, safety or welfare of any individual, or result in significant disruption to the operation of the Hospital. Summary suspensions imposed pursuant to this Section 4.3.1 need not follow the procedures set forth in Section 4.2. The following individuals or groups shall each have the authority to summarily suspend Staff Membership and/or all or any portion of a Staff Member's Clinical Privileges:

(a) Medical Staff President;

(b) Medical Staff Vice President (in the absence of the Medical Staff President);

(c) Hospital President, or in his/her absence, a designee (in consultation with the Medical Staff President and Department Chair, if available);

(d) a majority of the Medical Executive Committee; or

(e) a majority of the Governing Body or duly designated committee or representative thereof.

4.3.2 Communication with the Medical Executive Committee and the Governing Body.

In the event of a summary suspension, the individual or group imposing the summary suspension shall promptly contact the Hospital President. The Hospital President shall inform the Medical Executive Committee and the Governing Body of the summary suspension (if the suspension did not emanate from such body(ies)), and provide notice to the affected Staff Member as set forth in Section 4.3.3 below.[28]

4.3.3 Written Notice of Summary Suspension

The Hospital President shall contact the affected Staff Member as soon as reasonably possible to inform him/her of the summary suspension and shall thereafter provide the affected Staff Member with Written Notice of the summary suspension which describes the basis for the summary suspension ("Summary Suspension Notice"). The initial contact with the affected Staff Member may be verbal (in person or by telephone), and the Hospital President shall record the date and time of the contact. The summary suspension shall become effective upon the earlier of: (a) the date and time the Hospital President contacted the affected Staff Member; or (b) the Delivery Date of the Summary Suspension Notice. The Summary Suspension Notice shall:

(a) Advise the Staff Member of the Summary Suspension and the acts or omissions underlying the suspension; and

(b) Advise the Staff Member that he/she may request a preliminary interview with the Medical Executive Committee by submitting a written interview request ("Interview Request") to the Medical Staff President via personal/hand delivery or certified mail, return receipt requested within five (5) business days of the Delivery Date of the Summary Suspension Notice.

A copy of the Summary Suspension Notice shall be submitted to the Medical Executive Committee and the Governing Body by the Hospital President as soon as reasonably possible.

4.3.4 Preliminary Interview

If the Staff Member whose Clinical Privileges have been summarily suspended has requested a preliminary interview in accordance with Section 4.3.3(b), the Hospital President shall be informed and the interview shall be held within ten (10) days following the receipt of the preliminary interview request by the Medical Staff President. The informal preliminary interview shall include at least: (a) a review of the Summary Suspension Notice, and (b) an opportunity for the Staff Member to discuss the matter with the Medical Executive Committee. During such interview, the Staff Member shall be invited to discuss, explain or refute the allegations against the Staff Member. The Medical Executive Committee may request further information as required to make a recommendation regarding the summary suspension. This informal interview shall be preliminary in nature and none of the procedural rules provided in Article 5 with respect to hearings shall apply, except that a record of the interview shall be made in the minutes of the Medical Executive Committee. The Staff Member shall be entitled to be accompanied by legal counsel at the informal preliminary interview as a listener, but legal counsel may not speak on the Staff Member's behalf during the interview.

4.3.5 Medical Executive Committee Review and Action

Within two (2) business days following the imposition of a summary suspension, the Medical Staff President shall convene an ad hoc review committee which includes at least three (3) Medical Staff Members who are not currently serving on the Medical Executive Committee to consider the facts and report back to the Medical Executive Committee within seven (7) business days of the imposition of the summary suspension. Following receipt of the report of the ad hoc review committee, the Medical Executive Committee may request further information as it deems appropriate. The Medical Executive Committee shall promptly convene to consider the summary suspension, and if an informal preliminary interview has been held, take into account the information obtained through the informal interview.

(a) Adverse Medical Executive Committee Recommendation. In the event the Medical Executive Committee recommends that the summary suspension continue (with or without modification), then, before such Adverse Action is forwarded to the Governing Body, the Hospital President shall notify the affected Staff Member of the Adverse Action in accordance with the terms of Article 5 and the Staff Member shall be provided an opportunity to exercise his or her hearing rights (if any) as set forth in Article 5. The terms of the summary suspension shall remain in effect pending completion of the process described in Article 5.

(b) Affirmative Medical Executive Committee Recommendation. In the event the Medical Executive Committee elects to recommend that the summary suspension be terminated, revoked or voided, and that the Staff Member's Clinical Privileges be reinstated, the recommendation shall be forwarded to the Governing Body. The terms of the summary suspension shall remain in effect pending review by the Governing Body. If the Governing Body agrees with the recommendation of the Medical Executive Committee, the Staff Member's Clinical Privileges shall be reinstated and the Hospital President shall so notify the affected Staff Member. If the Governing Body determines that the summary suspension should continue (with or without modification), then, before such Adverse Action is finalized, the Hospital President shall notify the affected Staff Member of the Adverse Action in accordance with the terms of Article 5 and the Staff Member shall be provided an opportunity to exercise his or her hearing rights (if any), as set forth in Article 5. The terms of the summary suspension shall remain in effect pending, if applicable, completion of the hearing and appellate review process set forth in Article 5.

4.3.6 Enforcement and Alternative Coverage

The Medical Staff President shall take all steps necessary to effectuate the summary suspension with the assistance of the Hospital President and the applicable Department Chair(s). Immediately upon imposition of a summary suspension, the Medical Staff President shall have authority to appoint an alternative Staff Member to provide medical coverage for the suspended Staff Member's patients who remain at the Hospital at the time of such suspension. The wishes of the patients shall be considered in the selection of such alternative Staff Member. The suspended Staff Member shall confer with the alternative Staff Member to the extent necessary to ensure continuous quality care.

4.3.7 Communication with Hospital Departments

The Hospital President will ensure that the appropriate Departments and other Hospital patient care areas are informed of any summary suspension of a Staff Member's Clinical Privileges.

4.4 AUTOMATIC SUSPENSIONS AND/OR TERMINATIONS

4.4.1 Generally

Automatic suspensions and/or terminations may (or may not) be reportable to the Medical Board, depending on applicable state and federal law requirements.

4.4.2 Failure to Complete Medical Records

Whenever a Staff Member fails to complete medical records in accordance with the standards set forth in the applicable Medical Staff or Hospital Policies, the Staff Member shall be subject to automatic suspension as further described in the applicable Medical Staff or Hospital Policy.

4.4.3 Adverse Change in Licensure or Certification

(a) Revocation. If a Staff Member's license, certification or other credential authorizing professional practice in Texas is revoked by the applicable licensing or certifying authority, or if it is relinquished, such Staff Member's Staff Membership and Clinical Privileges shall be automatically terminated as of the date such revocation or relinquishment becomes effective.

(b) Suspension and Restriction. If a Staff Member's license, certification or other credential authorizing practice in Texas is suspended, limited, restricted or made subject to certain conditions (including without limitation, probation) by the applicable licensing or certifying authority, any of the Staff Member's Clinical Privileges that are within the scope of the suspension, limitation, restriction, or condition shall be automatically suspended, limited, restricted or conditioned by the Hospital in a similar manner, as of the date such action becomes effective and throughout the term thereof. As soon as reasonably possible after such automatic suspension, the Medical Executive Committee shall convene to review and consider the facts upon which the Staff Member's license, certification or other credential authorizing practice in Texas was suspended, limited, restricted or made subject to conditions. The Medical Executive Committee may then initiate such further corrective action as may be appropriate under the circumstances.

4.4.4 Exclusion from Health Care Program

If a Staff Member is involuntarily excluded or suspended from participation in Medicare, Medicaid or any health care program funded in whole or in part by the federal or state government, such Staff Member's Staff Membership and Clinical Privileges shall be automatically terminated or suspended as of the date such exclusion becomes effective.

4.4.5 Adverse Change in DEA Certification

If a Staff Member's Drug Enforcement Administration (DEA) certification is revoked, suspended or voluntarily relinquished, or whenever such certification is subject to probation, the Staff Member shall immediately and automatically be divested of the right to prescribe medications covered by such certification. As soon as reasonably possible after such automatic suspension, the Medical Executive Committee shall convene to review and consider the facts upon which the DEA certification was revoked, suspended, relinquished, or made subject to probation. The Medical Executive Committee may then initiate such further corrective action as may be appropriate under the circumstances.

4.4.6 Failure to Maintain Professional Liability Insurance

(a) Written Notice. If a Staff Member fails to submit or fails to maintain a Certificate of Insurance as required under these Bylaws or as otherwise requested, Medical Staff Services shall notify the Hospital President and the Hospital President shall send a Written Notice to the Staff Member. The Written Notice shall inform the Staff Member that the Staff Member must refrain from exercising Clinical Privileges at the Hospital unless the Certificate of Insurance is received by the Hospital, and that:

(i) If the Staff Member fails to submit a Certificate of Insurance to the Hospital within seven (7) business days after the Delivery Date of the Written Notice, the Staff Member's Clinical Privileges shall be automatically **suspended** effective as of 11:59 p.m. on the seventh (7^{th}) day after the Delivery Date, and remain suspended until the Certificate of Insurance is received; and

(ii) If the Staff Member fails to submit a Certificate of Insurance within three (3) months after the automatic suspension, the Staff Member's Staff Membership and Clinical Privileges shall be automatically **terminated**, effective as of 11:59 p.m. on the day three (3) months after the automatic suspension. If the Staff Member wishes to reestablish Staff Membership, the Staff Member shall be required to complete an initial Application, meet all of the requirements for initial appointment and Clinical Privileges, and pay any applicable Application fee.

(b) Submission of Certificate. If the Staff Member submits a Certificate of Insurance prior to the automatic termination of Staff Membership and/or Clinical Privileges, the Staff Member's Staff Membership and Clinical Privileges shall be automatically reinstated without further action on the part of the Staff Member or any Medical Staff committee. Medical Staff Services shall notify the Hospital President when the Certificate of Insurance has been received.

4.4.7 Failure to Pay Dues

(a) Written Notice. If a Staff Member fails to pay Medical Staff dues as required under these Bylaws, Medical Staff Services shall notify the Medical Staff President. The Medical Staff President shall send a Written Notice to the Staff Member. The Written Notice shall inform the Staff Member that:

(i) If the Staff Member fails to submit the appropriate Medical Staff Dues to Medical Staff Services within the time period specified in the Written Notice (which shall be at least sixty (60) days), the Staff Member's Clinical Privileges may be automatically **suspended** effective as of 11:59 p.m. on date specified in the Written Notice, and remain suspended until the Staff Member submits the required dues; and

(ii) If the Staff Member fails to submit Medical Staff Dues within three (3) months after the automatic suspension, the Staff Member shall be deemed to have voluntarily resigned from the Medical Staff and to have relinquished his/her Clinical Privileges, effective as of 11:59 p.m. on the day three (3) months after the automatic suspension (requiring the Staff Member, if he/she later seeks to regain his/her Clinical Privileges, to complete an initial Application, meet all of the requirements for initial appointment and Clinical Privileges, and pay any applicable Application fee).

(b) Submission of Dues. If the Staff Member submits the required Medical Staff dues prior to the automatic termination of Staff Membership and/or Clinical Privileges, the Staff Member's Staff Membership and Clinical Privileges shall be automatically reinstated without further action on the part of the Staff Member or any Medical Staff committee. Medical Staff Services shall notify the Hospital President when the Medical Staff dues have been received.

4.4.8 Failure to Maintain Collaborative Practice Relationship

If an Advanced Practice Professional is required, in accordance with these Bylaws, to maintain a Collaborative Practice Relationship and/or Collaborative Practice Agreement with one or more Medical Staff Members, and the Advanced Practice Professional (i) fails to maintain that relationship or agreement (including if the collaborating physician terminates the Collaborative Practice Agreement, leaves the Hospital, or his/her Clinical Privileges are reduced or revoked) in accordance with these Bylaws; or (ii) fails to comply with the terms of his/her Collaborative Practice Agreement, the Advanced Practice Professional's Clinical Privileges shall be automatically suspended and shall remain suspended until the Advanced Practice Professional provides Medical Staff Services with adequate evidence that an appropriate Collaborative

Relationship and/or (as applicable) Collaborative Practice Agreement are in effect. A failure to provide Medical Staff Services with adequate evidence that an appropriate Collaborative Practice Relationship and/or Collaborative Practice Agreement are in effect within one (1) month after the date the automatic suspension became effective shall be deemed to be a voluntary resignation of the Advanced Practice Professional's Staff Membership and a relinquishment of all Clinical Privileges.

4.4.9 Enforcement and Alternative Coverage

The Medical Staff President shall take all steps necessary to effectuate all automatic suspensions/terminations with the assistance of the Hospital President and the applicable Department Chair(s). Immediately upon imposition of an automatic suspension or termination, the Medical Staff President shall have authority to appoint an alternative Staff Member to provide medical coverage for the suspended/terminated Staff Member's patients who remain at the Hospital at the time of such suspension or termination. The wishes of the patients shall be considered in the selection of such alternative Staff Member. The suspended/terminated Staff Member shall confer with the alternate Staff Member to the extent necessary to ensure continuous quality care.

4.4.10 Communication with Hospital Departments

The Hospital President will ensure that the appropriate Departments and other Hospital patient care areas are informed of any automatic suspension/termination of a Staff Member's Clinical Privileges.

4.4.11 Automatic Suspensions Are Not Adverse Actions

Automatic suspensions or terminations imposed in accordance with this Section 4.4 are not considered Adverse Actions, even if reportable to the Medical Board, the National Practitioner Data Bank, or any state or federal agency, and do not entitle the affected Practitioner to hearing or appellate review rights pursuant to these Bylaws.

ARTICLE 5. HEARING & APPELLATE REVIEW PROCEDURE

5.1 GENERAL PROVISIONS

5.1.1 Purpose

The hearing and appellate review processes described herein are designed to ensure that: (1) Adverse Actions are issued or imposed in furtherance of quality health care and orderly health care operations, and only after full consideration of all relevant quality and safety issues; and (2) any Medical Staff Member who is subject to an Adverse Action has a fair opportunity to appeal such action.[29]

5.1.2 Application

For purposes of this Article 5, the term "Medical Staff Member" may include "Applicant," if applicable under the circumstances. The procedures and rights set forth in this Article 5 are not applicable to Advanced Practice Professionals who apply for or maintain Staff Membership and/or Clinical Privileges. The procedures and rights of Advanced Practice Professionals in connection with Adverse Actions are set forth in Medical Staff Policy.

5.1.3 Exhaustion of Remedies; Right to One Hearing/Appellate Review

If an Adverse Action is taken or recommended, the Medical Staff Member must exhaust the remedies afforded by these Bylaws before resorting to other legal action. No Medical Staff Member shall be entitled to more than one hearing and one appellate review on any matter that shall have been the subject of an Adverse Action.

5.1.4 Construction of Time Periods; Waiver

Failure by any Hearing Committee or Appellate Review Committee, the Medical Executive Committee, or the Governing Body, to comply with time limits specified in this Article 5 shall not be deemed to invalidate their actions, or give rise to any claim or cause of action by the affected Medical Staff Member. Notwithstanding the above, where these Bylaws specifically provide that any right shall be waived as a result of the failure to act within a specified time period, such provisions shall be strictly applied.

5.2 GROUNDS FOR A HEARING

5.2.1 Adverse Actions

Except as otherwise specified in these Bylaws, the following actions shall be deemed Adverse Actions. A Medical Staff Member shall be entitled to a hearing (and Advanced Practice Professionals Staff shall be entitled to process in accordance with Medical Staff Policy) if the Medical Executive Committee or the Governing Body recommends or implements any of the following Adverse Actions (this includes unfavorable initial Governing Body actions on Applications to the Staff, when following the favorable recommendation of the Medical Executive Committee as described in Section 2.6.7):

(a) Denial of initial appointment to the Medical Staff or Advanced Practice Professionals Staff, but only for reasons relating to professional competence or professional conduct;

(b) Denial of Medical Staff or Advanced Practice Professionals Staff reappointment under circumstances that would be reportable to the Medical Board or the National Practitioners Data Bank (NPDB);

(c) Revocation of Staff Membership under circumstances that would be reportable to the Medical Board or the NPDB;

(d) Refusal to reinstate a Practitioner following an approved leave of absence, or reinstatement with restrictions that would otherwise be deemed an Adverse Action hereunder;

(e) Involuntary change or denial of a requested change in Medical Staff category, if such involuntary change or denial results in the denial, reduction, or termination of Clinical Privileges;

(f) Denial of requested Clinical Privileges under circumstances that would be reportable to the Medical Board or the NPDB;

(g) Letters of warning, reprimand, censure or admonition, if such letters require a report to the Medical Board or the NPDB;

(h) A required course of education, training, counseling, or monitoring, if the requirement requires a report to the Medical Board or the NPDB ;

(i) Voluntary or involuntary reduction, restriction or suspension of Clinical Privileges under circumstances that would be reportable to the Medical Board or the NPDB;

(j) Termination of current Clinical Privileges under circumstances that would be reportable to the Board of Medicine or the NPDB; and/or

(k) Any other action that, if finalized, would be reportable to the Medical Board, the NPDB, or any other state or federal agency, unless otherwise stated herein.

5.2.2 Actions Which are Not Considered Adverse Actions

The following actions shall not be deemed Adverse Actions and shall not constitute grounds for a hearing and/or appellate review rights (unless the action, if finalized, would be reportable to the Medical Board, the NPDB, or any other state or federal agency):

(a) The denial of initial Medical Staff or Advanced Practice Professionals Staff appointment, if not for reasons relating to professional competence or professional conduct;

(b) The expiration, termination, or non-renewal of Staff Membership and/or Clinical Privileges that results from the termination of any contract with the Hospital, if the contract authorizes such expiration, termination or non-renewal of Staff Membership and/or Clinical Privileges, or if the action is not otherwise under circumstances that would be reportable to the Medical Board or the NPDB;

(c) Involuntary change or denial of a requested change in Medical Staff category, if such involuntary change or denial does not result in the denial, reduction or termination of Clinical Privileges;

(d) The denial or refusal to accept, or continue to process, an incomplete Application;

(e) The failure to satisfy, or refusal to recommend or approve waiver of, board certification requirements;

(f) The recommendation or imposition of monitoring, supervision, proctoring, review or consultation requirements that affect all similarly situated Medical Staff Members (e.g., required by Departmental policy);

(g) Appointment, reappointment or Clinical Privileges which are granted for a period of less than two (2) years;

(h) Failure to place a Medical Staff Member on any on-call or interpretation roster, or removal of any Medical Staff Member from any such roster;

(i) Denial or revocation of membership on the Honorary Medical Staff;

(j) The removal of a Staff Member from a Staff leadership position based on a determination by the Governing Body of a conflict of interest; and/or

(k) The removal of a Staff Member from any medico-administrative position, including removal from a Medical Staff Member's position as a Medical Staff Officer, Department Chair, or Division Chief.

Automatic suspensions or terminations imposed in accordance with Section 4.4 of these Bylaws are not considered Adverse Actions, even if reportable to the Medical Board, the National Practitioner Data Bank, or any state or federal agency.

5.3 PRE-HEARING PROCESS

5.3.1 Written Notice of Adverse Action [30]

The Hospital President shall be responsible for giving prompt Written Notice of any Adverse Action ("Adverse Action Notice") to any affected Medical Staff Member. The Adverse Action Notice shall:

(a) Advise the Medical Staff Member of the Adverse Action;

(b) Contain a brief statement identifying the acts and/or omissions upon which the Adverse Action is based;

(c) Advise the Medical Staff Member that he/she may request a hearing to review the Adverse Action by submitting a written hearing request ("Hearing Request") to the Hospital President via personal/hand delivery or certified mail, return receipt requested within thirty (30) days of the Medical Staff Member's receipt of the Adverse Action Notice[31];

(d) State that the Medical Staff Member's failure to submit a Hearing Request within the specified time, or to personally appear at the scheduled hearing, shall constitute a waiver of the Medical Staff Member's right to the hearing and any subsequent appellate review;

(e) Advise the Medical Staff Member that (i) the Medical Staff Member has the right to be represented at the hearing by a Medical Staff Member, legal counsel, or another individual chosen by the Medical Staff Member; and (ii) if the Medical Staff Member intends to be represented by legal counsel or another individual, the Medical Staff Member's Hearing Request should include the name and contact information for such counsel or individual;

(f) Advise the Medical Staff Member that the Medical Staff Member may: (i) call, examine and cross-examine witnesses; (ii) present evidence deemed relevant by the Hearing Committee Chair or the Chair's designee (regardless of its admissibility in a court of law); and (iii) submit written statements prior to, during and/or at the close of the hearing;

(g) Advise the Medical Staff Member that a record of the hearing shall be made, and that the Medical Staff Member has the right to receive a copy of such hearing record upon payment of reasonable charges for the preparation thereof; and

(h) State that following completion of the hearing procedure, the Medical Staff Member will receive a copy of the Hearing Committee Report, which shall include the Hearing Committee's recommendations and the basis therefor.

5.3.2 Hearing Request; Failure to Request Hearing

The Medical Staff Member's failure to timely submit a Hearing Request in the manner and time-frame described in Section 5.3.1 shall be deemed a waiver of the Medical Staff Member's right to such hearing, and to any appellate review to which the Medical Staff Member might otherwise have been entitled on the matter. If the Adverse Action was *imposed* by the Medical Executive Committee, it shall remain effective pending the Governing Body's action. If the Adverse Action was *recommended* by the Medical Executive Committee, it shall not become effective until the Governing Body takes action on the matter.

5.3.3 Appointment of Hearing Committee

(a) Generally. Hearing Committee members may not: (i) have participated in the Adverse Action decision (other than providing information); (ii) have (at the time or recently) a professional practice or family relationship with the affected Medical Staff Member; or (iii) be in direct economic competition with the affected Medical Staff Member.[32] Prior to the hearing, the Medical Staff President shall make the names of prospective Hearing Committee members available to the affected Medical Staff Member and the affected Medical Staff Member shall notify the Medical Staff President if he or she has questions regarding the ability of any Hearing Committee member to be objective or impartial. The Medical Staff President shall give due consideration to the questions raised, consistent with the provisions of this section and general considerations of fairness.

(b) Medical Executive Committee Review. When a hearing relates to an Adverse Action of the Medical Executive Committee, the Medical Executive Committee shall determine whether an ad hoc Hearing Committee shall be composed of (i) Active Medical Staff Members, or (ii) peers from the Hospital and/or an Affiliate hospital, and/or others who are outside independent experts. If the Medical Executive Committee chooses the former, the Medical Staff President, in consultation with the Hospital President and subject to the approval of the Medical Executive Committee, will appoint three (3) members of the Active Medical Staff to serve as Hearing Committee members. If the Medical Executive Committee elects to establish a Hearing Committee composed of the latter, the Medical Staff President, subject to the approval of the Medical Executive Committee, will appoint three (3) individuals to serve as Hearing Committee members, who may be members of the Active Medical Staff or an Affiliate hospital's Medical Staff, outside independent experts, and/or clinical administrative leaders of the Hospital or any Affiliate hospital. The Medical Staff President shall designate one of the Hearing Committee members to serve as the Hearing Committee Chair. All of the members of the Hearing Committee must be present to constitute a quorum for committee proceedings.

(c) Governing Body Review. When a hearing relates to an Adverse Action of the Governing Body that is not based on a prior Adverse Action of the Medical Executive Committee, the Governing Body shall appoint a Hearing Committee composed in the same manner as described in Section 5.3.3(b), subject to the restrictions set forth in Section 5.3.3(a). The Governing Body shall designate one of the Hearing Committee members to serve as the Hearing Committee Chair.

(d) Alternative to Hearing Committee. In the event that the size and/or composition of the Medical Staff renders appointment of an impartial hearing committee difficult, the Hospital

President may, as an alternative to a Hearing Committee, after consulting with the Medical Staff President, appoint a hearing officer (the "Hearing Officer"), preferably an attorney, to perform the functions of a Hearing Committee pursuant to this Article. The Hearing Officer may not be related to, or in direct economic competition with, the Practitioner requesting the hearing. If a Hearing Officer is appointed instead of a Hearing Committee, all references in this Article to the Hearing Committee or Hearing Committee Chairperson shall be deemed to refer to the Hearing Officer.

5.3.4 Scheduling of Hearing; Postponement[33]

Within ten (10) days after receipt of a Hearing Request, the Medical Executive Committee, if its actions gave rise to the hearing, or the Governing Body, shall schedule and arrange for such hearing. The hearing date shall be at least thirty (30), but not more than sixty (60), days from the date of the Hospital President's receipt of the Hearing Request, unless otherwise agreed by the affected Medical Staff Member and the Hearing Committee Chair. In the event the affected Medical Staff Member's Clinical Privileges are subject to a summary suspension, the affected Medical Staff Member may request an expedited hearing schedule, in which case the Hearing Committee Chair will schedule the hearing within ten (10) days of the Hearing Request, if reasonably possible. The approval or disapproval of rescheduling requests made by the affected Medical Staff Member or the Medical Executive Committee (or, if applicable, the Governing Body) is within the sole discretion of the Hearing Committee Chair.

5.3.5 Written Notice of Hearing[34]

The Hospital President shall be responsible for giving prompt Written Notice of the hearing ("Hearing Notice") to the affected Medical Staff Member, the Medical Executive Committee (or Governing Body, as applicable), and the Hearing Committee. The Hearing Notice shall:

(a) State the time, place and date of the hearing;

(b) Provide the Medical Staff Member:

(i) a list of witnesses (if any) who may testify on behalf of the Medical Executive Committee or the Governing Body (depending on which body's action prompted the Hearing Request);

(ii) access to written materials that the Medical Executive Committee or the Governing Body intends to present at the hearing; and

(iii) the name and address of the Medical Executive Committee's or the Governing Body's legal counsel (if it intends to be represented by legal counsel at the hearing);

(c) Inform the affected Medical Staff Member that he/she must provide the Medical Executive Committee or Governing Body (depending on which body's action prompted the Hearing Request) and the Hearing Committee with the following:

(i) a list of witnesses the affected Medical Staff Member intends to call at the hearing (which shall be provided within five (5) business days following receipt of the Hearing Notice);

(ii) access to written materials that the affected Medical Staff Member intends to present at the hearing (which shall be provided within within five (5) business days following receipt of the Hearing Notice); and

(iii) the name and address of the affected Medical Staff Member's legal counsel (if the affected Medical Staff Member intends to be represented by legal counsel at the hearing).

(d) Inform the affected Medical Staff Member that either party to the hearing may (and shall) update its list of witnesses and/or written materials until the time of the hearing, subject to the approval of the Hearing Committee Chair, provided that the other party is afforded reasonable opportunity to assess the updated information and prepare for the hearing.

5.3.6 Representation

The Medical Staff Member may appoint a Medical Staff Member, legal counsel, or another individual to represent him or her at the hearing, present facts in opposition to the Adverse Action, and cross-examine witnesses. The Medical Executive Committee, when its action has prompted the hearing, shall appoint one or more of its members, an Active Medical Staff appointee, and/or legal counsel, to represent it at the hearing, present facts in support of the Adverse Action, and examine witnesses. The Governing Body, when its action has prompted the hearing, shall appoint one or more of its members, and/or legal counsel to represent it at the hearing, present the facts in support of the Adverse Action, and examine witnesses. The Medical Executive Committee or Governing Body representative shall not simultaneously serve as a Hearing Committee member. If any party will be represented by legal counsel, that party shall inform the other parties of the name and address of such counsel.

5.4 HEARING PROCEDURE

5.4.1 Presiding Officer

The Hearing Committee Chair (or the Chair's designee), shall preside over the hearing to: (a) determine the order of procedure during the hearing, (b) assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and (c) maintain decorum.

5.4.2 Personal Presence Required

The Medical Staff Member for whom the hearing has been scheduled must be personally present during the hearing. An affected Medical Staff Member who fails without good cause to appear and participate at such hearing shall be deemed to have waived such Medical Staff Member's hearing and appellate review rights and to have accepted the Adverse Action, and the same shall thereupon become and remain in effect.[35]

5.4.3 Submission of Written Statements

Prior to or during the hearing, the affected Medical Staff Member and the Medical Executive Committee or the Governing Body (as applicable) may submit written statements concerning any issue of procedure or of fact, and such written statements shall become a part of the hearing record. Written statements may be submitted to the Hearing Committee Chair and the opposing party to the hearing by personal/hand delivery or by certified mail, return receipt requested, or brought to the hearing.

5.4.4 Hearing Record

An accurate record of the hearing must be kept. Participants in the hearing shall be informed of all matters officially noticed by the Hearing Committee Chair, and those matters shall be noted in the hearing record. The mechanism by which the hearing is recorded shall be established by the Hearing Committee and may be accomplished by use of a court reporter, electronic recording unit, detailed transcription, or by the taking of adequate minutes. A Medical Staff Member desiring an alternate method of recording the hearing shall request approval therefor from the Hearing Committee Chair and, if approved, shall bear the cost thereof.

5.4.5 Evidence; Witnesses

At the hearing, the affected Medical Staff Member (or his/her appointed representative), the Medical Executive Committee or Governing Body representative, and any member of the Hearing Committee (or its appointed representative) shall each have the right to: (a) call and examine witnesses, (b) introduce written evidence, (c) cross-examine any witness on any matter relevant to the issue(s) of the hearing, (d) challenge any witness, and (e) rebut any evidence. If the affected Medical Staff Member does not testify on such Medical Staff Member's own behalf, the affected Medical Staff Member may be called and examined as if under cross-examination. The Hearing Committee may order that oral evidence be taken only upon oath or affirmation administered by any person entitled to notarize documents in the State of Texas. The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant evidence may be considered, regardless of the existence of any common law or statutory rule which might make such evidence inadmissible in a civil or criminal action. The Hearing Committee may also impose, in advance, reasonable time limits on examination and cross-examination of witnesses.

5.4.6 Standard of Proof

It shall be the obligation of the Medical Executive Committee or Governing Body representative (as applicable) to present appropriate evidence in support of the Adverse Action. The affected Medical Staff Member shall thereafter be responsible for supporting such Medical Staff Member's challenge to the Adverse Action by an appropriate showing that the charges or grounds lack substantial factual basis, or that such basis or any action based thereon is either unreasonable, arbitrary, or capricious. The parties to the hearing shall be given the opportunity, on request, to refute any matters that are officially noticed by the Hearing Committee Chair by evidence or by written or oral presentation of authority, the manner of such refutation to be determined by the Hearing Committee.

5.4.7 Recess; Conclusion; Deliberations

The Hearing Committee may, in its sole discretion and without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence (as well as the submission of any written statements allowed by the Hearing Committee), the hearing shall be closed. Within ten (10) days after the hearing is closed, the Hearing Committee shall conduct its deliberations. The Hearing Committee may: (a) conduct its deliberations at a time convenient to itself, outside the presence of the Medical Staff Member for whom the hearing was convened; and (b) consider any pertinent information that was made available to the Medical Staff Member prior to or during the hearing.

5.4.8 Hearing Committee Report

Upon the conclusion of its deliberations, the Hearing Committee shall issue a written Hearing Committee Report, which (a) shall include the Hearing Committee's recommendations, including confirmation, modification, or rejection of the original Adverse Action and the basis therefore, and (b) may include the Hearing Committee's official notice of any generally accepted technical or scientific matter relating to the issues under consideration at the hearing and of any facts which may be judicially noticed by the Texas courts. Within fifteen (15) days after the hearing, the Hearing Committee shall: (a) submit the Hearing Committee Report, the hearing record, and all other related documentation, to the Governing Body and (b) deliver a copy of the Hearing Committee Report to the Medical Executive Committee and, by personal/hand delivery or certified mail, return receipt requested, to the Medical Staff Member through the Hospital President.

5.5 GOVERNING BODY REVIEW AND DETERMINATION

5.5.1 Favorable Recommendation

If the Hearing Committee's recommendation is favorable to the affected Medical Staff Member (i.e., does not recommend Adverse Action), the recommendation shall be forwarded to the Governing Body for action at its next regularly scheduled meeting. At such meeting, the Governing Body shall review the Hearing Committee Report, the hearing record and all other documentation considered by the Hearing Committee, and shall make a determination in the matter. If the Governing Body's determination is favorable to the Medical Staff Member, it shall be the final decision in the matter and the Hospital President shall provide the affected Medical Staff Member with Written Notice of the Governing Body's decision in accordance with Section 5.9.1 of these Bylaws.

5.5.2 Unfavorable Recommendation or Governing Body Determination

If the Hearing Committee's recommendation continues to reflect an Adverse Action, or if, following the Governing Body's review of the matter as described in Section 5.5.1, the Governing Body's determination in the matter would be unfavorable and an Adverse Action, the Hospital President shall promptly prepare a Written Notice of Appeal Right, as described in Section 5.7 of these Bylaws.

5.6 GROUNDS FOR APPELLATE REVIEW

Except in the event of a waiver as described herein, a Medical Staff Member shall be entitled to an appellate review of any Adverse Action which was subject to a hearing under Section 5.2.1, and which is or remains an Adverse Action following the hearing as provided in Section 5.5.2.

5.7 PRE-APPEAL PROCESS

5.7.1 Written Notice of Appeal Right [36]

The Hospital President shall be responsible for giving prompt Written Notice of Appeal Right to any affected Medical Staff Member who is entitled to appellate review. The Written Notice shall:

(a) Advise the Medical Staff Member of the unfavorable recommendation of the Hearing Committee or unfavorable determination of the Governing Body described in Section 5.5.2;

(b) Contain a brief statement identifying the bases for the unfavorable recommendation or determination;

(c) Advise the affected Medical Staff Member of such Medical Staff Member's right to request an appellate review in accordance with this Article 5, and specify that the Medical Staff Member shall have ten (10) days from receipt of the Written Notice of Appeal Right within which to submit a written Appellate Review Request to the Hospital President via personal/hand delivery or certified mail, return receipt requested;

(d) Inform the Medical Staff Member that unless the Medical Staff Member's Appellate Review Request specifically requests the opportunity for oral argument, the appellate review shall be held only on the record in the matter, supplemented by written statements of the parties (i.e., the affected Medical Staff Member and either the Medical Executive Committee or Governing Body) if the party(ies) so desire(s);

(e) State that the affected Medical Staff Member's failure to submit an Appellate Review Request within the specified time and/or to include a request for the opportunity to present an oral argument in such Appellate Review Request, shall constitute a waiver of the Medical Staff Member's right to appellate review and/or right to present an oral argument (as applicable);

(f) Advise the affected Medical Staff Member that: (i) the Medical Staff Member has the right to be represented at the appellate review by a Medical Staff Member, legal counsel, or another individual chosen by the Medical Staff Member; and (ii) if the Medical Staff Member intends to be represented by legal counsel, the Medical Staff Member's Appellate Review Request should include the name and contact information for such counsel, if available;

(g) Advise the Medical Staff Member of the Medical Staff Member's (and the Medical Executive Committee's or Governing Body's) right to submit a written statement prior to,

at, and/or at the close of, the appellate review and of the other party's right to submit written responses in the event that written statements are submitted;

(h) Advise the affected Medical Staff Member that a record of the appellate review shall be made, and of the Medical Staff Member's right to receive a copy of the record upon payment of reasonable charges for the preparation thereof; and

(i) State that following completion of the appellate review the Medical Staff Member shall receive a copy of the written recommendation of the Appellate Review Committee, including a statement of the basis of the recommendation.

5.7.2 Appellate Review Request; Failure to Request Appellate Review

An affected Medical Staff Member's failure to timely submit an Appellate Review Request in the manner and time-frame described in Section 5.7.1 shall be deemed a waiver of the Medical Staff Member's right to such appellate review and the Adverse Action shall thereupon become and/or remain effective pending the Governing Body's final decision on the matter. The Medical Staff Member shall be notified of the Governing Body's final decision as set forth in Section 5.9 of these Bylaws.

5.7.3 Appointment of Appellate Review Committee and Chair

Following receipt of a timely Appellate Review Request, the Governing Body shall: (a) appoint an Appellate Review Committee that includes at least three (3) Governing Body members, none of whom have been members of any separate committee (not including the Governing Body) that previously made a recommendation on the matter, or who have (or recently had) a professional practice or family relationship with the affected Medical Staff Member, or who are in economic competition with the affected Medical Staff Member; and (b) designate one Governing Body member to act as the Appellate Review Committee Chair.

5.7.4 Scheduling / Rescheduling of Appellate Review

Within ten (10) days after receipt of an affected Medical Staff Member's written Appellate Review Request, the Appellate Review Committee shall schedule a date for such appellate review, including a time and place for oral argument (if requested). The date of the appellate review shall be at least fifteen (15) days, but not more than thirty (30) days, from the date of receipt of the affected Medical Staff Member's Appellate Review Request, unless otherwise agreed by the affected Medical Staff Member and the Appellate Review Committee Chair. The approval or disapproval of rescheduling requests made by either party to the appellate review is within the sole discretion of the Appellate Review Committee Chair.

5.7.5 Written Notice of Appellate Review[37]

The Appellate Review Committee Chair shall, through the Hospital President, be responsible for giving prompt Written Notice of the appellate review to the affected Medical Staff Member. The Written Notice shall:

(a) State the time, place and date of the appellate review;

(b) Contain a concise statement that identifies the acts, omissions or transactions upon which the Adverse Action is based;

(c) Advise the affected Medical Staff Member of the Medical Staff Member's right to submit a written statement in advance of the appellate review, to support the Medical Staff Member's basis for appeal, and the right to submit additional written statements as provided in Section 5.8.3;

(d) If the affected Medical Staff Member requested the opportunity for oral argument, inform the Medical Staff Member that his/her failure to personally appear to present such oral argument shall constitute a waiver of his/her right to present an oral argument;

(e) If the affected Medical Staff Member has not requested the opportunity for oral argument, inform the Medical Staff Member that the appellate review shall be held only on the record on which the Adverse Action is based, supplemented by an "advance" written statement by the Medical Staff Member, if the affected Medical Staff Member so desires, and, if desired by such body, a written statement by the Medical Executive Committee or Governing Body, as applicable, and such other written statements as may be permitted pursuant to Section 5.8.3. If submitted, the advance written statement of the affected Medical Staff Member must be transmitted to the Hospital President by personal/hand delivery or certified mail, return receipt requested at least ten (10) days before the appellate review; and the Medical Executive Committee or Governing Body, as applicable, may submit a responsive statement at least five (5) days prior to the appellate review;

(f) Advise the affected Medical Staff Member that a record of the appellate review shall be made, and of the Medical Staff Member's right to receive a copy of the record upon payment of reasonable charges for the preparation thereof; and

(g) State that following completion of the appellate review the affected Medical Staff Member shall receive a copy of the written recommendation of the Appellate Review Committee, including a statement of the basis of the recommendation.

5.7.6 Representation

The affected Medical Staff Member may appoint a Medical Staff Member, legal counsel, or another individual chosen by the affected Medical Staff Member to represent him or her at the appellate review. The Medical Executive Committee, when its action (including as affirmed in whole or in part by the Hearing Committee) has prompted the appellate review, shall appoint one or more of its members, an Active Medical Staff appointee, and/or legal counsel, to represent it at the appellate review. The Governing Body, when its action has prompted the appellate review, shall appoint one or more of its members, and/or legal counsel to represent it at the appellate review. The Medical Executive Committee or Governing Body representative shall not serve on the Appellate Review Committee. If the affected Medical Staff Member or the party that recommended or imposed the Adverse Action will be represented by legal counsel, that party shall inform the other party of the name and address of such counsel.

5.7.7 Access to Information

The parties shall cooperate in good faith (within a reasonable period prior to the appellate review) to exchange information and written materials that will be presented at the appellate review and any changes to the same. The affected Medical Staff Member shall have access to the materials described below in Section 5.8.4(a)-(d).

5.8 APPELLATE REVIEW PROCEDURE

5.8.1 Presiding Officer

The Appellate Review Committee Chair shall preside over the appellate review to: (a) determine the order of procedure during the appellate review, (b) assure that the participants in the appellate review have a reasonable opportunity to present relevant oral argument (if oral argument has been requested), and (c) maintain decorum.

5.8.2 Quorum; Personal Presence of Affected Medical Staff Member Not Required

All Appellate Review Committee members must be present when the appellate review takes place and no member may vote by proxy. The personal presence of the affected Medical Staff Member for whom the appellate review has been scheduled is not required, unless the Medical Staff Member has requested the opportunity to present an oral argument. A Medical Staff Member who requested the opportunity for an oral argument but fails without good cause to appear and participate, shall be deemed to have waived such Medical Staff Member's right to present an oral argument.

5.8.3 Submission of Written Statements

Prior to or during the appellate review, the affected Medical Staff Member and the Medical Executive Committee or the Governing Body (as applicable) may submit written statements concerning any issue of procedure or of fact, and such written statements shall become a part of the appellate review record. Written statements may be submitted to the Appellate Review Committee through the Hospital President by personal/hand delivery or by certified mail, return receipt requested, or brought to the appellate review. A party to the appellate review will be afforded a reasonable period of time to respond to written statements submitted by the other party to the appellate review.

5.8.4 Review of Records; Standard of Proof

The Appellate Review Committee shall act as the appellate body for the purpose of determining whether the Adverse Action against the affected Medical Staff Member is supported by reasonable evidence and is not arbitrary or capricious. It shall review and consider:

(a) the Hearing Committee Report;

(b) the hearing record (and transcript, if any);

(c) all other material, favorable or unfavorable, that was considered by the Hearing Committee in the development of its report, or considered by the Medical Executive Committee or the Governing Body in undertaking the Adverse Action;

(d) any written statements and responses submitted pursuant to Section 5.8.3 of these Bylaws; and

(e) any oral argument.

New or additional matters not raised during the original hearing or in the Hearing Committee Report and not otherwise reflected in the hearing record may only be introduced at the appellate review with the approval of the Appellate Review Committee.

5.8.5 Oral Argument

If oral argument has been requested, the affected Medical Staff Member (or his/her representative) may present an oral argument against the Adverse Action, and any member of the Appellate Review Committee may direct questions to the affected Medical Staff Member. The representative of the entity that imposed the Adverse Action (the Medical Executive Committee or the Governing Body) shall be permitted to speak in favor of the Adverse Action recommendation, and any member of the Appellate Review Committee may direct questions to such representative.

5.8.6 Record of Oral Argument

An accurate record of the appellate review oral argument (if any) must be kept. Participants in the oral argument shall be informed of all matters noticed and those matters shall be noted in the record. The mechanism by which an oral argument is recorded shall be established by the Appellate Review Committee and may be accomplished by use of a court reporter, electronic recording unit, detailed transcription, or by the taking of adequate minutes. An affected Medical Staff Member desiring an alternate method of recording the appellate review shall bear the primary cost thereof.

5.8.7 Recess; Deliberations

The Appellate Review Committee may, in its sole discretion and without special notice, recess the appellate review and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. The affected Medical Staff Member or, as applicable, the Medical Executive Committee or Governing Body, shall be provided the opportunity to respond to any new or additional evidence. Upon conclusion of oral argument or, if applicable, the presentation of oral and written evidence and/or memoranda, the appellate review shall be adjourned (the "Adjournment Date"). Within ten (10) days after the Adjournment Date, the Appellate Review Committee shall complete its deliberations. The Appellate Review Committee may: (a) conduct its deliberations outside the presence of the Medical Staff Member for whom the appellate review was convened at a time convenient to itself; and (b) consider any pertinent information that was made available to the affected Medical Staff Member prior to or during the hearing and appellate review process.

5.8.8 Appellate Review Committee Report

Within fifteen (15) days after the Adjournment Date, the Appellate Review Committee shall issue a written Appellate Review Committee Report, which (a) shall include the Appellate Review Committee's recommendations, including confirmation, modification, or rejection of the Adverse Action under consideration and the basis therefore, and (b) may include the Appellate Review Committee's official notice of any generally accepted technical or scientific matter relating to the issues under consideration at the appellate review and of any facts which may be judicially noticed by the Texas courts. The Appellate Review Committee shall: (a) submit such Appellate Review Committee Report, the appellate review and hearing record, and all other documentation, to the Governing Body; and (b) deliver a copy of the Appellate Review Committee Report to the Medical Executive Committee and, by personal/hand delivery or certified mail, return receipt requested, to the Medical Staff Member (through the Hospital President).

5.9 FINAL DECISION BY GOVERNING BODY

5.9.1 Final Decision

At its next meeting after receipt of the Appellate Review Committee Report and the other documentation described in Section 5.8 of these Bylaws, or after the meeting following completion of the additional requirements of Section 2.6.7, if applicable, the Governing Body shall make a final decision in the matter and shall send notice thereof to the Medical Executive Committee and the Hospital President. The Hospital President shall send Written Notice of the Governing Body's final decision to the affected Medical Staff Member and such decision shall become effective upon the Delivery Date of such Written Notice.

5.9.2 Communication with Hospital Departments

The Hospital President will ensure that the appropriate Departments and other Hospital patient care areas are informed of any revisions or revocations of, or restrictions on, a Medical Staff Member's Clinical Privileges.[38]

ARTICLE 6. ORGANIZED MEDICAL STAFF

6.1 COMPOSITION

The Hospital has a single, self-governing organized Medical Staff, composed of Medical Staff Members.[39]

6.2 DUTIES & RESPONSIBILITIES

The purposes and responsibilities of the organized Medical Staff are as described below and herein. Provision shall be made in these Bylaws or by resolution of the Medical Executive Committee, approved by the Governing Body, for the effective performance of Medical Staff functions set forth in these Bylaws and Medical Staff Policies, and such other Medical Staff functions as the Medical Executive Committee or the Governing Body shall reasonably require. Said functions may be carried out through assignment to Departments, to Medical Staff committees, to Medical Staff Officers or officials, or to interdisciplinary Hospital committees

6.2.1 Administration and Enforcement of Bylaws and Policies

The organized Medical Staff develops, adopts and amends (subject to Governing Body approval), reviews, complies with, monitors and enforces compliance with these Bylaws and the Medical Staff Policies necessary for the proper functioning of the Medical Staff and the integration and coordination of Staff Members with the functions of the Hospital.[40]

6.2.2 Communication with and Accountability to the Governing Body

The organized Medical Staff is accountable to the Governing Body for the quality of medical care provided to Hospital's patients,[41] assists the Governing Body by serving as or forming one or more medical peer review committees,[42] and cooperates with the Governing Body, Administration, and Hospital staff to resolve conflicts with regard to issues of mutual concern.

6.2.3 Recommendations for Staff Membership and Clinical Privileges

The organized Medical Staff: (i) develops criteria for Staff Membership and Clinical Privileges that are designed to assure the Medical Staff and the Governing Body that patients of the Hospital will receive quality care, treatment, and services; (ii) utilizes the criteria to evaluate and recommend individuals for Staff Membership and/or Clinical Privileges; and (iii) monitors and evaluates the ethical and professional practice and conduct of individuals with Clinical Privileges in order to make recommendations regarding such individuals' continued Staff Membership and/or Clinical Privileges.

6.2.4 Quality Assurance and Performance Improvement

The organized Medical Staff provides leadership in, participates in, conducts, oversees, and/or coordinates Hospital activities related to quality assurance, performance improvement, patient safety, patient satisfaction, risk management, case management, utilization review, and resource management, including the following:[43]

(a) Establishes and maintains patient care standards and seeks to ensure that all Hospital patients receive care that is commensurate with applicable standards of care and available community resources;

(b) Monitors the quality of care, treatment and services provided by individuals with Clinical Privileges, including the performance and appropriateness of medical record documentation, the performance of invasive procedures, blood usage, and drug usage;

(c) Measures, assesses, and improves processes that primarily depend on the activities of individuals credentialed and privileged through the Medical Staff process;

(d) Pursues corrective action with respect to Staff Members and other Practitioners with Clinical Privileges when warranted;

(e) Communicates findings, conclusions, recommendations, and actions to improve performance to the Medical Executive Committee, the Governing Body, and such other committees as the Medical Executive Committee or the Governing Body may designate;

(f) Assists the Hospital in identifying community health needs and establishing services or programs to meet such needs and other institutional goals; and

(g) Coordinates the care, treatment and services provided by individuals with Clinical Privileges with those provided by the Hospital's nursing, technical, and administrative staff.

6.2.5 Continuing Education

The organized Medical Staff: (a) provides continuing education opportunities to promote current best practices, encourage continuous advancement in professional knowledge, and complement quality assessment/improvement activities; and (b) supervises the Hospital's professional library services.

6.2.6 Compliance with Laws, Regulations, and Accreditation Standards

The organized Medical Staff assists the Hospital in reviewing and maintaining Hospital accreditation and ensuring compliance with applicable accreditation standards and federal, state, and local laws and regulations.[44]

6.2.7 Other

The organized Medical Staff:

(a) Monitors the Hospital's infection control program and investigates and seeks to control nosocomial infections;

(b) Monitors pharmacy and therapeutic policies and practices within the Hospital;

(c) Develops the Medical Staff response plan for fire and other disasters; and

(d) Engages in other functions reasonably requested by the Medical Executive Committee or the Governing Body.

6.3 MEDICAL STAFF OFFICERS

6.3.1 Medical Staff Officers

The officers of the Medical Staff shall be:

- Medical Staff President
- Immediate Past Medical Staff President
- Medical Staff Vice President
- Medical Staff Secretary/Treasurer

6.3.2 Duties and Responsibilities

(a) Medical Staff President. The Medical Staff President shall serve as the organized Medical Staff's chief administrative officer and shall:

(i) fulfill those duties specified in these Medical Staff Bylaws and the Medical Staff Policies;

(ii) collaborate with the Hospital President in all matters of mutual concern within the Hospital;

(iii) be a member of the Medical Executive Committee;

(iv) call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff and Medical Executive Committee;

(v) serve as ex officio member of all other Medical Staff committees without vote;

(vi) be responsible for the enforcement of these Bylaws, Medical Staff Policies, and associated policies; for implementation of sanctions where indicated; and for the Medical Staff's compliance with procedural safeguards in connection with applications for appointment and reappointment to the Staff and for Clinical Privileges, and in all instances where corrective action has been requested against an appointee to the Staff;

(vii) make recommendations to the Medical Executive Committee regarding Staff Members qualified to serve as Medical Staff committee chairs and members (except the Medical Executive Committee);

(viii) present the views, policies, needs and grievances of the Medical Staff to the Governing Body and to the Hospital President;

(ix) receive, and interpret the policies and directives of the Governing Body to the Medical Staff and report to the Governing Body on quality improvement review with respect to the Medical Staff's responsibility to provide quality medical care; and

(x) be primarily responsible for the educational activities of the Medical Staff.

(b) Immediate Past Medical Staff President. The Immediate Past Medical Staff President shall:

(i) be a member of the Medical Executive Committee;

(ii) assist the Medical Staff President in the transition into his/her new role as Medical Staff President; and

(iii) perform such duties as may be delegated to the Immediate Past Medical Staff President by the Medical Staff President;

(c) Medical Staff Vice President. The Medical Staff Vice President shall:

(i) be a member of the Medical Executive Committee;

(ii) perform such duties as may be delegated to the Medical Staff Vice President by the Medical Staff President;

(iii) in the absence of the Medical Staff President, assume all the duties and have the authority of the Medical Staff President;

(iv) serve as the Medical Staff President in any circumstance in which the Medical Staff President is not able to serve; and

(v) attend to and perform such other duties as ordinarily pertain to such office.

(d) Medical Staff Secretary/Treasurer. The Medical Staff Secretary/Treasurer shall:

(i) be a member of the Medical Executive Committee;

(ii) ensure that attendance is taken and accurate, and that complete minutes are kept of all Medical Staff and Medical Executive Committee meetings;

(iii) attend to all correspondence of the Medical Staff;

(iv) be accountable for the management of all Medical Staff funds, arrange for and present an audit upon request by the Medical Executive Committee, and authorize expenditures in accordance with these Bylaws; and

(v) attend to and perform such other duties as ordinarily pertain to the office.

6.3.3 Qualifications

At the time of nomination and election, and throughout his or her term of office, each Medical Staff Officer must:

(a) Be an Active Medical Staff Member;

(b) Be eligible to serve as a Medical Staff Officer in accordance with Medical Staff and Hospital conflict of interest policies;

(c) Demonstrate an interest in maintaining quality patient care at the Hospital; and

(d) Constructively participate in Medical Staff affairs, including through active participation in peer review activities and on Medical Staff committees.

6.3.4 Nomination

Medical Staff Officer candidates shall be nominated by the Nominating Committee.

6.3.5 Election

Except for the Immediate Past Medical Staff President (who serves by virtue of his/her past service as Medical Staff President), Medical Staff Officers shall be elected every other year at the annual meeting of the Medical Staff. Only those individuals who are appointed to a Medical Staff category that entitles them to vote for Medical Staff Officer positions shall be eligible to vote. Election by the Medical Staff for each office shall be by a ballot vote requiring a simple majority for election as provided in Section 6.4.6. If, during the voting for a particular office, a candidate does not receive a simple majority to elect such candidate to office, successive balloting shall ensue with the name of the candidate receiving the fewest votes being omitted from the next ballot until a majority is obtained by one candidate.

6.3.6 Term

A Medical Staff Officer shall serve for a term of two (2) years or until his/her successor is elected and installed, unless he/she shall sooner die, resign or be removed from office. A Medical Staff Officer may serve a second two (2) year term, but shall not serve in the same office subsequent to such second term unless two-thirds (2/3) of the Active Medical Staff present at a regular or special meeting of the Medical Staff at which the question is considered vote to approve such consecutive term(s), and such consecutive term(s) is/are approved by the Governing Body. Such

additional consecutive term(s) shall become effective when approved by the Governing Body. Except as provided in Section 6.3.7, Medical Staff Officers shall take office on the first day of the Medical Staff year.

6.3.7 Vacancies in Office

Vacancies in office during a Medical Staff Officer's two (2) year term, except for the Medical Staff President, shall be filled by the Medical Executive Committee. If there is a vacancy in the office of the Medical Staff President, the Medical Staff Vice President shall serve as the Medical Staff President for the remainder of his or her term.

6.3.8 Removal from Office

(a) Automatic Removal. The Medical Executive Committee shall automatically remove from office any Medical Staff Officer upon verification of: (i) revocation, suspension or relinquishment of such Medical Staff Officer's license to practice medicine, podiatry or dentistry in the State of Texas; or (ii) revocation, denial or relinquishment of such Medical Staff Officer's Active Medical Staff Membership.

(b) Discretionary Removal. Other grounds for removal of a Medical Staff Officer may include, but shall not be limited to, mental and/or physical impairment or inability and/or unwillingness to perform the duties and responsibilities of the office; abuse of the office; conviction of a felony; automatic suspension, or restriction or suspension of, Clinical Privileges; and conduct or statements damaging to the Hospital or Medical Staff.

(i) Suspension of Appointment. Upon the suspension of any Medical Staff Officer's Medical Staff appointment or Clinical Privileges, the Medical Executive Committee shall consider the suspension of, and may suspend, such Medical Staff Officer pending the results, if applicable, of the hearing and appellate review procedures provided in these Bylaws.

(ii) Request for Removal. The Medical Executive Committee shall consider the removal of a Medical Staff Officer from office in the event:

- the Medical Executive Committee receives a written request to consider such removal signed (i) by at least one-quarter (1/4) of the Active Medical Staff or at least ten (10) Active Medical Staff Members, whichever is fewer, or (ii) by the Hospital President (any such request shall include a list of the allegations or concerns precipitating the request for removal);

- the Medical Executive Committee receives credible information indicating that it is unlikely that the Medical Staff Officer will be able to perform the duties of the office (including with reasonable accommodation) because of illness for a minimum of three (3) months, and the Medical Staff Officer either refuses to submit to a confirmatory examination by a clinician reasonably acceptable to both the Medical Executive Committee and Medical Staff Officer or, after such examination, the clinician confirms that the Medical Staff Officer is unlikely to be able to perform the duties of the office because of illness, with or without reasonable accommodation, for a minimum of three (3) months.

(c) Removal Procedure-Medical Executive Committee.

(i) Medical Executive Committee Meeting. A meeting of the Medical Executive Committee shall be called within seven (7) days of a suspension or request for removal, as set forth in Section 6.3.8(b), to consider the removal of the Medical Staff Officer. A quorum of the Medical Executive Committee must be present to act

on the removal. The Medical Staff Officer in question shall have no vote on his or her removal, and may be excluded from the meeting except as provided in (ii) below.

(ii) Appearance of Officer. The Medical Staff Officer in question shall be permitted to make an appearance before, and make a statement to, the Medical Executive Committee prior to the Medical Executive Committee taking a final vote on the Medical Staff Officer's removal.

(iii) Vote. A Medical Staff Officer may be removed by an affirmative vote of two-thirds (2/3) of the voting members of the Medical Executive Committee members present at a meeting of the Medical Executive Committee at which there is a quorum present. The Medical Staff Officer who is subject to the removal process may not participate or be present during the vote.

(d) Removal Procedure-Medical Staff. A Medical Staff Officer may also be removed from office by an affirmative vote of two-thirds (2/3) of the Active Medical Staff members present at a regular or special meeting of the Medical Staff at which the question is considered; provided that (i) a request to consider such removal has been signed by at least ten (10) members of the Active Medical Staff; and (ii) consideration of the contemplated removal is included in the notice of the meeting. The Medical Staff Officer in question shall have no vote on his or her removal, and may be excluded from the Medical Staff meeting, except that the Medical Staff Officer in question shall be permitted to make an appearance before, and make a statement to, the Medical Staff prior to the Medical Staff taking a final vote on the Medical Staff Officer's removal.

(e) Notification. The Hospital President shall provide the Medical Staff Officer with written notification of the final decision regarding removal of the Medical Staff Officer.

(f) No Hearing and Appeal Rights. There shall be no right of hearing or appellate review in connection with a removal from a Medical Staff Officer position.

6.3.9 Resignation

A Medical Staff Officer may resign his or her position at any time by delivering his or her resignation in writing to the Medical Executive Committee. Such resignation shall take effect at such time as is specified therein, or if no such time is specified, upon delivery thereof to the Medical Executive Committee, unless otherwise determined by the Medical Executive Committee following consultation with the individual submitting the resignation.

6.4 MEDICAL STAFF MEETINGS

6.4.1 Purpose

The primary objective of Medical Staff meetings shall be to report on the activities of the Medical Staff and to conduct other business as may be on the agenda.

6.4.2 Scheduling and Notice

(a) Regular Meetings. The Medical Staff shall meet at least once each year.

(b) Special Meetings. The Medical Staff President may call a special meeting of the Medical Staff at any time. In addition, the Medical Staff President must call a special meeting within twenty (20) days after receipt of:

(i) a written request signed by at least one-fifth (20%) of the members of the Active Medical Staff which states the purpose of such special meeting; or

(ii) a written Medical Executive Committee resolution which states the purpose of such special meeting.

(c) Notice.

(i) Regular Meetings. Written Notice of each regular Medical Staff meeting shall be sent to all Medical Staff Members and conspicuously posted. If an amendment to these Bylaws or the Medical Staff Policies, or a new Bylaw or Policy, is to be considered at any such meeting, the Written Notice shall include a summary of the new item or amendment and information regarding where the text of the item or amendment may be reviewed.

(ii) Special Meetings. Written Notice stating the time, place and purposes of any special Medical Staff meeting shall be sent to each member of the Medical Staff at least five (5) days before the date of such meeting and conspicuously posted; and if an amendment to these Medical Staff Bylaws or the Medical Staff Policies, or a new Bylaw or Policy is to be considered at any such meeting, the Written Notice of the special Medical Staff meeting shall include a summary of the new item or amendment and information regarding where the text of the item or amendment may be reviewed. No business shall be transacted at any special meeting, except for that stated in the notice of such special meeting.

(iii) Generally. Written Notices of Medical Staff meetings may be posted online. The attendance of a Medical Staff Member at a meeting shall constitute a waiver of notice of such meeting, unless the Member objects to the lack of proper notice at the start of the meeting.

(d) Place of Meetings. Meetings of the Medical Staff shall be held at the Hospital or within a reasonably accessible distance from the Hospital, as designated by the Medical Staff President.

6.4.3 Minutes

Written minutes of each Medical Staff meeting shall be prepared and recorded, made accessible to Medical Staff Members, and approved by the Medical Staff at its next regular or special Medical Staff meeting.

6.4.4 Attendance Requirements

In accordance with applicable Medical Staff Policies, Active Medical Staff Members are expected to attend Medical Staff Meetings and such attendance may be considered in evaluating Active Medical Staff Members at the time of reappointment. All other Staff Members are strongly encouraged to attend Medical Staff meetings.

6.4.5 Telecommunication

Medical Staff members may participate in regular or special Medical Staff meetings by, or through the use of, any means of communication by which all participants may simultaneously hear each other, such as by teleconference or videoconference. Any participant in a meeting by such means who, during the meeting, communicates such presence to the recording secretary for the meeting, shall be deemed present in-person at such meeting. Such presence shall be recorded by the recording secretary.

6.4.6 Voting Requirements and Quorum

Staff Members may vote electronically at Medical Staff meetings when participating in the meeting by telecommunication as provided in Section 6.4.5, but only those votes received prior to the close of in-person voting on the matter shall be considered. Subject to the foregoing, electronic voting shall be in accordance with applicable Medical Staff and Hospital Policies. For the purpose of determining a quorum, Staff Members participating in the Medical Staff meeting in person via telecommunication shall be considered present. For Medical Staff meetings, a quorum shall consist of those who are present in person (including those who are present by telecommunication) and who are eligible to vote on the matter. If a quorum exists, action on a matter shall be approved if the votes cast within the voting group favoring the action exceed the votes cast opposing the action, unless these Bylaws or any law, ordinance, or governmental rule or regulation requires a greater number or percentage of affirmative votes.

ARTICLE 7. MEDICAL STAFF COMMITTEES

7.1 MEDICAL EXECUTIVE COMMITTEE

7.1.1 Composition

The Medical Executive Committee shall include the members listed below. A majority of the voting members of the Medical Executive Committee must be Physician members of the Active Staff.[45] Notwithstanding the number of offices held by any individual, each Medical Executive Committee member shall have only one vote.

Voting Members:

1. Medical Staff President (shall serve as the Medical Executive Committee Chair)
2. Medical Staff Vice President
3. Medical Staff Secretary/Treasurer
4. Immediate Past Medical Staff President
5. At least two (2) and no greater than six (6) Medical Staff Members (the Medical Executive Committee shall determine whether the Medical Staff Members shall be elected by the Medical Staff or appointed by the Medical Executive Committee; however, the Medical Executive Committee may only appoint up to two Medical Staff Members. Such appointed Medical Staff Members shall serve for a two year term. The remaining Medical Staff Members shall be nominated by the Nominating Committee and elected by the Organized Medical Staff to serve a two year term.)
6. Each Department Chair

Non-Voting Members:

1. Hospital President
2. Hospital Chief Medical Officer
3. Vice President of Patient Care Services

The Medical Executive Committee by majority vote may choose to appoint additional non-voting administrative members to serve a two year term, subject to the approval of the Hospital President.

7.1.2 Duties and Responsibilities

The Medical Executive Committee is authorized to represent and act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws. The Medical Executive Committee acts on behalf of the Medical Staff between meetings of the Medical Staff, within the scope of its responsibilities as described in these Bylaws. The authority delegated to the Medical Executive Committee by the Medical Staff may be limited or removed by the Medical Staff by amending these Medical Staff Bylaws in accordance with Section 9.1. The duties and responsibilities of the Medical Executive Committee include the following:

(a) Coordinate the activities and general policies of the Departments;

(b) Receive, review and act upon Department and Medical Staff committee reports;

(c) Develop, approve (subject to Governing Body approval as appropriate), implement, and monitor Medical Staff Policies not otherwise the responsibility of the Departments;

(d) Provide liaison between the Medical Staff, the Hospital President and the Governing Body;

(e) Make recommendations to the Hospital President on matters of a medico-administrative nature;

(f) Make recommendations to the Governing Body and the Hospital President on matters concerning the management of the Hospital;

(g) Fulfill, or ensure the fulfillment of, the Medical Staff's accountability to the Governing Body for (i) the medical care rendered to patients in the Hospital, (ii) participation in quality improvement activities, and (iii) compliance with these Bylaws;

(h) Ensure that the Medical Staff actively participates in the Hospital's accreditation program and assists the Hospital in maintaining its accreditation status, licensure status, and payor participation status;

(i) Review and act on the credentials and qualifications of all Applicants and make recommendations to the Governing Body for staff appointment, assignments to Departments, and delineation of Clinical Privileges;

(j) Review periodically all information available regarding the performance and clinical competence of Staff Members and other individuals with Clinical Privileges, including as applicable, outcomes of OPPE and FPPE, and as a result of such reviews, make recommendations to the Governing Body for reappointments and renewal of or changes in Clinical Privileges;

(k) Take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all appointees to the Medical and Advanced Practice Professionals Staffs, including the initiation of and/or participation in corrective action and/or review measures when warranted;

(l) Appoint Medical Staff committee chairs and members;

(m) Report at each general Medical Staff meeting;

(n) Make recommendations relating to changes to the Medical Staff structure; and recommendations for revisions to and updating of the Medical Staff Bylaws and Medical Staff Policies;

(o) Review, recommend, and support Hospital sponsored educational activities that are relevant to the Medical Staff and to the nature and type of care offered by the Hospital. When applicable, these educational activities shall relate to performance improvement activities; and

(p) Provide for the consideration of differing points of view when conflicts arise between the Medical Executive Committee and Medical Staff on issues including, but not limited to, proposals to adopt a Medical Staff rule, regulation, or policy (or an amendment thereto). In such instances, the Medical Executive Committee shall invite one or more representatives of the Medical Staff to state and discuss the position of the Medical Staff, shall consider the Medical Staff's position, and, thereafter, shall report on such consideration and the Medical Executive Committee's determination relating thereto to the Medical Staff and the Governing Body.

7.1.3 Medical Executive Committee Meetings

(a) Scheduling and Notice.

(i) Regular Meetings. The Medical Executive Committee shall meet as often as necessary, but in no event less than quarterly, to fulfill its duties and responsibilities.

(ii) Special Meetings. The Medical Staff President or Hospital President may call a special meeting of the Medical Executive Committee at any time.

(iii) Notice. Medical Staff Services shall send Written Notice of each regular and special Medical Executive Committee meeting to all Medical Executive Committee members.

(b) Telecommunication. Medical Executive Committee members may participate in regular or special Medical Executive Committee meetings by, or through the use of, any means of communication by which all participants may simultaneously hear each other, such as by teleconference or videoconference. Any participant in a meeting by such means shall be deemed present in-person at such meeting.

(c) Quorum and Voting Requirements. A quorum for Medical Executive Committee meetings shall consist of at least fifty percent (50%) of the Medical Executive Committee's voting members. If a quorum exists, action on a matter shall be approved if the votes cast within the voting group favoring the action exceed the votes cast opposing the action, unless these Bylaws or any law, ordinance, or governmental rule or regulation requires a greater number or percentage of affirmative votes.

(d) Attendance Requirements. Medical Executive Committee members are expected to attend at least seventy percent (70%) of the meetings held.

(e) Minutes. Minutes (written or recorded) of each regular and special Medical Executive Committee meeting shall be prepared and shall include a record of the attendance of Medical Executive Committee members and the vote taken on each matter. The minutes shall be approved by the Medical Executive Committee at the next regular or special meeting of the committee and copies thereof shall be made available to the Governing Body. Minutes of each Medical Executive Committee meeting shall be maintained in a permanent Medical Staff file by Medical Staff Services.

7.1.4 Removal of Medical Executive Committee Members

(a) Automatic Removal. The status as members of the Medical Executive Committee of individuals who serve as such members by virtue of ex officio status shall automatically terminate at such time as they cease to serve in such ex officio capacity. Members of the Medical Executive Committee shall also cease to serve as such members upon verification of their: (i) revocation, suspension or relinquishment of license to practice medicine, podiatry or dentistry in the State of Texas; or (ii) revocation, denial or relinquishment of Active Medical Staff Membership.

(b) Discretionary Removal. Grounds for removal of a Medical Executive Committee member may include, but shall not be limited to, mental and/or physical impairment or inability and/or unwillingness to perform the duties and responsibilities of the office; abuse of the office; conviction of a felony; automatic suspension, or restriction or suspension, of Clinical Privileges; and conduct or statements damaging to the Hospital or Medical Staff.

(i) Suspension of Appointment. Upon the suspension of any Medical Executive Committee member's Medical Staff appointment, the Medical Executive Committee (not including the member in question) shall consider the suspension of, and may suspend the member, pending, if applicable, the results of the hearing and appellate review procedures provided in these Bylaws.

(ii) Request for Removal. The Medical Executive Committee (not including the member in question) shall consider the removal of an elected or appointed member of the Medical Executive Committee in the event:

- the Medical Executive Committee receives a written request to consider such removal signed (i) by at least one-quarter (1/4) of the Active Medical Staff or at least ten (10) Active Medical Staff Members, whichever is fewer, or (ii) by the Hospital President (any such request shall include a list of the allegations or concerns precipitating the request of removal);
- the Medical Executive Committee receives credible information indicating that it is unlikely that the Medical Executive Committee member will be able to perform the duties of the position (including with reasonable accommodation) because of illness for a minimum of three (3) months, and the Medical Executive Committee member either refuses to submit to a confirmatory examination by a clinician reasonably acceptable to both the Medical Executive Committee and Medical Executive Committee member or, after such examination, the clinician confirms that the Medical Executive Committee member is unlikely to be able to perform the duties of the position because of illness, with or without reasonable accommodation, for a minimum of three (3) months;
- with respect to a member of the Medical Executive Committee who is appointed by the Medical Executive Committee, at least four (4) voting members of the Medical Executive Committee request such removal (any such request shall include a list of the allegations or concerns precipitating the request for removal).

(c) Removal Procedure-Medical Executive Committee.

(i) Medical Executive Committee Meeting. A meeting of the Medical Executive Committee shall be called within seven (7) days of a suspension or request for removal, as set forth in Section 7.1.4(b), to consider the removal of the Medical Executive Committee member. A quorum of the Medical Executive Committee must be present to act on the removal. The Medical Executive Committee member in question shall have no vote on his or her removal, shall not be counted when determining a quorum, and shall be excluded from the meeting except as provided in (ii) below.

(ii) Appearance of Member. The Medical Executive Committee member in question shall be permitted to make an appearance before, and make a statement to, the Medical Executive Committee prior to the Medical Executive Committee taking a final vote on the Medical Staff Officer's removal.

(iii) Vote. An elected or appointed Medical Executive Committee member may be removed by an affirmative vote by ballot of two-thirds (2/3) of the voting Medical Executive Committee members present at a meeting of the Medical Executive Committee at which there is a quorum present. The Medical Executive Committee member who is subject to the removal process may not participate or be present during the vote.

(d) Removal Procedure-Medical Staff. A Medical Executive Committee member may also be removed from office by an affirmative vote by ballot of two-thirds (2/3) of the Active Medical Staff Members present at a regular or special meeting of the Medical Staff at

which the question is considered; provided that (i) a request to consider such removal has been signed by at least ten (10) members of the Active Medical Staff; and (ii) consideration of the contemplated removal is included in the notice of the meeting. The Medical Executive Committee member in question shall have no vote on his or her removal, and may be excluded from the Medical Staff meeting, except that the Medical Executive Committee member in question shall be permitted to make an appearance before, and make a statement to, the Medical Staff prior to the Medical Staff taking a final vote on the Medical Executive Committee member's removal.

(e) Notification. The Hospital President shall provide the Medical Executive Committee member in question with written notification of the final decision regarding the Medical Executive Committee member's removal.

(f) No Hearing and Appeal Rights. There shall be no right of hearing or appellate review in connection with a removal from the Medical Executive Committee of a Medical Executive Committee member.

7.1.5 Resignation

A member of the Medical Executive Committee may resign at any time by delivering his or her resignation in writing to the Medical Executive Committee. Such resignation shall take effect at such time as is specified therein, or if no such time is specified, upon delivery thereof to the Medical Executive Committee, unless otherwise determined by the Medical Executive Committee following consultation with the individual submitting the resignation.

7.2 OTHER MEDICAL STAFF COMMITTEES

7.2.1 Medical Staff Committees

At a minimum, the Medical Executive Committee shall establish the following standing Medical Staff Committees, in addition to the Medical Executive Committee:

- **Credentials Committee**
- **Bylaws Committee**
- **Nominating Committee**
- **Clinical Quality Committee**
- **Professional Conduct Committee**
- **Practitioner/Physician Health Committee**

Additional committees may be established and memorialized in the manner set forth in Section 7.2.2, below.

7.2.2 Formation, Composition and Dissolution

The Medical Executive Committee may, without amendment of these Bylaws: (a) establish additional standing and ad hoc Medical Staff committees to perform one or more Medical Staff functions, (b) determine the composition of such Medical Staff committees; (c) appoint Staff Members and other individuals to serve as committee members and chairs, delegate the authority to appoint Medical Staff committee members and chairs, or establish an election process; and (d) dissolve or rearrange the Medical Staff committee structure or composition, provided that no such action taken with respect to items (a)-(c) is inconsistent with these Bylaws (including the provisions in these Bylaws relating to the Medical Executive Committee). Medical Staff Committee members must be eligible to serve as Medical Staff Committee members in

accordance with Medical Staff and Hospital conflict of interest policies. To the extent not set forth in these Bylaws (including in regard to the Medical Executive Committee), Medical Staff Committee composition, other qualifications for membership, and the process for election or appointment (if any) shall be set forth in Medical Staff Policies.

7.2.3 Duties and Responsibilities

The Medical Executive Committee shall describe the duties and responsibilities of each Medical Staff committee (except the Medical Executive Committee) in the applicable Medical Staff Policy(ies). Such Medical Staff committees shall: (1) confine their activities to the purposes for which they are appointed; (2) ensure compliance with all applicable Medical Staff and Hospital Policies; and (3) report to the Medical Executive Committee and, as applicable, appropriate senior administrators, unless otherwise set forth in the Bylaws or Medical Staff Policies.

7.2.4 Medical Staff Committee Meetings

(a) Scheduling and Notice.

(i) Regular Meetings. Medical Staff Committees shall meet as often as necessary to fulfill their duties and responsibilities, as may be further described herein or in the Medical Staff Policies.

(ii) Special Meetings. The Committee Chair or the Medical Staff President or Hospital President may call a special meeting of a Medical Staff Committee at any time.

(iii) Notice. Notice provided to Committee members shall be as set forth in the applicable Medical Staff Policy.

(b) Telecommunication. Medical Staff Committee members may participate in regular or special Medical Staff Committee meetings by, or through the use of, any means of communication by which all participants may simultaneously hear each other, such as by teleconference or videoconference. Any participant in a meeting by such means shall be deemed present in-person at such meeting.

(c) Quorum and Voting Requirements. A quorum for Medical Staff Committee meetings shall consist of those voting members of the committee who are present and voting, unless a different quorum requirement is specified in these Bylaws or in a duly adopted Policy. If a quorum exists, action on a matter shall be approved if the votes cast within the voting group favoring the action exceed the votes cast opposing the action, unless these Bylaws or any law, ordinance, or governmental rule or regulation requires a greater number or percentage of affirmative votes.

(d) Attendance Requirements. Attendance requirements for Medical Staff Committees shall be as set forth in the applicable Medical Staff Policy.

(e) Minutes. Minutes (written or recorded) of each regular and special Medical Staff Committee meeting shall be prepared and shall include a record of the attendance of Medical Staff Committee members and the vote taken on each matter. The minutes shall be made available to Medical Staff Committee members and approved by the voting members of the Medical Staff Committee at the next regular or special meeting. Copies of the minutes shall be made available to the Medical Executive Committee and the Governing Body. Minutes of each Medical Staff Committee meeting shall be maintained in a permanent file by Medical Staff Services.

7.2.5 Proceedings, Reports and Records of Medical Peer Review Committees

The proceedings, reports and records of all medical peer review committees, to the extent practicable, shall be confidential in accordance with state and federal law and regulation and these Bylaws.

ARTICLE 8. DEPARTMENTS & DIVISIONS

8.1 ESTABLISHMENT OF DEPARTMENTS & DIVISIONS

The Medical Executive Committee, with the approval of the Governing Body, may establish Clinical Departments, as well as Divisions within such Departments. Such Departments and Divisions shall be identified and described in one or more Medical Staff Policies.

8.2 ASSIGNMENT TO DEPARTMENTS & DIVISIONS

8.2.1 Assignment

The Medical Executive Committee will, after consideration of the recommendations of the applicable Department Chair(s), recommend Department and Division assignments for each Staff Member in accordance with the Staff Member's qualifications. Each Staff Member shall be assigned to at least one Department, but may also be assigned to and/or granted Clinical Privileges in one or more other Departments. The exercise of Clinical Privileges or the performance of specified services within any Department shall be subject to the policies of that Department.

8.2.2 Multiple Departments

A Staff Member who wishes to be assigned to more than one Department must declare which Department shall be designated as his/her primary affiliation. A Medical Staff Member who meets the qualifications in Section 8.3.1 of these Bylaws shall be eligible for nomination as Department Chair only in that Department which he/she has declared as his/her primary Department affiliation. Membership in Departments other than the declared primary Department does not confer the privilege to be nominated for the position of Department Chair, but does confer all other privileges, including discussion, voting and appointment to committees, which may be established by the Department.

8.3 DEPARTMENT CHAIR

8.3.1 Qualifications

At the time of appointment or election, and throughout his or her term of office, a Department Chair must:

(a) Be and remain a member of the Active Medical Staff;

(b) Be and remain board certified in his/her specialty;

(c) Be eligible to serve as a Department Chair in accordance with Medical Staff and Hospital conflict of interest policies;

(d) Demonstrate an interest in maintaining quality patient care at the Hospital and in the Department, and in compliance with these Bylaws, applicable Hospital accreditation and licensure requirements, and law; and

(e) Constructively participate in Medical Staff affairs, including by actively participating in peer review activities and on Medical Staff committees.

8.3.2 Appointment / Election of Department Chairs

A Department Chair may be appointed or elected as set forth below. The Governing Body, through the Hospital President, will determine whether the Department Chair will be appointed or elected.

(a) Appointment Process. The Hospital President, [in consultation with the Medical Staff President and the Governing Body Chair, will recommend] one or more individuals eligible to serve as the Department Chair. The Hospital President, in consultation with the Medical Executive Committee and the Governing Body, shall appoint one of such individuals to serve as the Department Chair.

(b) Election Process. The Department Chair shall be elected by a 2/3 majority vote of all of the Active Medical Staff Members of the applicable Department. In the event no nominee receives 2/3^{rds} of such votes, the Medical Executive Committee shall, in consultation with the Hospital President, appoint one of the candidates to serve as the Department Chair, subject to the approval of the Governing Body.

8.3.3 Term

Appointed Department Chairs shall serve for the term specified by the Hospital President or in the applicable contract of engagement. Elected Department Chairs shall serve two year terms or until their successors are elected and begin serving, unless they sooner resign, die, or are removed from office. Elected Department Chairs may serve two consecutive two year terms, but may not serve subsequent terms unless two-thirds (2/3) of the Active Medical Staff within the Department approve such subsequent term(s), and such subsequent term(s) is/are approved by the Governing Body. All Department Chairs shall be subject to periodic review and may be removed from their position as set forth in Section 8.3.5.

8.3.4 Duties and Responsibilities

The primary responsibility delegated to each Department Chair is to implement and conduct or oversee specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the Department. To carry out this responsibility, each Department Chair shall:

(a) Be a member of the Medical Executive Committee.

(b) Report to the Medical Executive Committee and the Hospital Chief Medical Officer regarding all professional and administrative activities within the Department.

(c) Regularly conduct morbidity and mortality conferences. Such conferences are expected to be held monthly, but at a minimum must occur quarterly. Morbidity and mortality conference reports shall be submitted to the Medical Executive Committee and the Hospital Chief Medical Officer;

(d) Cooperate with Administration and the Hospital Chief Medical Officer in connection with all operations of the Department.

(e) Serve as Chair of the Department meetings.

(f) Establish, when appropriate, Divisions within the Department, and appoint Chiefs thereof, subject to approval by the Medical Executive Committee and the Governing Body in accordance with Section 8.1.

(g) Be responsible for the enforcement within the Department of actions taken by the Medical Executive Committee and the Governing Body.

(h) Be responsible for the enforcement within the Department of these Medical Staff Bylaws, Medical Staff Policies and Hospital Policies.

(i) Recommend to the Medical Executive Committee the criteria for Clinical Privileges that are relevant to the care provided by the Department.

(j) Establish guidelines for the granting of Clinical Privileges and the performance of specified services within the Department.

(k) Make recommendations to the Medical Executive Committee regarding Staff Membership (e.g. appointment and reappointment) and Clinical Privileges for Department members.

(l) Conduct or participate in, and make recommendations regarding the need for, continuing education programs relating to the Department and its services, based upon current best practices and the findings of review, evaluation and monitoring activities.

(m) Be responsible for all clinical and administrative activities of the Department (including maintaining quality and medical records), unless otherwise provided for by the Hospital.

(n) Maintain continuing surveillance of the professional performance of all individuals in the Department who have delineated Clinical Privileges, and report thereon to the Medical Executive Committee as part of the reappointment process and at other such times as may be indicated.

(o) Be responsible for the integration of the Department into the primary functions of the Hospital and for the coordination and integration of interdepartmental and intradepartmental services.

(p) Develop and implement Departmental Policies to guide and support the provision of care, treatment and services within the Department. Such Departmental Policies are subject to the approval process set forth in Section 9.3.

(q) Make recommendations for a sufficient number of qualified and competent Practitioners to provide care, treatment and services within the Department.

(r) Make recommendations regarding the qualifications and competence of Department or Division personnel who are not Practitioners and who provide care, treatment, and services.

(s) Working in conjunction with the Clinical Quality Committee and its representatives, be responsible for the continuous assessment and improvement of the quality of care, treatment, and services provided within the Department, including by assisting in the preparation of, and reviewing applicable OPPE and FPPE data and documentation relating to members of the Department for purposes of peer review and credentialing; reviewing applicable reports of rule indicator events (i.e., variations from general rules, standards, generally recognized professional guidelines, or accepted medical practices) and case review results; and formulating, developing, monitoring and reporting to the Clinical Quality Committee and/or Medical Executive Committee on improvement plans and FPPEs, and/or corrective action matters (and/or the need for same).

(t) Be responsible for the maintenance of quality control programs relating to the Department, as appropriate.

(u) Be responsible for the orientation and continuing education of Department members, including but not limited to education on fire and other regulations designed to promote safety.

(v) Make recommendations for space and other resources needed by the Department.

(w) Report and make recommendations to Administration when necessary with respect to matters affecting patient care in the Department such as personnel, budget planning, supplies, special regulations, standing orders and techniques.

(x) Be responsible for arranging and securing appropriate Department emergency service on-call coverage in accordance with the needs of the Hospital.

(y) Monitor, on a continuing and concurrent basis, adherence within the Department to:

(i) Hospital, Medical Staff and Department policies and procedures;

(ii) requirements for alternative coverage and for consultations;

(iii) sound principles of clinical practice; and

(iv) fire and other regulations designed to promote patient safety.

(z) Coordinate the patient care provided by the Department's appointees with nursing and ancillary patient care services and with administrative support services.

(aa) Submit written reports to the Medical Executive Committee on a regularly scheduled basis concerning:

(i) findings of the Department's evaluation and monitoring of tissue review, medical records review, blood utilization review and utilization review, actions taken thereon, and the results of such actions;

(ii) recommendations for maintaining and improving the quality of care provided in the Department and the Hospital; and

(iii) such other matters as may be requested from time to time by the Medical Executive Committee.

(bb) Conduct quarterly meetings of the Department for the purpose of performing the functions described herein.

(cc) Establish Departmental committees or other mechanisms as are necessary and desirable to properly perform Department functions.

8.3.5 Removal of a Department Chair

(a) Removal of an Appointed Department Chair. The Hospital President may remove an appointed Department Chair at any time without cause, subject to the approval of the Governing Body. The Staff Members of a Department may recommend removal of an appointed Department Chair upon a two-thirds (2/3) majority vote of all Active Medical Staff Members of the applicable Department, but such removal shall not be effective unless and until it has been approved by the Hospital President or the Governing Body. In the event an appointed Department Chair is removed, the Hospital President shall appoint an Active Medical Staff Member of the applicable Department to serve as the interim Department Chair until another Department Chair is appointed or elected in accordance with Section 8.3.2.

(b) Removal of an Elected Department Chair. The Governing Body may remove an elected Department Chair at any time without cause. The Staff Members of a Department may recommend removal of a Department Chair upon a two-thirds (2/3) majority vote of all Active Medical Staff Members of the applicable Department, but such removal shall not be effective unless and until it has been approved by the Medical Executive Committee and

the Hospital President. In the event a Department Chair is removed, the Medical Staff President and the Hospital President shall appoint an Active Medical Staff Member of the applicable Department to serve as the interim Department Chair until another Department Chair is appointed or elected in accordance with Section 8.3.2. If the Medical Staff President and Hospital President cannot agree on an interim Department Chair, then the interim Department Chair may be appointed by the Governing Body.

(c) No Hearing or Appeal Rights. A Practitioner shall not be entitled to hearing or appellate review rights in connection with his or her removal as a Department Chair.

8.3.6 Resignation

An appointed Department Chair may resign at any time by delivering his or her resignation in writing to the Hospital President. Such resignation shall take effect at such time as is specified therein, or if no such time is specified, upon delivery thereof to the Hospital President, unless otherwise determined by the Hospital President following consultation with the individual submitting the resignation.

An elected Department Chair may resign at any time by delivering his or her resignation in writing to the Medical Executive Committee. Such resignation shall take effect at such time as is specified therein, or if no such time is specified, upon delivery thereof to the Medical Executive Committee, unless otherwise determined by the Medical Executive Committee following consultation with the individual submitting the resignation.

8.4 DIVISION CHIEFS

8.4.1 Appointment/Election

A Division Chief may be appointed or elected as set forth below. The Governing Body, through the Hospital President, will determine whether the Division Chief will be appointed or elected. The Division Chief shall meet the qualifications set forth in Section 8.4.3. The Division Chief shall have the authority, duties and responsibilities set forth in Medical Staff Policies.

(a) Appointment Process. The Hospital President, in consultation with the applicable Department Chair and the Governing Body Chair may appoint a qualified Practitioner to serve as a Division Chief. The Governing Body may at any time reject the appointment of a Division Chief and require the Hospital President to select another candidate.

(b) Election Process. The applicable Department Chair shall propose one or more qualified candidates for Division Chief. The Division Chief shall be elected by a 2/3 majority vote of all of the Active Medical Staff Members of the applicable Division. In the event no nominee receives 2/3^{rds} of the votes of all of the Active Medical Staff Members of the Division, the Department Chair shall, in consultation with the Hospital President, appoint one of the candidates to serve as the Division Chief, subject to the approval of the Medical Executive Committee. The Governing Body may at any time reject the appointment of a Division Chief and require the Department Chair to select another candidate.

8.4.2 Term

Appointed Division Chiefs shall serve for the term specified by the Hospital President or in a Hospital contract, as applicable. Elected Division Chiefs shall serve two year terms or until their successors are elected and begin serving, unless they sooner resign, die, or are removed from office. Elected Division Chiefs may serve two consecutive two year terms, but may not serve subsequent terms unless two-thirds (2/3) of the Active Medical Staff within the Division approve

such subsequent term(s), and such subsequent term(s) is/are approved by the Department Chair and the Governing Body. All Division Chiefs shall be subject to periodic review and may be removed from their position as set forth in Section 8.4.5.

8.4.3 Qualifications of Division Chiefs

At the time of appointment, and throughout his or her term of service, a Division Chief must:

(a) Be an Active Medical Staff Member;

(b) Be and remain board certified in his/her specialty by an entity referenced in Section 2.3.5(a)(i);

(c) Be eligible to serve as a Division Chief in accordance with Medical Staff and Hospital conflict of interest policies;

(d) Demonstrate an interest in maintaining quality patient care at the Hospital, including in the applicable Department and Division, and in compliance with these Bylaws, applicable Hospital accreditation and licensure requirements, and law; and

(e) Constructively participate in Medical Staff affairs, including active participation in peer review activities and on Medical Staff committees.

8.4.4 Duties and Responsibilities

The primary responsibility delegated to each Division Chief is to implement and conduct specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in his/her Division. To carry out this responsibility, each Division Chief shall act in accordance with all applicable Medical Staff and Hospital Policies, and under the direction of the applicable Department Chair and appropriate senior administrators.

8.4.5 Removal of Division Chief

(a) Removal of an Appointed Division Chief. The Hospital President may, after consultation with the applicable Department Chair, remove an appointed Division Chief at any time without cause, subject to the approval of the Governing Body. The Staff Members of a Division may recommend removal of an appointed Division Chief upon a two-thirds (2/3) majority vote of all Active Medical Staff Members of the applicable Division, but such removal shall not be effective unless and until it has been approved by the Hospital President or the Governing Body. In the event an appointed Division Chief is removed, the Hospital President, after consultation with the applicable Department Chair, shall appoint an Active Medical Staff Member of the Division to serve as the interim Division Chief until another Division Chief is appointed or elected in accordance with Section 8.4.1.

(b) Removal of an Elected Division Chief. The Governing Body may remove an elected Division Chief at any time without cause. The applicable Department Chair may remove an elected Division Chief at any time without cause, subject to the approval of the Medical Executive Committee. The Staff Members of a Division may recommend removal of a Division Chief upon a two-thirds (2/3) majority vote of all Active Medical Staff Members of the Division, but such removal shall not be effective unless and until it has been approved by the applicable Department Chair and the Medical Executive Committee. Any removal of an elected Division Chief approved by the Medical Executive Committee may be overturned by the Governing Body upon request by the Hospital President. In the event that an elected Division Chief is removed, the applicable Department Chair and the Hospital President shall appoint an Active Medical Staff Member of the Division to serve

as the interim Division Chief until another Division Chief is appointed or elected in accordance with Section 8.4.1. If the applicable Department Chair and Hospital President cannot agree on the interim Division Chief, then the interim Division Chief may be appointed by the Governing Body.

(c) No Hearing or Appeal Rights. A Practitioner shall not be entitled to hearing or appellate review rights in connection with his or her removal as an elected Division Chief.

8.4.6 Resignation

An appointed Division Chief may resign at any time by delivering his or her resignation in writing to the Hospital President. Such resignation shall take effect at such time as is specified therein, or if no such time is specified, upon delivery thereof to the Hospital President, unless otherwise determined by the Hospital President following consultation with the individual submitting the resignation.

An elected Division Chief may resign at any time by delivering his or her resignation in writing to the Medical Executive Committee. Such resignation shall take effect at such time as is specified therein, or if no such time is specified, upon delivery thereof to the Medical Executive Committee, unless otherwise determined by the Medical Executive Committee following consultation with the individual submitting the resignation.

8.5 DEPARTMENT AND DIVISION MEETINGS

8.5.1 Scheduling and Notice

(a) Regular Meetings. Each Department and each Division may set the time for holding the Department's or Division's regular meetings by resolution. Department and Division meetings shall be held at least quarterly.

(b) Special Meetings**.** A special meeting of a Department or Division may be called at any time by or at the request of the Department Chair or Division Chief thereof (as applicable), the Medical Staff President, or the Hospital President.

(c) Telecommunication. Department and Division members may participate in regular or special Department or Division meetings by, or through the use of, any means of communication by which all participants may simultaneously hear each other, such as by teleconference or videoconference. Any participant in a meeting by such means shall be deemed present in-person at such meeting.

(d) Notice. Written Notice stating the place, day, and hour of any special meeting or of any regular Department or Division meeting not held pursuant to resolution shall be delivered or sent to each Department or Division member (as applicable) at least five (5) business days before the time of such meeting. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting, unless the member objects to the notice at the start of the meeting.

8.5.2 Attendance Requirements

In accordance with applicable Medical Staff Policies, Active Medical Staff Members are expected to attend Medical Staff Department and Division Meetings and such attendance may be considered in evaluating Active Medical Staff Members at the time of reappointment. All other

Staff Members are strongly encouraged to attend Medical Staff Department and Division meetings.

8.5.3 Participation by Hospital President

The Hospital President may attend any Medical Staff Department or Division meeting.

8.5.4 Minutes

Minutes of each regular and special Department and Division meeting shall be prepared and shall include a record of the Department or Division members in attendance and the vote taken on each matter. The minutes shall be signed by the Department Chair or Division Chief, provided that, if the Chair or Chief (as applicable) was not present at the meeting which is the subject of the minutes or if the Chair or Chief is unavailable, the minutes can be signed by a designee of the Chair or Chief. Copies of the minutes shall be submitted to the Medical Executive Committee. Minutes of Department and Division meetings shall be maintained in a permanent file by Medical Staff Services.

8.5.5 Quorum and Voting Requirements

For Department and Division meetings, a quorum shall consist of those present, eligible to vote, and voting, unless a different quorum requirement is specified in these Bylaws or in a duly adopted Policy. If a quorum exists, action on a matter shall be approved if the votes cast within the voting group favoring the action exceed the votes cast opposing the action.

ARTICLE 9. MEDICAL STAFF BYLAWS & POLICIES

9.1 MEDICAL STAFF BYLAWS – ADOPTION & AMENDMENT

9.1.1 Adoption

These Bylaws may be adopted at any regular or special meeting of the Active Medical Staff and shall become effective only when approved by the Governing Body.

9.1.2 Periodic Review

These Bylaws shall be reviewed periodically by the Medical Executive Committee or its designee.

9.1.3 Amendment of Bylaws

Any Medical Staff Member, Medical Staff committee, Medical Staff Department, the Hospital President, or the Governing Body, may submit a request for amendment of these Bylaws to the Medical Executive Committee or Medical Staff at any time. A request for amendment of these Bylaws shall thereafter be submitted to the Medical Staff at the next regular Medical Staff meeting, or at a special Medical Staff meeting duly called for such purpose. A proposed amendment so presented, to be deemed approved by the Medical Staff, shall require the affirmative vote of a majority of the Active Medical Staff voting, in aggregate, at the meeting in person and by mail or email ballot (or electronic ballot, if so approved in advance by the Medical Executive Committee) received within seven (7) business days following the meeting at which the amendment was presented (provided that individuals casting such votes participated in the meeting in person or by means of a conference telephone or similar communications equipment by means of which all persons participating in the meeting could hear each other at the same time). An amendment so approved by the Medical Staff shall be submitted to the Governing Body for its approval and shall become effective if and when it is approved by the Governing Body. The Medical Executive Committee will ensure that amendments approved by the Governing Body are communicated to the Medical Staff.

In the event the Governing Body determines that the Medical Staff is not acting in accordance with its responsibilities as set forth in these Bylaws and/or that an amendment to the Bylaws is necessary or appropriate to ensure compliance with applicable law, regulation, or accreditation standards, the Governing Body may, following notice to the Medical Staff directed to the Medical Executive Committee, including (i) its reason, (ii) the proposed amendment, and (iii) a ninety (90) day period to enable the Medical Staff to respond (unless adverse legal or accreditation action is threatened against the Hospital within a shorter period, in which case, the response period will be shortened accordingly), amend these Bylaws by majority Governing Body vote. The Governing Body shall take into consideration Medical Staff recommendations and/or views received by the Governing Body prior to its vote.

These Bylaws shall not conflict with the bylaws or policies of the Hospital.

9.1.4 Technical Modifications of Bylaws

Modifications to these Bylaws that do not materially change any Bylaw provision, such as reorganization, reformatting, renumbering, correction of grammatical, spelling, or punctuation errors, and the like shall not be considered an amendment of these Bylaws and shall not require approval as described above.

9.2 MEDICAL STAFF POLICIES – ADOPTION AND AMENDMENT

The Medical Executive Committee is authorized to, and shall, adopt and amend such Medical Staff policies as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Governing Body. Such Medical Staff policies must be consistent with these Bylaws and with applicable Hospital bylaws, policies, rules and regulations.

9.2.1 Process for Adoption and Amendment

Any Medical Staff Member, Medical Staff committee, Department, the Medical Staff as a body, the Hospital President or the Governing Body may submit a proposal to adopt or amend a Medical Staff policy to the Medical Executive Committee for approval at a regular Medical Executive Committee meeting, or at a special Medical Executive Committee meeting called for such purpose; or the Medical Executive Committee may initiate its own proposal to adopt or amend a Medical Staff policy at such meeting. Any proposed policy or amendment thereof, including those proposed initially by the Medical Executive Committee, shall be communicated to the Medical Staff. To be approved by the Medical Executive Committee, a proposed policy or amendment thereof must be approved by a majority vote of the voting members of the Medical Executive Committee, including by mail, email and electronic ballot received within seven (7) days of the meeting at which the proposal was considered (provided that individuals casting a mail, email or electronic ballot participated in the meeting by means of a conference telephone or similar communications equipment by means of which all persons participating in the meeting could hear each other at the same time). A policy or amendment thereof approved by the Medical Executive Committee shall be forwarded to the Governing Body for its approval and shall become effective if and when it is approved by the Governing Body. If a proposed policy or amendment thereof is not approved by the Medical Executive Committee, the Medical Staff may submit the proposed policy, rule, regulation or amendment directly to the Governing Body if a majority of the aggregate Active Medical Staff members voting at a Medical Staff meeting in person, and voting by mail or email ballot received within seven (7) business days following the meeting (provided that individuals casting a mail, email or electronic ballot participated in the meeting in person or by means of a conference telephone or similar communications equipment by means of which all persons participating in the meeting could hear each other at the same time), vote to submit the proposed policy or amendment directly to the Governing Body. Such a proposed policy or amendment shall become effective if and when it is approved by the Governing Body. Approved policies and amendments thereto shall be communicated to the Medical Staff.

9.2.2 Urgent Amendments

The foregoing notwithstanding, in cases of a documented need for an urgent amendment to Medical Staff policies necessary to comply with law, regulation or accreditation requirement, the Medical Executive Committee may provisionally approve such amendment without prior notification to the Medical Staff. In such cases, the Medical Staff shall promptly be notified of the provisional approval by the Medical Executive Committee, and the Medical Staff shall have the opportunity for retrospective review and comment on the provisionally approved amendment. If there is no conflict over the provisional amendment (i.e., if a majority of the aggregate Active Medical Staff members voting in person at a duly called and held meeting of the Medical Staff, and voting by mail, email or electronic ballot received within seven (7) business days following the meeting, for those who attended the meeting in person or by telephone or video conference, does not vote in opposition to the provisional amendment), the provisional amendment shall stand. If there is conflict between the Medical Executive Committee and the Medical Staff regarding the provisional amendment, the conflict will be addressed by the Medical Executive Committee in accordance with the terms of Section 7.1.2(p) of these Bylaws.

In the event the Governing Body determines that the Medical Executive Committee is not acting in accordance with its responsibilities as set forth in these Bylaws and/or that an amendment to the Medical Staff policies is necessary or appropriate to ensure compliance with applicable law, regulation, or accreditation standards, the Governing Body may, following notice to the Medical Executive Committee, including (i) its reason, (ii) the proposed amendment, and (iii) a forty-five (45) day period to enable the Medical Executive Committee to respond (unless adverse legal or accreditation action is threatened against the Hospital within a shorter period, in which case, the response period will be shortened accordingly), amend the Medical Staff policies by majority Governing Body vote. The Governing Body shall take into consideration Medical Executive Committee recommendations and/or views received by the Governing Body prior to its vote. Any such approved policy or amendment shall be communicated to the Medical Staff.

9.2.3 Technical Modifications of Medical Staff Policies

Modifications that do not materially change any Medical Staff policy, rule or regulation provision, such as reorganization, reformatting, renumbering, correction of grammatical, spelling, or punctuation errors, and the like, shall not be considered an amendment of the Medical Staff policies and shall not require approval as described above.

9.3 DEPARTMENT POLICIES – ADOPTION & AMENDMENT

Each Department may develop, and propose amendments to, Department policies intended to guide and support the provision of care, treatment and services in such Department, or govern the administration of such Department. Such policies or proposed amendments must: (1) be consistent with these Bylaws, Medical Staff policies, and applicable Hospital policies; and (2) be approved by the Department chair, the Medical Executive Committee, and the Hospital President.

In the event of any conflict or inconsistency between these Bylaws and Medical Staff policies, these Bylaws shall supersede and prevail. In the event of any conflict or inconsistency between Medical Staff policies and Department policies, the Medical Staff policies shall supersede and prevail. In the event of conflict or inconsistency between Medical Staff policies and Hospital policies, the Hospital policies shall supersede and prevail.

9.4 HISTORY AND PHYSICAL EXAMINATIONS

A medical history and physical examination (H&P) must be performed and documented by a Physician, Oral Surgeon, or other qualified licensed individual (as identified in applicable Medical Staff or Hospital Policies), no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but in all cases prior to surgery or a procedure requiring anesthesia services (as described in the Medical Staff or Hospital Policies);[46] provided, however, that if the H&P is performed within thirty (30) days prior to the patient's admission or registration, a Physician, Oral Surgeon, or other qualified licensed individual (as identified in the Medical Staff or Hospital Policies) must complete and document an updated examination of the patient, including any changes in the patient's condition, within 24 hours after the patient's admission or registration, but in all cases prior to surgery or a procedure requiring anesthesia services (as described in Medical Staff or Hospital Policies).[47] Please refer to the Medical Staff and Hospital Policies for more information regarding H&P documentation requirements.

ARTICLE 10. PRACTITIONER HEALTH COMMITTEE

10.1 IMPAIRED PROFESSIONALS

10.1.1 Practitioner Health Committee

The Practitioner Health Committee (PHC) exists to: (i) evaluate and assist in the supervision and rehabilitation of Staff Members who may suffer with physical or mental health problems which affect their professional responsibilities; and (ii) educate Staff Members and Hospital employees regarding the nature of Practitioner health issues and the purpose of the PHC. The PHC will function as a medical peer review committee and is separate from the Medical Staff disciplinary functions. The Medical Executive Committee shall, directly or through formulated Medical Staff Policy, describe PHC functions and appoint PHC members. PHC members should not have responsibilities or duties within the Hospital that discourage self-referral or referral from others to the PHC. The PHC will accept and review referrals concerning any Staff Member. Confidentiality of the Staff Member seeking referral or referred for assistance shall be maintained to the extent practicable, except as limited by law, ethical obligation, or when the health and safety of a patient is threatened.

10.1.2 Evaluation and Intervention

The PHC shall, upon obtaining a self-referral or referral from others, gather information, evaluate the credibility of issues and discuss the issues with the Staff Member in question. The PHC may obtain a consultation from, and/or possible referral of the affected Staff Member to, appropriate professional internal or external resources, including the Texas State Medical Association, for evaluation, diagnosis and/or treatment of the condition or concern, and to assist in the determination of the appropriateness of intervention, treatment and/or monitoring. If appropriate, the affected Staff Member will be monitored in an effort to ensure the safety of patients will be assured until the rehabilitation or any disciplinary process is complete. To the extent required by law and consistent with patient safety, reasonable accommodations shall be made for impaired practitioners. The PHC will consider and make recommendations regarding appropriate accommodations for impaired practitioners. Monitoring may take place periodically thereafter, if required. The PHC shall report to the Medical Staff President or Medical Executive Committee any unsafe treatment instances or recommendations that require further action, including corrective action.

10.1.3 Reports and Records.

The reports, records, and proceedings of the PHC shall be treated as confidential, to the extent practicable, with the following exceptions: (i) proceedings conducted by the licensing boards in medicine, social work, and psychology; (ii) documents, incidents, reports or records otherwise available from original sources; (iii) in an action against a committee member for bad faith or unreasonable action, and (iv) testimony where information is known to an individual independently of committee proceedings.

ARTICLE 11. MISCELLANEOUS

11.1 COMPLIANCE WITH LAWS AND REGULATIONS

Any act or omission that may be considered inconsistent with the provisions set forth in these Medical Staff Bylaws, but which was undertaken in order to comply with applicable federal or state statutes or regulations, shall not be considered a violation of these Medical Staff Bylaws. In the event these Medical Staff Bylaws are inconsistent with such statutes or regulations, the Medical Executive Committee shall initiate the amendment process set forth in these Bylaws in a timely manner.

11.2 GOVERNING LAW; VENUE; WAIVER OF JURY TRIAL

The validity, construction, and enforcement of these Bylaws shall be construed and enforced solely in accordance with the laws of the State of Texas. The parties agree that jurisdiction and venue for any dispute shall be in _____ County, State of Texas and no party or person may object to personal jurisdiction in, or venue of such courts or assert that such courts are not a convenient forum. Both parties waive trial by jury in any action hereunder.

11.3 ELECTRONIC RECORDKEEPING

Wherever these Bylaws call for the maintenance of written records, such records may be recorded and/or maintained in electronic format.

11.4 HEADINGS

The captions or headings used in these Medical Staff Bylaws are for convenience only and are not intended to limit or otherwise define the scope or effects of any provisions of these Medical Staff Bylaws.

11.5 IDENTIFICATION

Although the masculine gender and the singular are sometimes used throughout these Bylaws and associated policies for simplicity, words which import one gender may be applied to any gender and words which import the singular or plural may be applied to the plural or the singular, all as a sensible construction of the language so requires.

11.6 SEVERABILITY

In the event that any provision of these Bylaws shall be determined to be invalid, illegal, or unenforceable, the validity and enforceability of the remaining provisions shall not in any way be affected or impaired by such a determination.

11.7 RULES OF ORDER

The latest edition of ROBERT'S RULES OF ORDER shall prevail at all Medical Staff, Medical Executive Committee, and other Medical Staff Committee meetings except: (1) the Medical Staff President may vote at Medical Staff meetings; (2) the Medical Staff President may vote at Medical Executive Committee Meetings, (3) the Department Chair may vote at Department meetings; (4) the Division Chair may vote at Division meetings; and (5) in the event that a specific provision of these Bylaws is in conflict with Robert's Rules of Order, the provision contained in these Bylaws shall supersede and control (e.g., specific quorum requirement set forth in these Bylaws).

REFERENCES

[1] 42 C.F.R. § 482.22(c)(5)(i) (Interpretive Guidelines, effective June 5, 2009).
[2] 42 U.S.C. § 11151(9).
[3] 42 U.S.C. § 11151(10).
[4] 42 C.F.R. § 482.12(a)(3); 42 C.F.R. § 482.22(c)
[5] 42 C.F.R. § 482.12(a).
[6] 42 C.F.R. § 482.12(a)(3-4)
[7] 42 C.F.R. § 482.12(a)(1).
[8] 42 C.F.R. § 482.12(a)(2).
[9] 42 C.F.R. § 482.12(a)(6).
[10] 42 C.F.R. § 482.12(a)(7).
[11] 42 C.F.R. § 481.12(a)(5).
[12] 42 C.F.R. § 482.12(a)(7)
[13] Texas Code § 3701.351
[14] 42 C.F.R. § 482.22(a)(1)
[15] 42 C.F.R. § 482.22(c)(2) (Interpretive Guidelines, dated June 5, 2009).
[16] 42 C.F.R. § 482.22(c)(4)
[17] 42 C.F.R. § 482.11(c); 42 C.F.R. § 482.22(c)(4)
[18] 21 C.F.R. 1301.12 (b)(3). When an Applicant practices in more than one State, he or she must obtain a separate registration for each State. See 71 Fed. Reg. 231, 69478-69480 (Dec. 1, 2006).
[19]
[20] The background check may not be delegated to a DSTE.
[21] 42 C.F.R. § 482.22(a)(1)-(2) (Interpretive Guidelines, effective June 5, 2009).
[22] 42 C.F.R. § 482.22(a)(2).
[23] 42 C.F.R. § 489.12(a)(2)
[24] 42 C.F.R. § 482.22(c)(3).
[25] 42 U.S.C. § 11112(a)(1).
[26] 42 U.S.C. § 11112(a)(2).
[27] 42 U.S.C. § 11112(c)(2)
[28] See also Hospital Bylaws, Article IV, Section 4.
[29] 42 U.S.C. § 11112(a)(1-2)
[30] 42 U.S.C. § 11112(b)(1)(A-B).
[31] 42 U.S.C. § 11112(b)(1)(B)(i-ii).
[32] 42 U.S.C. § 11112(b)(3)(A)(iii).
[33] 42 U.S.C. § 11112(b)(2)(A)
[34] 42 U.S.C. § 11112(b)(2)(A-B).
[35] 42 U.S.C. § 11112(b)(3)(B).
[36] 42 U.S.C. § 11112(b)(1)(A-B).
[37] 42 U.S.C. § 11112(b)(2)(A-B).

[38] 42 C.F.R. § 482.22(a)(2) (Interpretive Guidelines, effective June 5, 2009).

[39] 42 C.F.R. § 482.22

[40] 42 C.F.R. § 482.22(c)

[41] 42 C.F.R. § 482.22(b) (Interpretive Guidelines, effective June 5, 2009).

[42] 42 C.F.R. § 482.12(a)(5).

[43] 42 C.F.R. § 482.22(b)(1); 42 C.F.R. § 482.22(c)(3)

[44] 42 C.F.R. § 482.11(a).

[45] 42 C.F.R. § 482.22(b)(2) (Interpretive Guidelines, effective June 5, 2009).

[46] 42 C.F.R. § 482.22(c)(5)(i) (Interpretive Guidelines, effective June 5, 2009); The Conditions of Participation provide that H & P documentation requirements must be included in the Medical Staff Bylaws.

[47] 42 C.F.R. § 482.22(c)(5)(ii) (Interpretive Guidelines, effective June 5, 2009); The Conditions of Participation provide that H & P documentation requirements must be included in the Medical Staff Bylaws.