BYLAWS OF THE MEDICAL STAFF

OF

ATLANTICARE REGIONAL MEDICAL CENTER

Approved By The Board September 18, 2025

BYLAWS OF THE MEDICAL STAFF

OF

ATLANTICARE REGIONAL MEDICAL CENTER

CONTENTS

Article 1 .... **4**
Name **4**
1.1. Name 4
Article 2 .... **4**
Purposes, Responsibilities and Communication **4**
2.1. Purposes 4
2.2. Communication 5
2.3. Participation in Performance Improvement Activities 5
Article 3 .... **6**
Medical Staff Membership **6**
3.1. Nature of Medical Staff Membership 6
3.2. Criteria for Membership 6
3.2-1. Licensure and Competence 6
3.2-2. Professional Standing 7
3.2-3. Legal Requirements 7
3.2-4. Malpractice Insurance 7
3.2-5. Ethics 7
3.2-6. Board Certification, Qualification and Recertification 7
3.2-7. Conviction of a Crime 8
3.2-8. Waiver 8
3.3. Conditions and Duration of Appointment 9
3.3-1. Medical Staff Role 9
3.3-2. Duration of Appointments 9
3.3-3. Clinical Privileges of Appointment 9
3.3-4. Responsibilities of Staff Membership 9
3.3-5. Dues 11
3.3-6. Reporting of Malpractice Cases 11
3.3-7. Reporting of Adverse Actions 11
3.4. Provider Impairment 11
Article 4 .... **12**
Categories of the Medical Staff **12**
4.1. Categories of Medical Staff Membership 12
4.2. Active Medical Staff 12
4.2-1. Responsibilities of Active Medical Staff 12
4.2-2. [Reserved] 12
4.2-3. Prerogatives of Active Medical Staff 12
4.2-4. Psychologist Members of the Active Medical Staff 12
4.2-5. Senior Medical Staff 13
4.2-6. Prerogatives of Senior Medical Staff 13

4.2-7. Responsibilities of Senior Medical Staff 13
4.3. Medical Staff Alumni 13
4.4. Visiting Medical Staff.. 13
4.5. Telemedicine Staff... 14
4.6. Administrative Physicians 14
4.7. Advanced Practice Provider Staff.. 14
4.7-1. Review of Applicant Credentials 14
4.7-2. Review of the Application of the Advanced Practice Provider 16
4.7-3. Termination of Advanced Practice Provider Provision of Patient Care Services 16
4.7-4. Responsibilities of Advanced Practice Provider Staff............................. 17
4.7-5. Prerogatives of Advanced Practice Provider Staff.................................. 18
4.7-6. Visiting Advanced Practice Provider Staff 19
Article 5.. 19
Procedures for Appointment and Reappointment... 19
5.1. Application Process 19
5.1-1. Pre-Application Process... 19
5.1-2. Grounds for Not Providing Application Form.. 19
5.2. Application for Appointment... 20
5.2-1. Application Contents 20
5.2-2. Applicant’s Burden 23
5.2-3. Effect of Application.. 23
5.2-4. Applicant’s Adherence to Bylaws 24
5.2-5. Applicant Pledge.. 24
5.2-6. Basis for Initial Appointment... 25
5.3. Appointment Process 25
5.3-1. Verification 26
5.3-2. Categories of Applications... 26
5.3-3. Departmental Review... 26
5.3-4. Credentials Committee Review 27
5.3-5. Executive Committee Review.. 28
5.3-6. Executive Committee Deferral 28
5.3-7. Favorable Executive Committee Action 28
5.3-8. Adverse Executive Committee Recommendations................................. 29
5.3-9. Board Subcommittee Action - Category One applications (expedited appointment) 29
5.3-10. Board Action.. 29
5.3-11. Notice of Final Decision 31
5.3-12. Reapplication After Adverse Appointment Decision 31
5.4. Initial Appointments 31
5.5. Criteria for Reappointment 31
5.5-1. Application for Reappointment.. 31
5.5-2. Information to be Submitted 32
5.5-3. Applicant’s Burden 33
5.5-4. Effect of Application.. 33
5.5-5. Applicant’s Adherence to Bylaws 33

5.5-6. Applicant Pledge 33
5.5-7. Verification 33
5.5-8. Departmental Review 33
5.5-9. Basis for Reappointment 34
5.5-10. Process 34
5.6. Department Assignment 34
5.7. Request for Modification of Appointment 34
Article 6 35
Clinical Privileges 35
6.1. Clinical Privileges Restricted 35
6.2. Clinical Privileges Delineated 35
6.3. Criteria for Granting Clinical Privileges to Providers 35
6.3-1. Applicant's Burden 36
6.3-2. Prior Verification 36
6.3-3. Oral Surgeon Privileges 36
6.3-4. Podiatric Privileges 36
6.4. Determination of Individual Clinical Privileges 37
6.4-2 Changes in Clinical Privileges 37
6.5. Temporary Privileges 37
6.5-1. Circumstances for Granting Temporary Privileges= 38
6.5-2. Care of a Specific Patient 38
6.5-3. Locum Tenens/Practitioner Coverage 38
6.5-4. Visiting Clinical Privileges 39
6.5-5. New Privileges for Current Providers 39
6.5-6. Verification of Credentials 39
6.5-7. Conditions 39
6.5-8. Termination of Temporary Privileges 39
6.5-9. Transplant Teams Privileges 40
6.5-10. Disaster Privileges 40
6.6. Emergency Privileges 41
6.6-1. Conclusion of Emergency 41
6.6-2. Definition of Emergency 41
6.7. Telemedicine Privileges 41
6.7-1. Delineation of Clinical Services 41
6.7-2. Privileging Process 41
6.8. Voluntary Leave of Absence 42
6.8-1. Acceptable Reasons for Leave of Absence 42
6.8-2. Termination of Leave 43
6.8-3. Failure to Request Reinstatement 43
6.8-4. Impact on Adverse Actions and Recommendations 43
6.8-5. Arrangements for Advanced Practice Provider Staff 43
6.9. Assignment to Departments and Divisions 43
6.10. Other Providers 44
6.11. Ongoing Professional Practice Evaluation 44
6.12. Focused Professional Practice Evaluation 44

6.12-1. APPs 44
6.13. History and Physical Examination 44
6.13-1. Generally 44
6.13-2. Pre-admission Evaluation 45
6.13-3. Use of H&Ps Prepared Prior to Current Admission 45
6.13-4. H&Ps by Advanced Practice Nurses and Certified Nurse Midwives 45
6.13-5. H&Ps by Physician Assistants 45
6.13-6. H&Ps by Interns and Residents 46
6.13-7. Service On Call and Interpretation Rosters 46
6.14. Rights Accorded on Temporary, Locum Tenens, Emergency and Disaster Privileges 46
Article 7 46
Corrective Action 46
7.1. Bases for Routine Corrective Action 46
7.1-1. Collegial Intervention 47
7.1-2. Violations 47
7.1-3. Unprofessional or Unethical Conduct 47
7.1-4. Disruptive Behavior 47
7.1-5. Breach of Confidentiality 48
7.1-6. Clinical Deficiencies 48
7.1-7. Medicare or Medicaid Sanctions 48
7.1-8. Violation of the Hospital Sexual, Racial and Ethnic Harassment Policy 48
7.1-9. Actions by Board of Medical Examiners 48
7.1-10. Criminal Activity, Certain Misdemeanors 48
7.2. Requests 49
7.3. Formal Notice to Provider 49
7.4. Investigation 49
7.4-1. Notice to Provider of Investigation 49
7.4-2. Conduct of Investigation 50
7.4-3. Report of Investigating Committee 50
7.5. Executive Committee Action 50
7.5-1. Types of Action 51
7.5-2. Procedural Rights 51
7.5-3. Effect if No Hearing Right Pertains 52
7.6. Board Intervention 52
7.7. Precautionary Suspension Pending Investigation 52
7.7-1. Notice 52
7.7-2. Provision of Patient Care 53
7.7-3. Executive Committee Review 53
7.7-4. Provider Rights 53
7.8. Automatic Suspensions or Limitations 53
7.8-1. Action as a Result of Automatic Suspension or Limitation 53
7.8-2. Revocation Or Suspension Of License To Practice 53
7.8-3. Drug Enforcement Administration Action/CDS Number 54

7.8-4. Suspension Or Exclusion From Federal Or State Insurance Programs Or Conviction For Insurance Fraud 54
7.8-5. Medical Records 55
7.8-6. Maintenance Of Professional Liability Insurance 56
7.8-7. Failure To Pay Medical Staff Dues 56
7.8-8. Failure To Participate In An Evaluation Or Assessment 56
7.8-9. Conviction Of A Crime 57
7.8-10. Failure To Comply with Required Screenings and Vaccinations as Determined by the Medical Staff 57
7.8-11. Failure To Become Board Certified Or To Maintain Board Certification 57
7.8-12. Failure To Notify Hospital Of Certain Actions 58
7.8-13. Failure To Return From A Leave Of Absence 59
7.8-14. Executive Committee Deliberation 59
7.9. Right to Fair Hearing and Appellate Review 59
Article 8 59
Fair Hearing Plan 59
8.1. Right to Hearing and to Appellate Review 59
8.1-1. Appellate Review from Executive Committee Decision 60
8.1-2. Hearing and Appellate Review by the Board 60
8.2. Bases for Action 60
8.2-1. Adverse Recommendations Defined 60
8.2-2. Adverse Actions Enumerated 60
8.3. Procedural Rights 61
8.4. Notice, Request and Waiver for Hearing 61
8.4-1. Request 61
8.4-2. Waiver 61
8.4-3. Effect of Waiver 62
8.5. Notice of Hearing 62
8.5-1. Date of Hearing 62
8.5-2. Contents of Notice 62
8.5-3. Access to Information 62
8.5-4. Confidentiality 63
8.5-5. Effect of Hearing 63
8.5-6. Hospital Employees 63
8.5-7. Pre-Hearing Conference 63
8.6. Composition of Medical Staff Fair Hearing Committee 64
8.6-1. Qualifications 64
8.6-2. Additional Panelists 64
8.6-3. Hearing Officer 65
8.7. Board Hearing 65
8.7-1. Qualifications 65
8.7-2. Alternates 65
8.8. Conduct of Hearing 65
8.8-1. Committee Presence 66
8.8-2. Practitioner Presence 66

8.8-3. Record of Proceedings 66
8.8-4. Hearing Postponement 66
8.8-5. Evidence 66
8.8-6. Hearing Rights 67
8.8-7. Chair of the Fair Hearing Committee 67
8.8-8. Representation 67
8.8-9. Burden of Proof 68
8.8-10. Deliberations, Recesses and Adjournment 68
8.8-11. Written Report 68
8.8-12. Notice 68
8.8-13. Action on Fair Hearing Committee Report 68
8.8-14. Effect of Favorable Action 69
8.8-15. Effect of Adverse Action 69
8.8-16. Board Remand 69
8.9. Appeal to the Board 69
8.9-1. Waiver of Appeal 69
8.9-2. Notification to Practitioner 70
8.9-3. Composition of the Appeals Panel 70
8.9-4. Scheduling the Appeal 70
8.9-5. Rights of Parties 70
8.9-6. Written Submissions 70
8.9-7. Scope of Review 71
8.9-8. Oral Argument 71
8.9-9. Appellate Review Committee Determinations 72
8.9-10. Exhaustion of Appellate Review 72
8.10. Final Decision by Board 72
8.11. One Hearing on Each Matter 73
8.12. Confidentiality 73
Article 9 73
Officers of the Medical Staff 73
9.1. Officers of the Medical Staff 73
9.2. Qualifications for Elective Office 73
9.3. Nominations 74
9.3-1. By the Nominating Committee 74
9.3-2. By the Membership 74
9.4. Elections 74
9.5. Term of Office 75
9.6. Vacancies 75
9.7. Removal of Officers 75
9.7-1. Failure to Maintain Qualification 75
9.7-2. Other Good Cause 75
9.8. Duties of Officers 76
9.8-1. President 76
9.8-2. Vice-President 76
9.8-3. Immediate Past President 77
9.8-4. Secretary 77

9.8-5. Treasurer ... 77
Article 10 ... 77
Departments ... 77
10.1. Departments, Divisions and Sections ... 77
10.1-1. Departmental Organization ... 77
10.1-2. Changes in Departments, Divisions and Sections ... 80
10.1-3. Department, Division and Section Meetings ... 80
10.1-4. Functions of Departments ... 80
10.1-5. Functions of Divisions ... 81
10.2. Department Chairs, Division Directors and Section Chief ... 81
10.2-1. Removal ... 82
10.2-2. Duties of Chairs ... 82
10.2-3. Duties of Division Directors ... 83
10.2-4. Associate Chairs and Directors ... 83
Article 11 ... 84
[Reserved] ... 84
Article 12 ... 84
Committees ... 84
12.1. Medical Staff Committees ... 84
12.1-1. Minutes ... 84
12.1-2. Membership ... 84
12.1-3. List of Medical Staff Committees ... 84
12.2. Institutional Committees Chaired by Physicians ... 85
12.3. Other Institutional Committees ... 85
12.4. Executive Committee ... 85
12.4-1. Duties ... 86
12.4-2. Meetings ... 88
12.5. Officers' Council ... 88
12.5-1. Duties ... 88
12.5-2. Meetings ... 89
12.6. Bylaws Committee ... 89
12.6-1. Duties ... 89
12.6-2. Meetings ... 89
12.7. Continuing Medical Education Committee ... 89
12.7-1. Duties ... 89
12.7-2. Meetings ... 90
12.8. Credentials Committee ... 90
12.8-1. Duties ... 90
12.8-2. Meetings ... 90
12.9. Medical Staff Excellence Committee ... 90
12.10. Nominating Committee ... 91
12.10-1. Duties ... 91
12.10-2. Meetings ... 91
12.11. Cancer Committee ... 91
12.12. Patient Care and Resource Management Committee ... 91
12.13. Ad Hoc Committees ... 91

Article 13 .... **91**
Medical Staff Meetings **91**
13.1. Regular Medical Staff Meetings 91
13.2. Special Meetings 92
13.3. Quorum 92
13.4. Attendance Requirements. 92
13.5. Administrative Involvement 92
13.6. Minutes 92
13.7. Voting 93
Article 14 .... **93**
Confidential, Immunity and Releases **93**
14.1. Special Definitions 93
14.2. Authorization and Conditions 93
14.3. Confidentiality of Information 94
14.4. Immunity from Liability for Action Taken 94
14.5. Immunity from Liability for Providing Information 94
14.6. Activities and Information Protected 95
14.7. Information Protected 95
14.8. Releases 95
14.9. Cumulative Effect 95
Article 15 .... **96**
Rules and Regulations **96**
15.1. Medical Staff Rules and Regulations 96
15.1-1. Adoption and Amendment 96
15.1-2. Effect of Rules and Regulations 96
15.2. Departmental Rules and Regulations 96
Article 16 .... **97**
Adoption and Amendment of Bylaws **97**
16.1. Review 97
16.2. Medical Staff Responsibility and Authority 97
16.2-1. Request for a Bylaws Amendment 97
16.2-2. Notice of Proposed Bylaws and/or Rules and Regulations Amendments 97
16.2-3. Adoption of Amendments 97
16.2-4. Adoption of Technical Amendments 98
16.2-5. Adoption of Urgent Amendments 98
16.3. Recording 98
Article 17 .... **98**
Conflict Resolution **98**
17.1. Conflict Resolution Process 98
17.2. Conflict Resolution Committee 99
17.3. Conflicts within the Medical Staff 99
17.4. Conflicts with the Board 99
17.5. Resolution Techniques 99
Article 18 .... **100**
Parliamentary Authority **100**

BYLAWS OF THE MEDICAL STAFF

Preamble

WHEREAS, AtlantiCare Regional Medical Center is organized under the laws of the State of New Jersey; and

WHEREAS, its purpose is to serve as a hospital providing patient care, education, and research; and

WHEREAS, it is recognized that one of the aims and goals of the Medical Staff is to strive for appropriate medical care in the Hospital; and

WHEREAS, the Medical Staff and Board of Governors must work together, with the ultimate authority resting with the Board of Governors; and

WHEREAS, the cooperative efforts of the Medical Staff and the Board of Governors are necessary to provide appropriate medical care to patients of the Hospital;

THEREFORE, the Providers practicing in this Hospital hereby organize themselves into a Medical Staff in conformity with these Bylaws, and the Rules and Regulations interpreting them, and subject to the following general principles:

These Bylaws originated with the Medical Staff and were approved by the Board of Governors of AtlantiCare Regional Medical Center. These Bylaws are adopted in order to organize the Medical Staff, provide a framework for its self-governance, and establish the mechanisms through which the Medical Staff will discharge its responsibilities.

These Bylaws provide the professional structure of the Medical Staff and its operations, organized Medical Staff relations with the Board, and Medical Staff relations with Members, other Providers, and applicants for Medical Staff Membership and Clinical Privileges.

In the event of a conflict between the Medical Staff Bylaws and the Medical Staff Rules and Regulations, or any other Medical Staff or Department policies, these Bylaws shall prevail.

These Bylaws shall not be unilaterally amended by the Board or by the Medical Staff. In any instance in which the Board shall seek to amend the corporate Bylaws of AtlantiCare Regional Medical Center on a matter which affects the Medical Staff, it shall do so only after providing reasonable prior notice to the Executive Committee to permit consideration and comment by the Medical Staff through the Executive Committee, which comments shall be taken into consideration by the Board. Any request of the Board for an amendment to these Bylaws shall be submitted to the Bylaws Committee for consideration pursuant to these Bylaws.

The Board of Governors shall inform the Medical Staff of Hospital activities which affect the discharge of Medical Staff responsibilities and shall provide the Medical Staff with a meaningful opportunity to participate in Hospital deliberations concerning matters which do, or could, affect the discharge of Medical Staff responsibilities.

The Medical Staff, each Member of the Medical Staff and the Board of Governors shall comply and act in accordance with these Bylaws and the Medical Staff Rules and Regulations, approved by the Board of Governors and any policies that are adopted by the Medical Staff or, as delegated by the Medical Staff to the Executive Committee.

Definitions

1. Advanced Practice Provider or APP means an Advanced Practice Nurse ("APN"), Physician Assistant ("PA"), Certified Nurse Midwife ("CNM"), or other licensed or certified individual who collaborates or consults with, or practices under the supervision and direction of a Physician. A single Provider may hold both APN and CNM licensure.

2. Associated Physician means a collaborating physician as to an APN, a supervising physician as to a PA, and a consulting physician as to a CNM.

3. Board of Governors or Board means the governing body of the Hospital.

4. Call or "On Call" means the responsibility to attend to a Practitioner's own patients outside of normal working hours and/or to patients assigned to the Practitioner from the Emergency Department.

5. Chief Executive Officer ("CEO") means the individual appointed by the Board of Governors to act on its behalf in the overall administrative management of the Hospital, or the CEO's designee.

6. Chief Medical Officer ("CMO") means the medical officer appointed by the Board who has primary responsibility for liaison between the Medical Staff and the Hospital administration.

7. Chief Physician Executive ("CPE") means the medical officer appointed by the Board of the AtlantiCare Health System ("System") to oversee the clinical activities of all Providers throughout the System. The CPE may also be referred to as the System CMO.

8. Chief Hospital Executive ("CHE") means the chief hospital officer for the System.

9. Clinical Privileges or Privileges means those services and procedures which the Medical Staff has determined, with the approval of the Board, that a Provider may provide to patients of the Hospital. Clinical Privileges are separate and distinct from Membership.

10. Days means calendar days.

11. Ex-officio means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.

12. Executive Committee means the Executive Committee of the Medical Staff. The Executive Committee may also be referred to as the Medical Executive Committee or the MEC.

13. Hospital means the AtlantiCare Regional Medical Center.

14. Medical Staff or Staff means the formal organization of all Practitioners who are privileged to attend or visit patients in the Hospital.

15. Membership or Member, unless otherwise indicated, means that status with the Medical Staff as determined by the Medical Staff with the approval of the Board, which defines a Practitioner's rights, prerogatives and responsibilities to participate in the Medical Staff organization.

16. Oral Surgeon means an individual who is licensed to practice dentistry in the State of New Jersey and is board-certified in Oral and Maxillofacial Surgery.

17. Physician means an individual who is licensed to practice medicine, osteopathic medicine, dentistry or podiatry in the State of New Jersey.

18. Physician Designee means a Physician designated to provide coverage or clinical services. An APP may not be a Physician Designee.

19. Practitioner means, unless otherwise expressly limited, any Physician or Psychologist applying for or exercising Clinical Privileges in the Hospital.

20. Provider means, unless otherwise expressly limited, all Physicians, Psychologists and Advanced Practice Providers.

21. Psychologist means an individual who is licensed to practice psychology in the State of New Jersey.

22. Telemedicine means the delivery of a health care service using electronic communications, information technology, or other electronic or technological means to bridge the gap between a health care provider who is located at a distant site and a patient who is located at an originating site, either with or without the assistance of an intervening health care provider. For purposes of these Bylaws, the definition of Telemedicine includes Telehealth.

23. Telehealth means the use of information and communications technologies, including telephones, remote patient monitoring devices, or other electronic means, to support clinical health care, provider consultation, patient and professional health-related education, public health, health administration, and other services. Telemedicine and telehealth do not include the use, in isolation, of audio-only telephone conversation, electronic mail, instant messaging, phone text, or facsimile transmission.

24. Written Notice means written notification sent by hand delivery with a signed receipt, certified mail, return receipt requested, or a commercial delivery service which obtains a signed receipt upon delivery or delivery confirmation.

25. These Bylaws apply with equal force to both sexes. As used in these Bylaws, the singular shall be read to include the plural and vice versa, as the context permits. The captions or headings are for convenience only and none shall be interpreted as limiting, defining the scope of, broadening or affecting any substantive provision.

Article 1

Name

1.1. Name

The name of this organization shall be the Medical Staff of the AtlantiCare Regional Medical Center.

Article 2

Purposes, Responsibilities and Communication

2.1. Purposes

The purposes of the Medical Staff are:

(a) To initiate and maintain a formal organizational structure for self-government of the Medical Staff, as an integral part of the Hospital, subject to the ultimate authority of the Board of Governors;

(b) To serve as the primary means for accountability to the Board of Governors for the appropriateness of the professional performance of Practitioners and APPs authorized to practice in the Hospital and the quality of medical care, treatment and services provided to patients;

(c) To delineate the Clinical Privileges of, and monitor and evaluate quality of care provided by, Practitioners and APPs to patients of the Hospital and to provide a mechanism to create a uniform standard of quality patient care, treatment and services;

(d) To provide a means through which the Medical Staff may participate in the Hospital's policy making and planning process, so that the Medical Staff is represented in any discharge of Medical Staff responsibilities;

(e) To provide education to patients and their families and to Members of the Medical Staff, and to ensure that a continuing active medical education program

is maintained and prioritized by the Medical Staff, including regular Hospital-sponsored programs;

(f) To provide oversight of the quality of care, treatment and services provided by the Medical Staff and to provide for a uniform quality of patient care, treatment and services;

(g) To contribute to the scientific advancement of the Staff, by maintaining educational standards and by encouraging research activities and providing opportunities for the conduct of research;

(h) To ensure that all patients admitted to or treated in any of the facilities of the Hospital receive appropriate and uniform care so far as the Hospital can provide such care, regardless of a patient's race, color, creed, physical or mental disability, sexual orientation or national origin; and

(i) To work with clinical leaders in providing advice about the sources of clinical services to be provided through contracted agreements.

2.2. Communication

Communication between the Medical Staff, administration and the Board of Governors shall occur by the following mechanisms:

(a) The CEO or designee shall attend all Medical Staff Meetings. Other administrative personnel and members of the Board of Governors may attend.

(b) Administrative personnel may be invited to attend Department and Division meetings.

(c) The CEO, hospital administrators, and corporate nurse executive may attend Executive Committee meetings ex-officio without voting privileges.

(d) Designated Medical Staff officers shall serve on the Board of Governors and other members of Medical Staff may serve on Board committees as delineated in the Bylaws of the Board of Governors of the AtlantiCare Regional Medical Center.

2.3. Participation in Performance Improvement Activities

The Medical Staff and Advanced Practice Provider ("APP") Staff shall participate in the following performance improvement activities:

(a) Education of patients and their families;

(b) Coordination of care, treatment and services with other Practitioners, APP Staff and Hospital personnel as relevant to the care, treatment and services of individual patients;

(c) Accurate, timely and legible completion of patient medical records;

(d) Determining the use of findings of the assessment process that are relevant to a Provider's performance in the ongoing evaluation of the Provider's competence; and

(e) Communication of findings, conclusions, recommendations and actions to improve performance to appropriate Medical Staff Members, the Executive Committee and the Board of Governors.

Article 3

Medical Staff Membership

3.1. Nature of Medical Staff Membership

Membership on the Medical Staff of the AtlantiCare Regional Medical Center is a privilege which shall be extended only to professionally competent Practitioners who continuously meet and comply with the qualifications, standards and requirements set forth in these Bylaws. Membership and Clinical Privileges are granted without regard to age, race, color, gender, national origin/identity, handicap, religion, sexual preference or other criteria which do not concern: the delivery of quality patient care; the applicant's professional ability and judgment, moral character and ethical conduct; the applicant's ability to work with others, and willingness, availability and ability to discharge Medical Staff responsibilities and comply with the Medical Staff Bylaws, Rules and Regulations; the availability of adequate facilities and support services; or community need.

3.2. Criteria for Membership

Only Practitioners licensed to practice in the State of New Jersey who meet the qualifications provided for in these Bylaws shall be qualified for Membership on the Medical Staff. No Practitioner shall be entitled to Membership on the Medical Staff or to exercise particular Clinical Privileges in the Hospital merely by virtue of the fact that they are duly licensed to practice in New Jersey or any other state or that they are a member of any professional organization, or that they are affiliated with any other institution, medical group, third party payor or managed care organization, or that they had in the past, or presently have, such privileges at another hospital.

3.2-1. Licensure and Competence

Members of the Medical Staff shall document their experience; background; training; current licensure; current NJ Medicaid enrollment number; current enrollment in the Medicare program for members of the Active Staff and current enrollment or opt-out status in the Medicare program for members of the Visiting Staff and those current members of the Active Staff who maintained opt-out status as of April 1, 2019, current CDS and DEA status (the applicant may supply evidence of an active DEA in any State so long as a current NJ DEA is supplied before the applicant exercises Clinical Privileges); demonstrated current competence; current physical and mental status relevant to privileges requested; can provide evidence of

required health screenings and mandatory vaccinations as determined by the Medical Staff; adherence to the ethics of their profession; good reputation; compliance with applicable laws, rules and regulations; ability to meet Departmental criteria; and ability to meet geographic requirements necessary to assure timely and continuous care for their patients as approved by the Board sufficiently to assure the Medical Staff and Board that any patient treated by them in the Hospital will be given appropriate medical care.

3.2-2. Professional Standing

Members of the Medical Staff shall demonstrate their good reputation and their ability to work with others.

3.2-3. Legal Requirements

Members of the Medical Staff shall adhere to applicable laws, rules and regulations, and regulatory standards, including those which permit payment to the Hospital for services ordered or provided by such Members.

3.2-4. Malpractice Insurance

Members of the Medical Staff shall demonstrate their maintenance of malpractice insurance in amounts no less than $1,000,000 per occurrence and $3,000,000 in the aggregate, or, in the case of Members employed by the Hospital, evidence of self-insurance in no less than such limits and shall demonstrate a satisfactory claims loss history as required by law.

3.2-5. Ethics

Each Member of the Medical Staff and applicant for Membership shall:

(a) Follow the ethical principles of their profession;

(b) Seek consultation when necessary, and shall not deceive a patient as to the identity of an operating surgeon, or any other medical Practitioner providing treatment or services;

(c) Not delegate the responsibility for diagnosis or care of hospitalized patients to another medical Practitioner unless they believe such Practitioner to be qualified to undertake this responsibility; and

(d) Not engage in any activity which would be fee splitting or fraudulent or abusive under federal or state law.

3.2-6. Board Certification, Qualification and Recertification

Applicants for Medical Staff Membership after October 25, 2011 shall have board certification by the American Board of Medical Specialties, the American Board of Osteopathic Specialties, or other certifying boards approved by the Executive Committee, or be qualified (in the tracking process) for certification, in accordance with the requirements of their specialty. If

in the tracking process, board certification must be obtained within five (5) years of completion of post-graduate training. Nothing in this provision shall be inferred to relieve those in the tracking process as of October 25, 2011 from the obligation to obtain and maintain board certification. Practitioners shall also maintain certification and be recertified in their specialty consistent with the requirements of the applicable board. If board certification or recertification is not obtained, the Practitioner's Medical Staff appointment will be terminated and considered a voluntary relinquishment of Membership and Clinical Privileges. It is the intent of the Medical Staff that all members of the Medical Staff be board certified and recertified.

(a) Termination under this section will not entitle a Practitioner to the rights in Article 8;

(b) The Executive Committee may assess and recommend the waiver of requirement for Board certification, Board qualification or maintenance of certification based on clinical need if current clinical competence is demonstrated, for the period of the appointment or reappointment as applicable;

(c) A Board qualified Physician may be appointed to the Division which is applicable to their subspecialty boards, pending board certification; and

(d) Notwithstanding the foregoing, Physicians who have served on the Medical Staff for no less than twenty (20) years without interruption of service, who have continually maintained Board certification and who have no quality concerns, may upon request to the Credentials Committee at the time of reappointment, and approval by the Executive Committee and the Board, be relieved of the obligation for maintaining Board certification after the expiration of such Physician's current certification.

3.2-7. <u>Conviction of a Crime</u>

No Practitioner or APP who is an applicant after May 1, 2017 shall have been convicted of, or entered a plea of guilty or no contest to any felony or indictable crime or any misdemeanor relating to controlled substances, illegal drugs, insurance, healthcare fraud, or violence. Notwithstanding the foregoing, Providers with misdemeanors or motor vehicle/traffic violations involving drugs or alcohol such as but not limited to DUIs and refusal to consent to testing with no other history of felony or indictable crimes may petition the Executive Committee for a waiver of this provision for good cause, which may be granted in the Executive Committee's discretion subject to approval of the Board.

3.2-8. <u>Waiver</u>

The Executive Committee may assess and recommend the waiver of the requirements of §3.2 based upon clinical need if current clinical competence, licensure and malpractice coverage is demonstrated, for the period of the appointment or reappointment as applicable. The Joint Conference/Medical Affairs subcommittee shall specifically consider the waiver prior to action on the application or appointment or reappointment.

3.3. Conditions and Duration of Appointment

Initial appointments and reappointments to the Medical Staff shall be made by the Board.

3.3-1. Medical Staff Role

The Board shall act on all appointments, reappointments or revocation of appointment only after there has been a recommendation from the Executive Committee as provided by these Bylaws.

(a) In the event of unwarranted delay (more than one hundred eighty (180) Days from the date that an application for appointment or reappointment is completed and verified) on the part of the Executive Committee, the Joint Conference/Medical Affairs Committee shall review the application and make a recommendation to the Board. The Joint Conference/Medical Affairs Committee may act without Executive Committee recommendations on the basis of documented evidence of the applicant's or Staff Member's professional and ethical qualifications which must be similar to the type of evidence which would be used by the Executive Committee in making its recommendations, obtained from reliable sources other than the Medical Staff;

(b) The Joint Conference/Medical Affairs Committee shall send its recommendation to the Board. Prior to acting without an Executive Committee recommendation, the Board shall notify the Executive Committee of its intent and shall designate an action date prior to which the Executive Committee may still fulfill its responsibility.

3.3-2. Duration of Appointments

Initial appointments and reappointments shall be for no more than two (2) years. Notwithstanding the foregoing, Practitioners and APPs may not commence the exercise of Clinical Privileges until they have completed the Hospital's orientation requirements.

3.3-3. Clinical Privileges of Appointment

Appointment to the Medical Staff shall confer on the appointee only such Clinical Privileges as have been approved by the Chair of the Department in which the Practitioner is appointed and otherwise approved in accordance with §5.3, which are granted by the Board in accordance with these Bylaws.

3.3-4. Responsibilities of Staff Membership

Each applicant or Member of the Medical Staff is subject to the following continuing obligations:

(a) To provide their patients with a level of care commensurate with generally recognized criteria of quality;

(b) To provide continual care and supervision of their patients in the Hospital;

(c) To abide by the Medical Staff Bylaws and all other standards, policies and Rules and Regulations of the applicable Division, Department, Medical Staff and Hospital, including all policies related to conduct and behavioral expectations;

(d) To notify the Medical Staff Office in writing, within five (5) days of receiving information pertinent to any question in the most recent appointment or reappointment application and/or which bears upon the applicant's or Member's eligibility and qualifications as described in these Bylaws, including, but not limited to: changes in contact information including practice affiliation; changes in licensure; changes in certification or registration status including CDS and DEA; changes in Medicare, Medicaid or other federal or state health care status or sanctions; arrest, charges, indictment, conviction, plea of guilty or no contest to motor vehicle/traffic violations involving drugs or alcohol (including but not limited to DUIs and refusal to consent to testing); arrest, charges, indictment, conviction, plea of guilty or no contest to a felony, indictable crime, or a misdemeanor related to controlled substances, illegal drugs, insurance or healthcare fraud or violence or to the Member's fitness to practice medicine; sanctions by the Board of Medical Examiners including, but not limited to, entry into a Consent Order and/or reprimands not specifically designated as private; changes in other hospital and other affiliations where the Member has medical staff status such as hospitals and ambulatory surgery centers; changes in designated back-up coverage; changes in malpractice insurance; and changes to those representations made in §5.2 of these Bylaws;

(e) To discharge such Staff, Department, Division, committee and Hospital functions for which the Member is responsible by appointment, election or otherwise;

(f) To prepare and complete in a prescribed manner the medical and other required records for all patients the Member admits or treats in the Hospital or its constituent facilities, Departments and services;

(g) To abide by the ethical standards established as the basis for Membership;

(h) To cooperate with the Hospital in complying with technical and substantive requirements of third-party payers, pursuing appeals or reconsideration of denials or reimbursement and in all dealings with third-party payers;

(i) To participate in and collaborate with the peer review, risk management, performance improvement, quality and utilization management activities of the Hospital and Medical Staff;

(j) To undergo any type of health evaluation, including random or "for cause" substance testing, as requested by the Chief Medical Officer, CPE and/or the Executive Committee when, in their reasonable judgment, it appears necessary to protect the well-being or patients and/or staff or the Hospital or as part of an evaluation of the Member's ability to exercise Clinical Privileges safely and

competently or as part of a post-treatment monitoring plan and to supply evidence of compliance with health screenings/testing and vaccinations required in policies applicable to the Medical Staff from time to time; and

(k) To participate in any type of competency evaluation when determined necessary by the Executive Committee and/or Board to properly delineate the Member's requested or current Clinical Privileges.

(l) To arrange for coverage by a Practitioner of at least the same level, when unavailable.

3.3-5. Dues

Members of the Medical Staff shall pay dues in the amount established by the Medical Staff in accordance with their relevant category of Medical Staff Membership in the manner set forth in the Medical Staff Dues Policy from time to time. Failure to pay dues within thirty (30) Days after Written Notice of delinquency shall be a voluntary relinquishment of Medical Staff Membership and Clinical Privileges without the right to a hearing.

3.3-6. Reporting of Malpractice Cases

Members of the Medical Staff shall notify the Medical Staff Office within fifteen (15) Days of becoming informed of any malpractice action filed against them and within fifteen (15) Days of the resolution of any such action. The Hospital shall notify any Member of the Medical Staff, within fifteen (15) Days of becoming informed of any malpractice action in which the Member is named as a defendant, and within fifteen (15) Days of the resolution of any such action.

3.3-7. Reporting of Adverse Actions

Members of the Medical Staff are obligated to notify the Medical Staff Office within five (5) Days of any changes to the disclosures made in their most recent appointment or reappointment application and those matters set forth in §3.3-4(d).

3.4. Provider Impairment

Members of the Medical and APP Staff are obligated to notify the Medical Staff Office if they have entered into a contract or agreement with any impaired physician committee or similar entity as a result of any substance abuse or other disease or disorder. Providers shall comply with the applicable Impaired Practitioner Policy (the current policy applicable to non-employed Providers is "Impaired Medical Staff Member/Allied Health Professional – Non Employed) and for employed Providers is that policy in addition to the Drug and Alcohol Free Workplace Policy") that addresses the education process for impairment identification; referral issues; investigation and evaluation of the credibility of a complaint, allegation or concern; treatment; maintenance of confidentiality; monitoring of the Provider and safety of their patients; and reporting to the appropriate Department Chair instances of unsafe behavior and related patient care concerns.

Article 4

Categories of the Medical Staff

4.1. Categories of Medical Staff Membership

The Medical Staff shall be divided into the following categories.

Active
Senior
Visiting
Telemedicine

4.2. Active Medical Staff

The Active Medical Staff shall consist of Physicians who admit or participate in the care of patients at the Hospital including performing diagnostic and/or therapeutic procedures at the Hospital and/or its outpatient services and facilities and Psychologists who participate in the care of patients at the Hospital and/or its outpatient services and facilities. Active Medical Staff Membership may be granted with or without admitting privileges. Active Medical Staff Members shall be located within sufficient geographic proximity, at the discretion of the Medical Staff, to be able to provide continual care to Hospital patients, consistent with the hospital's on-call policy.

4.2-1. Responsibilities of Active Medical Staff

Each Member of the Active Medical Staff shall meet the basic qualifications for Membership in §3.2 of these Bylaws and shall be appointed to a specific Department. Except as set forth with respect to Active Staff Members under regional contracts or who are Psychologists, members of the Active Medical Staff are required to attend Medical Staff meetings, accept committee assignments, accept clinic assignments, perform emergency service, and accept unassigned patients and consultation assignments in accordance with Department and Medical Staff Rules and Regulations. Members of the Active Medical Staff are responsible for oversight activities. Active Medical Staff Members shall pay dues.

4.2-2. [Reserved]

4.2-3. Prerogatives of Active Medical Staff

Physician Members of the Active Medical Staff shall be eligible to hold elective office, to chair committees, to serve on Medical Staff Committees, and to vote.

4.2-4. Psychologist Members of the Active Medical Staff

Psychologists shall provide care subject to overall medical management by the attending Physician. Psychologists shall be permitted to write orders within the scope of their licenses and shall record appropriate reports of examinations and treatments. They may attend Medical Staff meetings but may neither vote at Medical Staff or Department meetings nor hold office. They

may be requested to serve on Medical Staff committees in which case they shall serve without vote.

4.2-5. Senior Medical Staff

Active Medical Staff Members who have reached the age of sixty-five (65) or who have provided at least twenty (20) years of service on the Medical Staff may apply for Membership on the Senior Medical Staff. Each Member of the Senior Medical Staff shall meet the basic qualifications for Membership in §3.2 of these Bylaws.

4.2-6. Prerogatives of Senior Medical Staff

Physician Members of the Senior Medical Staff shall be eligible to hold elective office, to chair committees, to serve on Medical Staff Committees, and to vote.

4.2-7. Responsibilities of Senior Medical Staff

Members of the Senior Medical Staff are required to attend Department meetings on quality issues. They are not required to attend Medical Staff meetings or accept committee assignments. Senior Medical Staff Members may be relieved of their emergency on-call service, interpretation, and/or clinic obligations, at the discretion of the Department Chair, depending upon the availability of other Physicians to provide such coverage. Senior Medical Staff must apply for, and be approved by the Department Chair, for removal from their emergency on-call service, interpretation, and/or clinic obligations during each reappointment cycle. Senior Medical Staff Members are required to pay dues.

4.3. Medical Staff Alumni

Medical Staff Alumni shall be those Physicians who have been appointed to such status by the Board upon recommendation of the Executive Committee by virtue of longstanding service to the Medical Staff or age. They shall not have Clinical Privileges, admit patients or be responsible for their care. They shall relinquish any previously granted access to view patient medical records. They shall not have voting privileges. They are not required to attend meetings or pay dues. Medical Staff Alumni are not Members of the Medical Staff.

4.4. Visiting Medical Staff

The Visiting Medical Staff shall consist of Physicians who meet the basic qualifications for Membership in §3.2 of these Bylaws. Visiting Staff Physicians shall not have Clinical Privileges but may review patient hospital charts and/or computerized medical records. They may not make entries into the inpatient encounter section of the patient's chart or computerized medical record. Physicians seeking Visiting Staff membership will follow the application procedure as outlined in Article 5 of the Bylaws. They will not be eligible to vote or hold office. They will be required to pay the initial appointment fee, reappointment fee and dues. They may serve on committees and attend meetings but have no vote.

4.5. Telemedicine Staff

The Telemedicine Staff shall consist of Providers who meet the basic qualifications for Membership on the Medical or APP Staff contained in these Bylaws, and provide care to patients of the Hospital remotely from an outside facility. Except for telepsychiatrists who may be granted admitting privileges, Telemedicine Staff may not admit but may attend, consistent with the Clinical Privileges granted to them, patients of the Hospital. They may serve and vote on committees if assigned. They will not be required to attend Staff, Division or Department meetings and may not vote if they do attend such meetings. They may not hold elective office or chair committees. Providers on the Telemedicine Staff are required to pay dues, and to pay initial application fees and reappointment application fees.

4.6. Administrative Physicians

The Board, after seeking and considering the advice and recommendations of the Executive Committee, may appoint Physicians, who hold an administrative role at the Hospital ("Administrative Physicians"), to the Medical Staff with or without Clinical Privileges. An Administrative Physician shall qualify for Medical Staff Membership and Clinical Privileges, if applicable, in accordance with these Bylaws. Administrative Physicians not seeking Clinical Privileges shall not be required to meet the Board Certification requirements contained in these Bylaws. The terms of an Administrative Physician's employment agreement shall govern all other aspects of the relationship between the Administrative Physician and the Hospital.

4.7. Advanced Practice Provider Staff

APP Staff are APPs including but not limited to, Advanced Practice Nurses including Advance Practice Nurses/Anesthesia, Physician Assistants, and Certified Nurse Midwives, employed by the Hospital or other entities within AtlantiCare Health System or sponsored and employed by an Active Medical Staff Member to assist that Staff Member in their personal practice in the Hospital. They shall practice either in collaboration with (for the prescriptive practice of Advanced Practice Nurses and Certified Nurse Midwives) or under the supervision and direction (for PAs) of a Member of the Active or Senior Medical Staff, consistent with the Clinical Privileges of such Associated Physician Active Medical Staff Member. Although APP Staff are granted Clinical Privileges through Medical Staff channels, they are not Members of the Medical Staff. Initial appointments shall be for no more than two (2) years. The applicant must demonstrate continuing current clinical competence.

4.7-1. Review of Applicant Credentials

The applications of APP Staff for Clinical Privileges shall be reviewed and approved by the Medical Staff as set forth herein. APPs shall complete the same application and be subject to the same appointment and reappointment processes as Physicians, as described in Article V. The basis for approval is the same regardless of the APP's employment status, but the review mechanism for approval differs as set forth herein, depending on who employs the applicant.

(a) No APP shall provide services in the Hospital unless and until the Department Chair has received from the Associated Physician an application form approved by the Board, which shall include information regarding:

(i) Current licensure in the field of the APP in the State of New Jersey;

(ii) Current certification from the New Jersey State Board of Nursing or the New Jersey Board of Medical Examiners, or other applicable State Regulatory Agency;

(iii) Current NJ Medicaid enrollment number and current enrollment or opt-out status in the Medicare program as applicable to their practice;

(iv) CDS and DEA registration (for APP Staff as appropriate);

(v) For initial appointments, three (3) professional peer references, at least one (1) of which must be from the Department Chairs or Program Director of past affiliations, as applicable. For reappointments, applicants with low/no volume during the prior period of appointment may supply one (1) peer reference in lieu of the Division Director or Department Chair reference;

(vi) Evidence of physical and mental health status relevant to the requested scope of Clinical Privileges along with evidence of vaccinations, testing, and health screenings as required by policy or applicable law;

(vii) Evidence of current malpractice insurance in amounts required by the Hospital;

(viii) National specialty certification in the field of primary practice, if applicable;

(ix) APPs shall maintain their certifications and be recertified in accordance with the requirements of the applicable board if and as applicable. If applicable board certification or recertification is not obtained, the APPs appointment will be terminated and considered a voluntary relinquishment from the APP Staff and of all Clinical Privileges.

(x) Continuing education requirements for board certification/licensure, which in part must relate to the Clinical Privileges requested;

(xi) A collaborative agreement on a form prescribed by the Hospital;

(xii) A delineation of Clinical Privileges or a job description signed by the Associated Physician as applicable to the Physician Assistant, Advanced Practice Nurse, or Certified Nurse Midwife; and

(xiii) Signed authorization/release form.

(b) The application shall be signed by the Associated Physicians and the appropriate Medical Staff Committee or Medical Staff Officer may discuss the application and any concerns with the Associated Physician; and

(c) The Chair of the Department in which the APP shall exercise Clinical Privileges shall review the APP's application and recommend the scope of Clinical Privileges for such individual to the Credentials Committee.

At its next meeting, the Credentials Committee shall review the APP's application and the Department Chair's recommendations.

4.7-2. Review of the Application of the Advanced Practice Provider

The Credentials Committee shall recommend to the Executive Committee that it either grant or deny the scope of Clinical Privileges for the APP, outlined by the Department Chair.

(a) At its next meeting, the Executive Committee shall review the application and the recommendations of the Department Chair and the Credentials Committee and shall recommend to the Board either to grant or deny to the APP the requested scope of Clinical Privileges.

(b) An adverse decision by the Board of Governors in regard to the initial grant of Clinical Privileges to an APP who is not an employee of the Hospital shall entitle the applicant to an Article 8 Fair Hearing by the Board.

(c) If the Executive Committee intends to deny or reduce the scope of Clinical Privileges requested for an APP who is an employee of the Hospital, it shall provide the Hospital with the opportunity to discuss the proposed delineation before any final action is taken on it by the Board. This meeting shall be informal. The meeting shall not be a hearing. No lawyers shall advise any parties during the meeting and the rules of evidence shall not pertain to this meeting. The Executive Committee shall thereafter make its recommendation to the Board, which shall make its determination at the next meeting after the Executive Committee's final determination. Executive Committee, Board or Hospital decisions shall be reviewable only in accordance with the Hospital's general personnel policies or as set forth in the contract between the Hospital and the APP as applicable.

4.7-3. Termination of Advanced Practice Provider Provision of Patient Care Services

An APP who is employed by a Member of the Active Medical Staff may provide direct patient care in the Hospital pursuant to the approved scope of Clinical Privileges only so long as such individual remains an employee of the Associated Physician. The APP's Clinical Privileges may also be terminated upon the occurrence of any of the following events:

(a) The termination of the Medical Staff Membership or Clinical Privileges of the employing Associated Physician; and

(b) Loss of the APP's professional liability insurance coverage, license, certification or other necessary regulatory status.

4.7-4. Responsibilities of Advanced Practice Provider Staff

APP Staff shall not be entitled to the rights, privileges, and responsibilities of appointment to the Medical Staff and may only engage in acts within the scope of Clinical Privileges specifically granted by the Board. Each APP shall agree:

(a) To provide patients with a level of care commensurate with generally recognized criteria of quality;

(b) To provide continual care and supervision of patients in the Hospital;

(c) To abide by the Bylaws and all other standards, policies and Rules and Regulations of the applicable Division, Department, APP Staff and Hospital including all policies related to conduct and behavioral expectations;

(d) To notify the Medical Staff Office within five (5) days of receiving information pertinent to any question in the most recent appointment or reappointment application and/or which bears upon the APPs eligibility and qualifications as described in these Bylaws, including but not limited to: changes in contact information including practice affiliation; changes in licensure; changes in certificate or registration status including CDS and DEA as applicable; changes in Medicare, Medicaid or other federal or state health care status or sanctions as applicable; arrest, charges, indictment, conviction, plea of guilty or no contest to motor vehicle/traffic violations involving drugs or alcohol (including but not limited to DUIs and refusal to consent to testing); arrest, charges, indictment, conviction, plea of guilty or no contest to a felony, indictable crime or to a misdemeanor related to controlled dangerous substances, illegal drugs, insurance or healthcare fraud or violence or to the APP's fitness to practice; sanctions by the applicable licensing or certifying Board including, but not limited to, entry into a Consent Order and/or reprimands not specifically designated as private; changes in the designation of the APP's Associated Physician; changes in the APP's other hospital and other affiliations where the APP has affiliate or medical staff status such as ambulatory surgery centers; changes in back-up coverage; changes in malpractice insurance; and changes to those representations made in § 5.2 of these Bylaws;

(e) To discharge such APP Staff, Department, Division, Committee and Hospital functions for which the APP is responsible by appointment, election or otherwise;

(f) To prepare and complete in a prescribed manner the medical and other required records for all patients the APP treats in the Hospital or its constituent facilities, Departments and services;

(g) To abide by ethical standards established as the basis for APP Staff Membership;

(h) To cooperate with the Hospital in complying with technical and substantive requirements of third-party payers, pursuing appeals or reconsideration of denials or reimbursement and in all dealings with third-party payers;

(i) To participate in and collaborate with the peer review, risk management, performance improvement, quality and utilization management activities of the Hospital and Medical Staff;

(j) To undergo any type of health evaluation, including random or "for cause" substance testing, as requested by the Chief Medical Officer and/or the Executive Committee when, in their reasonable judgment, it appears necessary to protect the well-being of patients and/or staff or the Hospital or as part of an evaluation of the APP's ability to exercise Clinical Privileges safely and competently or as part of a post-treatment monitoring plan and to supply evidence of compliance with health screenings/testing and vaccinations required in policies applicable to the APP Staff from time to time;

(k) To participate in any type of competency evaluation when determined necessary by the Executive Committee and/or Board to properly delineate the APP's requested or current Clinical Privileges; and

(l) To authorize the appropriate Medical Staff Committee or Medical Staff officer to discuss any concerns regarding the APP's application or reapplication, peer review, competency evaluations, qualifications and activities within the Hospital with the APP's Associated Physician.

4.7-5. <u>Prerogatives of Advanced Practice Provider Staff</u>

APP Staff shall exercise their scope of Clinical Privileges within the Hospital as follows:

(a) Physician Assistants shall provide care only under the continuous supervision of the Associated Physician. Continuous supervision of a PA shall not require the actual physical presence of the Associated Physician, unless such supervision is required by state law or regulation or by federal laws, rules or regulations including those concerning reimbursement. In the absence of actual Physician presence, the PA's Associated Physician shall maintain contact through electronic or telephonic communication;

(b) The number of APP Staff providing care under the supervision of or with the collaboration of any Medical Staff Member, as well as the acts they may undertake, shall be consistent with applicable state statutes and regulations, the Rules and Regulations of the Medical Staff and the policies of the Board; and

(c) It shall be the responsibility of the employing Physician, or the Hospital if such APP is employed by the Hospital, to provide professional liability insurance for the APP in the amounts of one million dollars ($1,000,000) per occurrence and

three million dollars ($3,000,000) in the aggregate or, in the event of APP Staff employed by the Hospital, evidence of self-insurance in no less than such limits.

4.7-6. Visiting Advanced Practice Provider Staff

The Visiting APP Staff shall consist of APP who meet the basic qualifications contained in §4.7 of these Bylaws. Visiting APP Staff shall not have Clinical Privileges, but may review patient hospital charts and/or computerized medical records. They may not make entries into the inpatient encounter section of the patient's chart or computerized medical record. APP seeking Visiting APP Staff status shall follow the application procedure as outlined in the Bylaws.

Article 5

Procedures for Appointment and Reappointment

5.1. Application Process

The Medical Staff shall oversee the quality of care, treatment and services by recommending Members of the Medical and APP Staff for appointment to the Medical or APP Staff in accordance with this Article 5. Each Practitioner or APP who seeks to apply for Membership in the Medical or APP Staff shall be provided with an application packet which shall include a pre-application form, a summary of the appointment process and the applicant's responsibilities, and a copy of the Medical Staff Bylaws and Rules and Regulations.

5.1-1. Pre-Application Process

An interested Provider shall complete a pre-application process which provides sufficient basic practice data to permit the Hospital to determine that the Provider meets the basic qualifications for Medical Staff or APP Staff Membership and is eligible to apply for such Membership.

5.1-2. Grounds for Not Providing Application Form

No application for appointment shall be provided to a Provider, nor shall an application be accepted from a proposed applicant, if it is determined based on information from a pre-application questionnaire or any other source that:

(a) The Hospital does not have the ability to provide adequate facilities or services for the applicant or the patients to be treated by the prospective applicant;

(b) The prospective applicant is not participating in Medicare if the applicant is applying to the Active or Senior Staff and/or is currently suspended or excluded or has been excluded from participation in Medicare or Medicaid;

(c) The prospective applicant does not meet the requirements relating to licensure and registration, professional liability insurance, board certification, CDS/DEA status as applicable, or reapplication after adverse decision;

(d) The prospective applicant is not a type of Provider approved by the Board of Governors to provide patient care services in the Hospital;

(e) The Provider has been convicted of or entered a plea of guilty or no contest to: (i) any felony or, (ii) a misdemeanor related to the Provider's fitness to practice medicine;

(f) The Provider is seeking Clinical Privileges and/or assignment to a Department that is subject to an exclusive contract at the Hospital, unless they are a party to such contract; and/or

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

No application for reappointment shall be provided to a Provider who is currently a member of the Medical Staff or holds Clinical Privileges if the Provider has not provided requested information or documents or has not responded to requests for comments concerning peer review or quality improvement matters or the Provider's qualification for Medical Staff or APP Staff membership and privileges, provided the staff member has received Written Notice of the requested information and has not responded within sixty (60) days.

The applicant or prospective applicant shall be advised of the information relied on as grounds for not providing an application and the applicant or prospective applicant shall have a reasonable opportunity to submit information or evidence that the information relied on is not accurate.

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

5.2. Application for Appointment

An application for appointment to the Medical Staff shall be in writing on an approved form obtained from the Medical Staff Office and shall require information including but not limited to that set forth in these Bylaws, and shall be signed by the applicant. The processes described in §5.2-§5.7 apply to all contract physicians.

5.2-1. Application Contents

The application form shall require detailed information concerning the applicant's professional qualifications and shall include, but not be limited to, the following:

(a) Evidence of professional education; compliance with New Jersey continuing education requirements which in part must relate to the Clinical Privileges requested, unless the applicant has completed a residency or fellowship training within the past six (6) months; current professional licensure; malpractice insurance; current NJ Medicaid enrollment number; current enrollment in the Medicare program for applicants seeking Active or Senior Staff status and current

enrollment or opt-out status in the Medicare program for applicants seeking Visiting Staff status; and CDS and DEA registration if applicable;

(b) The names of at least three (3) persons in the same professional discipline who have had experience in observing and working with the applicant, who are not affiliated by either family relationship or professional and financial association with the applicant (e.g. partners, shareholders, or employees in the same practice), and who can provide adequate references pertaining to the applicant's current professional competence, ethics, ability to work with others, and character;

(i) If the Physician applicant is within three (3) years of completing a residency or other training program, one reference must include the director of that training program; and

(ii) If the Physician applicant is not within three (3) years of completing a residency or other training program, two (2) of the references shall be from individuals in the specialty of the Department in which the applicant seeks Clinical Privileges.

(c) For APP Staff, at least one (1) reference must be a Department Chair or Program Director of past affiliations, as applicable;

(d) For the ten-year period preceding the application, the applicant's malpractice claims/settlements/judgments history within the Hospital and at all other practice settings and employers;

(e) Information as to whether the applicant's Medical Staff or APP Staff Membership status, and/or Clinical Privileges have ever been (or such action is currently pending) voluntarily or involuntarily relinquished, revoked, suspended, surrendered, reduced, or non-renewed at any other hospital or institution including but not limited to ambulatory surgery centers;

(f) The applicant's physical and mental health status as relevant to the specific Clinical Privileges, including a statement by the applicant that no health problems exist that could affect the applicant's ability to perform the Clinical Privileges requested which statement shall be maintained in the applicant's credentials file at all times along with evidence of vaccinations, testing, and health screenings as required by policy or applicable law; whether the applicant's license to practice any profession in any jurisdiction or their CDS or DEA registration has ever been (or such action is currently pending) voluntarily or involuntarily relinquished or surrendered, suspended, terminated, or otherwise limited; whether the applicant has ever voluntarily or involuntarily withdrawn from, relinquished or surrendered participation in, been suspended from, terminated from, been limited under, or has ever been or is presently the subject of sanctions or investigations under Medicare, Medicaid, other federal payment, professional health care organizations, drug control authorities, third party payors, managed care organizations programs any program under the federal Social Security laws, or

any program under the jurisdiction of the federal Department of Health and Human Services;

(g) Evidence of the applicant's professional liability insurance coverage in the amount considered adequate by the Board, but not in amounts less than $1,000,000 per occurrence and $3,000,000 in the aggregate, in the form of an original document;

(h) Whether the applicant has entered into a contract or agreement with an impaired physician's committee or similar entity as a result of any substance abuse or other disease or disorder;

(i) Whether the applicant has ever been arrested, charged, indicted, convicted of or entered into a plea of guilty or no contest to any felony or indictable crime or any misdemeanor relating to their fitness to practice medicine or as an APP, controlled dangerous substances, illegal drugs, insurance fraud or abuse, or violence;

(j) Whether the applicant has ever been arrested, charged, indicted, convicted of or entered into a plea of guilty or no contest to a motor vehicle/traffic violation involving drugs or alcohol (including but not limited to DUIs and refusal to consent to testing);

(k) Whether the applicant currently uses illegal substances;

(l) Whether the applicant is the subject of any investigation by any state board of medical examiners or professional board;

(m) Whether the applicant has any pending actions against their medical or professional license in any jurisdiction;

(n) Whether the applicant's Board Certification or national certification has ever been or currently is voluntarily or involuntarily relinquished, surrendered, suspended, terminated, or otherwise limited; and

(o) APP applications shall further include:

    (i) A collaborative agreement on a form prescribed by the Hospital;

    (ii) A delineation of Clinical Privileges or a job description signed by the Associated Physician as applicable; National specialty certification; and

    (iii) For APNs, an Advanced Practice Nurse Certification issued by the New Jersey Board of Nursing.

5.2-2. Applicant's Burden

The applicant shall have the burden of producing adequate information for a proper evaluation of their competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications, and a release signed by the applicant as described in §5.2-3.

(a) Neither the Board, the Chief Executive Officer, nor the Medical Staff shall have any duty or obligation to review any application until the applicant completes it in all respects and submits it as required in a properly executed and unmodified manner and all required information and supporting materials are received in accordance with the provisions of these Bylaws;

(b) The failure of an applicant to complete an application after notice, or to timely supply requested information, or to supply a modified application shall be deemed a voluntary withdrawal of such application;

(c) An application is complete only when the process of verification as required in §5.3-1 has been completed; and

(d) The applicant shall attest to the truth of the information submitted, and any omission or misstatement therein shall be grounds for denial of the application and termination of Membership and/or Clinical Privileges if discovered after appointment. A termination pursuant to this provision shall be processed as if a denial of initial appointment and shall entitle the applicant to a fair hearing under Article 8 of these Bylaws.

5.2-3. Effect of Application

By applying for appointment or reappointment to the Medical Staff or APP Staff, each applicant shall undertake the following obligations:

(a) Signify their willingness to participate in interviews in regard to their application;

(b) Authorize the Hospital to consult with Members of the medical staffs of other hospitals, facilities, institutions and practice settings with which the applicant has been associated, and with others who may have information bearing on the applicant's competence, character and ethical qualifications;

(c) Consent to the Hospital's inspection of all records and documents including otherwise confidential information that may be material to an evaluation of the applicant's professional qualifications, competence, character, morals and ethics to carry out the requested Clinical Privileges as well as the applicant's moral and ethical qualifications for Staff Membership;

(d) Agree not to sue and release from any liability all representatives of the Hospital and its Medical Staff and their designees including without limitation any credentialing verification organization for their acts performed in connection with

evaluating the applicant's qualification, competence, character, moral, ethical and other qualifications;

(e) Agree not to sue and releases from any liability, and consent to and direct the production of information, by all individuals and organizations who possess and/or provide information, in writing or oral form, to the Hospital, its Medical Staff and their designees including without limitation credentialing verification organizations, concerning the applicant's competence, character, morals, ethics, and other qualifications for Staff appointment and Clinical Privileges, including otherwise privileged or confidential information;

(f) Authorize and consent to Hospital representatives providing other hospitals, or healthcare organizations, third-party payers and insurance companies, medical associations, and other organizations concerned with provider performance and the quality and efficiency of patient care with any information relevant to such matters the Hospital may have concerning the applicant, and release Hospital representatives from liability for so doing; and consent to Hospital representatives obtaining information about any disciplinary action against the applicant or any other information concerning the applicant available from the New Jersey Board of Medical Examiners and the Boards of other states, New Jersey professional licensing boards and the professional licensing boards of other states, the National Practitioner Data Bank, and/or any other relevant source, public or private; and

(g) Agrees to maintain as confidential all information and documents related to patients' condition or treatment, peer review, performance improvement and evaluation, risk management, utilization review, and other information related to the evaluation of the provision of health care or actions or conduct of health care providers.

5.2-4. Applicant's Adherence to Bylaws

The application form shall include a statement that the applicant has received and read the Bylaws and Rules and Regulations of the Medical Staff and that the applicant agrees to be bound by the terms thereof, if they are granted Membership and/or Clinical Privileges, and to act in accordance with the terms thereof without regard to whether or not the applicant is granted Membership and/or Clinical Privileges in all matters relating to consideration of the application. The applicant shall agree that when an adverse ruling is made with respect to their Staff Membership, Staff status, and/or Clinical Privileges, they will exhaust the administrative remedies afforded by these Bylaws before resorting to formal legal action.

5.2-5. Applicant Pledge

The application shall include and each applicant shall execute an ethical pledge to:

(a) Provide for continual care for their patients;

(b) Seek consultation when necessary;

(c) Refrain from delegating the responsibility for diagnosis or care of hospitalized patients to a Provider who is not qualified to undertake this responsibility; and

(d) Provide treatment and medical services without discrimination based upon age, race, color, religion, national origin, sex, sexual preference, handicap, diagnosis, ability to pay, or source of payment.

5.2-6. Basis for Initial Appointment

The appointment of a Medical Staff or APP Staff Member and Clinical Privileges awarded shall be based upon the following professional criteria which are designed to assure the Medical Staff and the Board of Governors that patients will receive quality care, treatment and services: the applicant's current license and/or certification, as appropriate, verified with the primary source; specific relevant training, verified with the primary source; demonstrated professional competence; physical ability to perform the requested privileges; data from professional practice review by an organization(s) that currently grants clinical privileges to the applicant (if available); peer and/or faculty recommendation; clinical judgment and technical skills in the treatment of patients; performance as documented by outside performance improvement activities including practitioner specific information in comparison to aggregate data, and morbidity and mortality data when available; ethics and conduct; current physical and mental status relevant to privileges requested; attestation of compliance with New Jersey continuing medical education requirements that relate to current or requested Clinical Privileges when relevant; and conformity with relevant state and federal regulatory standards. In addition, the applicant shall be evaluated against the following six (6) areas of "general competencies" developed by a joint initiative of the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS): patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and systems-based practice.

5.3. Appointment Process

An applicant shall submit their application to the Medical Staff Office. The Medical Staff Office shall seek to verify information set forth in the application. The verification process shall begin only if the application is complete. Specifically, the Medical Staff Office shall verify that the applicant is the same Provider identified in the application by viewing any of a current hospital picture identification card or a valid picture identification issued by a state or federal agency (e.g., driver's license or passport). Applications that fulfill the Board approved criteria for Category One (expedited credentialing) listed in §5.3-2(a) and receive a favorable recommendation, without limitation, from the Executive Committee will be eligible for the expedited appointment process defined in §5.3-9. This process will be utilized in the event the next regularly scheduled Board of Governors meeting is more than seven (7) days from the date of the Executive Committee's recommendation.

5.3-1. Verification

The Medical Staff Office shall verify information in the application by contacting primary sources, wherever feasible, or a credentials verification organization for such information. Specifically, the Medical Staff Office shall verify the applicant's current licensure at the time of initial granting, renewal and revision of Clinical Privileges and at the time of license expiration, the applicant's education, DEA and CDS registrations, relevant training, work history, board certification (if applicable), history of professional liability claim settlements and judgements, licensure sanctions, restrictions or limitations, Medicare and Medicaid sanctions and exclusions, and the applicant's current competence.

(a) If verification cannot be obtained within sixty (60) Days of a request, the Medical Staff Office shall notify the applicant of their obligation to assist in obtaining verification;

(b) An application deemed incomplete within ninety (90) Days after submission shall be considered to have been voluntarily withdrawn by the applicant; and

(c) In no instance will an appointment be made or Clinical Privileges awarded until the process of verification is complete. Verification includes querying the National Practitioner Data Bank.

5.3-2. Categories of Applications

(a) Category One - Eligible for expedited appointment process;

All criteria listed below must be fulfilled for the applicant to qualify for the expedited appointment process.

(i) The application is complete; and

(ii) The Executive Committee has not made a final recommendation that is adverse or has limitations.

(b) Category Two - Not eligible for expedited appointment process;

(i) The applicant submits an incomplete application; and/or

(ii) The Executive Committee has made a final recommendation that is adverse or has limitations.

5.3-3. Departmental Review

When an application is complete, the Medical Staff Office will transmit it with all supporting documentation to the appropriate Department Chair and Division Director, if applicable.

(a) Within thirty (30) Days of receipt, the Chair of the Department, and the Division Director if applicable, shall review the application and supporting documentation, may conduct a personal interview with the applicant, and document in writing the evaluation of the applicant in the application file;

(b) Upon completion of the review in accordance with Departmental criteria approved by the Medical Executive Committee and the Board of Governors, the Department Chair shall consult with the Division Director, if applicable, and shall transmit a written report and recommendation with the entire application file to the Credentials Committee; and

(c) The Chair's report shall document a recommendation regarding Staff appointment, Staff category, Department and Division, Clinical Privileges to be granted, and any special conditions relating to the appointment. The reason for each recommendation shall be stated and supported by reference to the completed application and all other information considered by the Chair.

5.3-4. Credentials Committee Review

At the next regularly scheduled meeting the Department Chair or the Chair's designee shall present this report to the Credentials Committee. The Credentials Committee shall review the application and all supporting documentation, and such other information available to it as may be relevant to consideration of the applicant's qualifications and may, at its discretion, interview the applicant and request a physical and/or mental health examination.

(a) No later than ninety (90) Days from the completion of and verification of the application, the Credentials Committee shall complete its interview of the applicant, if any, and shall consider the application; supporting documentation; information contained in references and from other available sources; the interview; evidence of the current licensure status, training, experience, character, professional competence, qualifications, ability to perform the requested Clinical Privileges and ethical standing of the applicant; information regarding quality of care, treatment and services; and shall determine whether the applicant has established and meets all the necessary qualifications for the category of Staff Membership and Clinical Privileges requested. The Credentials Committee shall document its report including recommendations concerning Staff appointment, Staff category and Department, Clinical Privileges to be granted and any special conditions relating to the appointment, and transmit the file and all supporting documentation to the Executive Committee.

(b) The Credentials Committee may recommend that the Executive Committee approve, reject or defer action on the application.

(c) The reason for each recommendation shall be stated and supported by reference to the completed application and all other documentation considered.

5.3-5. Executive Committee Review

At its next regularly scheduled meeting, the Executive Committee shall consider the Credentials Committee report and other relevant information available to the Executive Committee. The Executive Committee shall recommend that the applicant be appointed to the Medical or APP Staff, that the applicant be rejected for Membership, or that their application be deferred for future consideration and returned to the Credentials Committee as set forth in this §5.3-6. All recommendations to appoint shall specifically recommend the Clinical Privileges to be granted, which may, where appropriate, be qualified by probationary or other conditions.

(a) As the basis for its recommendation, the Executive Committee shall examine the Credentials Committee report and other available information. If the Executive Committee has questions about the Credentials Committee report or requires additional information in order to make a recommendation, it may defer to the Credentials Committee for further review and it may request an evaluation of an applicant to the Medical or APP Staff if there is doubt concerning the applicant's ability to perform the Clinical Privileges requested.

(b) The reasons for each recommendation shall be documented and supported by reference to the file developed, all of which shall be available to the Board of Governors or its designated subcommittee.

5.3-6. Executive Committee Deferral

When the recommendation of the Executive Committee is to defer the application for further consideration by the Credentials Committee, the Credentials Committee's review must be completed and returned prior to the next regularly scheduled meeting of the Executive Committee. The Executive Committee shall review and act upon the new recommendation as under §5.3-7 of these Bylaws. No application may be deferred more than once without specific exception for due cause noted by the Executive Committee.

5.3-7. Favorable Executive Committee Action

(a) Favorable Executive Committee recommendations, without limitation, for appointment of Providers who fulfill all of the Category One criteria defined in §5.3-2(a), and have been approved by the Department Chair, Division Director and Credentials Committee, shall be submitted promptly to the members of the designated subcommittee of the Joint Conference/Medical Affairs Board of Governors for expedited Board approval. This subcommittee shall include at least two (2) non-physician Board members and the President and Vice-President of the Medical Staff.

(b) Favorable Executive Committee recommendations for appointment of Providers who do not fulfill all of the Category One criteria defined in §5.3-2(a), who have any of the Category Two criteria defined in §5.3-2(b), or who have limitations placed on their appointment, shall be submitted directly to the Board of Governors for consideration at its next regularly scheduled meeting.

5.3-8. Adverse Executive Committee Recommendations

When the recommendation of the Executive Committee is adverse to the applicant either in respect to appointment or to Clinical Privileges, no later than five (5) Days from the date of such recommendation, the Chief Medical Officer shall notify the applicant by Written Notice.

(a) If the applicant exercises their rights under Article 8 of these Bylaws, the Executive Committee shall review and consider the report and recommendations of the Fair Hearing Committee and the hearing record.

(b) If the reconsidered recommendation of the Executive Committee is favorable to the applicant, the favorable reconsidered recommendation shall be transmitted to the Board of Governors for its action.

(c) If such recommendation continues to be adverse, the Chief Medical Officer shall provide Written Notice to the applicant, and shall notify the Chief Executive Officer within five (5) Days of such recommendation. The Chief Executive Officer shall also forward such recommendation and documentation to the Board of Governors, but the Board shall not take any action thereon until after the applicant has exercised or has been deemed to have waived their right to an appellate review as provided in Article 8.

5.3-9. Board Subcommittee Action - Category One applications (expedited appointment)

(a) Expedited appointment requires a quorum of two (2) non-physician Board members and one (1) Physician Board member. Approval is by majority vote. Available subcommittee members shall meet or convene a conference call or otherwise take electronic action where each member can participate in electronic consideration and voting to approve or disapprove the recommendations for appointment within seven (7) days of receipt of such recommendations.

(b) The subcommittee shall make a report to the Board at its next regular meeting for ratification of the expedited appointments by the full Board.

(c) Recommendations for appointment that do not receive subcommittee approval shall be referred back to the Executive Committee at its next regularly scheduled meeting.

5.3-10. Board Action

The Board of Governors shall act upon any final recommendation of Category One or Two applications of the Executive Committee at its next regularly scheduled meeting after receipt of such final recommendation. The Board of Governors shall ratify expedited appointments and reappointments of the designated Joint Conference/Medical Affairs subcommittee at its next regularly scheduled meeting.

(a) If the Board of Governors decision is adverse to the applicant in respect to either appointment or Clinical Privileges, the Chief Executive Officer shall provide Written Notice to the applicant within seven (7) Days of such adverse decision. In the case of denial of Clinical Privileges, such Written Notice shall specify the reason for such denial. Such Written Notice shall notify the applicant of their rights pursuant to the Fair Hearing Plan in accordance with Article 8 of these Bylaws. Such adverse decision shall be held in abeyance until the applicant has exercised or has been deemed to have waived their rights under Article 8 of these Bylaws. The fact that the adverse decision is held in abeyance shall not be deemed to confer Clinical Privileges where none existed before.

(b) After the applicant has exhausted or waived their rights under Article 8, the Board of Governors shall act on the matter.

(c) The Board of Governors may defer final determination by referring the matter back to the Executive Committee for further reconsideration. Any such referral back shall state the reasons therefor, shall set a time limit within which a subsequent recommendation to the Board of Governors shall be made, and may include a directive that the hearing be reopened to clarify issues which are in doubt. The Executive Committee shall report to the Board in accordance with the Board's request for review.

(d) After receipt of such subsequent recommendation, and new evidence in the matter, if any, the Board of Governors shall make a decision either to appoint the applicant to the Staff or to reject the applicant for Staff Membership. All decisions to appoint shall include a delineation of the Clinical Privileges which the applicant may exercise.

(e) If the Medical Staff has failed to act in accordance with these Bylaws, the Joint Conference Medical Affairs Committee may take action on its own initiative to grant Medical or APP Staff Membership and Clinical Privileges in accordance with Article 3 of these Bylaws using the same information the Medical Staff would have considered in rendering a recommendation. If such action is favorable, it shall become effective as the final decision and submitted to the next regularly scheduled meeting of the Board of Governors for ratification. If such action is adverse, the applicant shall be entitled to their rights pursuant to the Fair Hearing Plan.

5.3-11. Notice of Final Decision

Written Notice of the Board of Governors' final decision shall be given through the Chief Executive Officer or designee to the applicant, the President of the Medical Staff and the Chair of the Credentials Committee within thirty (30) days. A decision which includes a notice to appoint shall state, if applicable, the Staff category to which the applicant is appointed, the Department to which the applicant is assigned, the Clinical Privileges the applicant may exercise, and any special conditions attached to the appointment.

5.3-12. Reapplication After Adverse Appointment Decision

An applicant who has received a final adverse decision regarding appointment shall not be eligible to reapply to the Medical or APP Staff for a period of two (2) years from the date of the final adverse decision unless set forth to the contrary by the Board of Governors in rendering its final decision. Any such reapplication shall be processed as an initial application, and the applicant shall submit additional information as the Medical Staff or the Board of Governors may require in demonstration that the basis for the earlier adverse action no longer exists.

5.4. Initial Appointments

All initial appointments to any category of the Medical or APP Staff shall not exceed two (2) years. All initial appointments shall be subject to the supervision of the Department Chair or the Chair's designee in accordance with Medical Staff policy.

5.5. Criteria for Reappointment

Every Member of the Medical or APP Staff shall be subject to reappointment which shall be for a period of not more than two (2) years from the date of the previous appointment. An applicant shall submit their application to the Medical Staff Office. Applications that fulfill the Board approved criteria for Category One (expedited credentialing) listed in §5.3-2(a) and §5.5-10(b) and receive a favorable recommendation without limitation from the Executive Committee will be eligible for the expedited reappointment process as defined in §5.3-9(a) for initial appointment. This process will be utilized only in the event that a reappointment will expire prior to the next regularly scheduled Board of Governors meeting. The decision to reappoint a Medical or APP Staff Member for less than two (2) full years shall not entitle the appointee to any of the rights established in Article 8 of these Bylaws.

5.5-1. Application for Reappointment

At least ninety (90) Days prior to the expiration date of the current appointment, the Medical Staff Office shall provide each reappointment candidate with an application for reappointment, via USPS or other postal service, electronically or via hand delivery.

(a) Each applicant for reappointment shall return the completed form to the Medical Staff Office no later than thirty (30) Days after receipt.

(b) If the applicant for reappointment fails to return the application within thirty (30) Days of its receipt and/or fails to pay any fines for late submission of the

reappointment application, the Medical Staff Office shall give the applicant Written Notice that they have fifteen (15) Days from receipt to submit the application and/or outstanding fines and shall notify the applicant of the effect of a failure to timely submit the application and/or pay outstanding fines as stated in §5.5-1(c).

(c) Failure to timely return the completed application for reappointment or to provide information requested shall be deemed a voluntary resignation from Staff status and shall result in automatic termination of Staff status, together with all Clinical Privileges at the expiration of such person's current term. Such resignation shall not entitle the person resigning to any of the rights in Article 8 of these Bylaws.

(d) No application for reappointment shall be considered by the Credentials Committee until all of the information required in §5.5-2 of these Bylaws has been submitted and verified.

5.5-2. Information to be Submitted

The application form shall require and, when complete, shall contain information including but not limited to the following:

(a) Evidence of current licensure; malpractice insurance; current NJ Medicaid enrollment number; current enrollment in the Medicare program for Providers with Active or Senior status and current enrollment or opt-out status in the Medicare program for Providers with Visiting status; CDS and DEA registration; and attestation of compliance with New Jersey continuing education requirements, which in part must relate to the Clinical Privileges granted, for the two (2) years preceding the application;

(b) Experience that qualifies the reappointment applicant for the status and/or Clinical Privileges sought on reappointment;

(c) A reference from the Division Director, if applicable, or the Department Chair pertaining to the applicant's continuing current clinical competence, ethics, required meeting attendance, ability to work with others, and character. Applicants with low/no volume during the prior period of appointment may supply one (1) peer reference in lieu of the Division Director or Department Chair;

(d) Malpractice claims, settlements and judgments in the past two (2) years within the Hospital and at all other practice settings and employers;

(e) Any requests for modification of Staff status or Clinical Privileges which the reappointment applicant may desire to make;

(f) Information set forth in §5.2-1(d)-(l) of these Bylaws.

5.5-3. Applicant's Burden

The applicant for reappointment shall have the same burden set forth in §5.2-2.

5.5-4. Effect of Application

The applicant for reappointment shall have the same obligations set forth in §5.2-3.

5.5-5. Applicant's Adherence to Bylaws

The application form shall include a statement that the applicant has received and read the Bylaws and Rules and Regulations of the Medical Staff and that the applicant agrees to be bound by the terms thereof, both with respect to the application process and to Staff Membership without regard to whether or not the applicant is granted reappointment to the Staff. The applicant shall also agree that if an adverse ruling is made with respect to their reappointment to Staff Membership, Staff status and/or Clinical Privileges, the applicant will exhaust the administrative remedies afforded in these Bylaws before resorting to formal legal action.

5.5-6. Applicant Pledge

The application shall include and each applicant shall execute an ethical pledge as set forth in §5.2-5.

5.5-7. Verification

The Medical Staff Office shall seek to verify information in the application regarding the applicant's qualifications. The verification process shall begin only if the application is complete. Verification includes querying the National Practitioner Data Bank.

(a) Each Member shall be required to assist with verification upon request of the Medical Staff Office, if verification has not been completed within thirty (30) Days of receipt of a completed application for reappointment.

(b) A Member who does not assist in obtaining verification shall be deemed to have withdrawn their application voluntarily. A voluntary withdrawal does not entitle the applicant to any of the rights pursuant to Article 8.

(c) When the verification process is completed, the Medical Staff Office shall transmit the application and related materials to the Department Chair and Division Director, if applicable.

5.5-8. Departmental Review

No later than seven (7) Days prior to the applicable scheduled Credentials Committee review, the Department Chair or Department Chair's designee shall submit to the Medical Staff Office the Department's report on the applicant. The Medical Staff Office shall transmit the Department's report to the Credentials Committee for its review.

5.5-9. Basis for Reappointment

The reappointment of a Medical or APP Staff Member and Clinical Privileges awarded shall be based upon such Member's current licensure and/or certification, as appropriate, verified with the primary source; specific relevant training verified with the primary source, demonstrated professional competence, clinical judgment and technical skills in the treatment of patients; physical ability to perform the requested Clinical Privileges; performance as documented by the results of Hospital and Medical Staff peer review and performance improvement activities including Practitioner-specific information in comparison to aggregate data and morbidity and mortality data when available; non-use of privileges for high-risk procedures or treatments over two (2) years; use of emerging technologies; ethics and conduct; current physical and mental status relevant to Clinical Privileges requested; documented participation in continuing education activities that relate to current or requested Clinical Privileges; peer and/or faculty recommendation; compliance with the Medical Staff Bylaws Rules and Regulations; conformity with relevant state and federal regulatory standards; cooperation with Hospital personnel and other Practitioners; use of the Hospital's facilities; general attitude toward patients, the Hospital, other Practitioners and the public; and evidence of professional liability insurance in the amount considered adequate by the laws of the State of New Jersey and Board of Governors. In addition, the Member shall be evaluated against the following six (6) areas of "general competencies" developed by a joint initiative of the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS): patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and systems-based practice. If there is insufficient peer review and performance improvement information available based on limited or no clinical activity at the time of reappointment application information may be obtained from other hospitals where similar Clinical Privileges are maintained. If there has been nonuse of Clinical Privileges or the applicant is unable to demonstrate continuing current clinical competence Staff Privileges may be reduced, suspended or terminated.

5.5-10. Process

When submitted to the Credentials Committee, the application for reappointment shall be reviewed and acted upon as provided for in §5.3-1 through §5.3-11 of these Bylaws.

5.6. Department Assignment

Every Provider awarded Clinical Privileges and/or Staff Membership shall be assigned to a Department and Division if appropriate, and shall adhere to the applicable Rules and Regulations of each Department/Division/Section assigned.

5.7. Request for Modification of Appointment

A Provider may, either in connection with application for reappointment or at any other time, request modification of their Staff category, Departmental assignment or Clinical Privileges by submitting a written application to the Medical Staff Office on the prescribed form. Such application shall be processed in accordance with the procedures for an application for reappointment. The National Practitioner Data Bank will be queried during the approval

process. The reasons for granting the change in Clinical Privileges (e.g., emergence of new technologies, nonuse of Clinical Privileges for procedures or treatments, etc.) shall be documented in the Practitioner or APP's file. Clinical Privileges may not be relinquished solely for the purpose of removal from the Department/Division on call responsibilities.

Article 6

Clinical Privileges

6.1. Clinical Privileges Restricted

Every Provider practicing at this Hospital shall, in connection with such practice, be entitled to exercise only those Clinical Privileges specifically granted to them by the Board, except as provided in §6.5 and 6.6 of these Bylaws.

6.2. Clinical Privileges Delineated

All Clinical Privileges for any Provider (including contract physicians) shall be specifically delineated. The scope of Clinical Privileges available in the Hospital shall be determined by the Board, taking into consideration the recommendations of the Medical Staff. Prior to the granting or renewal of Clinical Privileges, the Board shall determine, after consideration of recommendations of the respective Departments, whether sufficient space, equipment, staffing and financial resources are currently in place or available within a specified time frame to support the requested Clinical Privileges. Documentation that this evaluation has been performed shall be maintained by the Board. The Board shall consistently determine the resources needed for each requested Clinical Privilege. Information regarding a Provider's scope of Clinical Privileges shall be updated as changes in such Provider's Clinical Privileges are made. This § 6.2 also applies to APNs.

6.3. Criteria for Granting Clinical Privileges to Providers

Evaluation of all requests for Clinical Privileges shall be based upon information including but not limited to the applicant's current licensure and/or certification, verified with the primary source, specific relevant training, verified with the primary source, education, participation in continuing education, experience, demonstrated current competence, physical ability to perform the Clinical Privileges requested, professional peer and/or faculty recommendations, data from professional practice review by an organization that currently privileges the applicant (if available), ability to work with others, other relevant information, and, in the case of reappointments, results of quality management activities, observed clinical performance and review of patient records. The Board of Governors shall determine whether there is sufficient clinical performance information to make a decision to grant, limit or deny any requested Clinical Privileges. Each of the criteria set forth in this §6.3 shall be consistently evaluated for all Providers requesting the related Clinical Privileges.

The Credentials Committee and Executive Committee shall consider the recommendations of peers and/or faculty on the Medical Staff or at other healthcare institutions. Deliberations by the Credentials Committee and Executive Committee in developing recommendations for appointment to or termination from the Medical or APP Staff and for the

initial granting, revision or revocation of Clinical Privileges shall include an evaluation of information provided by peer(s) of the applicant.

Peer recommendations shall be obtained and evaluated for all new applicants for Clinical Privileges. In addition, peer recommendations shall be obtained upon an application for renewal of Clinical Privileges and/or for evaluating an applicant for Clinical Privileges when insufficient applicant-specific peer review data is available.

Peer recommendations shall include written information regarding the applicant's current: (a) medical/clinical knowledge, (b) technical and clinical skills, (c) clinical judgment, (d) interpersonal skills, (e) communication skills, and (f) professionalism. Peer recommendations shall be obtained from a Provider in the same professional discipline as the applicant with personal knowledge of the applicant's ability to practice and shall reflect a basis for recommending the granting of privileges. The provisions of § 6.3-§ 6.3.2 also apply to APPs

6.3-1. Applicant's Burden

The applicant shall have the burden of establishing their qualifications and competence for the requested Clinical Privileges. The applicant shall be provided Written Notice when insufficient evidence exists to grant Clinical Privileges.

6.3-2. Prior Verification

Action on an application for Clinical Privileges is withheld until information providing the basis for granting such Clinical Privileges has been verified.

6.3-3. Oral Surgeon Privileges

Oral Surgeons may be granted surgical privileges by the Chair of the Department of Surgery and Director of the Division of Oral and Maxillofacial Surgery. Oral Surgeons may be privileged to do histories and physicals for their patients. Patients admitted by an Oral Surgeon without such privileges shall receive an equivalent admission history and physical by a Physician Member of the Medical Staff as patients admitted to other surgical services. Admission in all instances is contingent upon concurrent care by a Physician Member of the Medical Staff. A Physician Member of the Medical Staff shall be responsible for the medical appraisal of any medical problem that may be present at the time of admission or that may arise during hospitalization.

6.3-4. Podiatric Privileges

Podiatrists may be granted surgical privileges by the Director of the Division of Podiatric Surgery and the Chair of the Department of Surgery. Podiatrists may perform pre-surgical history and physical examinations if qualified and if granted such Clinical Privileges and within the scope of Podiatrist's practice. A Physician Member of the Medical Staff shall be responsible for the medical appraisal of any medical problem that may be present at the time of admission or that may arise during hospitalization and for performance of history and physical examinations of patients with co-existing pathology. A Podiatrist's history and physical cannot supplant the pre-anesthesia assessment and evaluation to be performed by appropriate anesthesia personnel.

6.4. Determination of Individual Clinical Privileges

Each initial application for Staff appointment by a Provider and each application for reappointment shall contain a request for specific Clinical Privileges.

6.4-1 Process of Determination

Clinical Privileges shall be evaluated and determined as part of the initial appointment and reappointment processes and in accordance with the processes established in Article 5 of these Bylaws. Providers must request specific Clinical Privileges in writing and must justify the request by reference to relevant training and experience on a form provided by the Medical Staff Office.

6.4-2 Changes in Clinical Privileges

(a) A Provider with Clinical Privileges may at any time apply in writing for changes in their Clinical Privileges. Providers must request the specific change in Clinical Privileges in writing and must justify the request by reference to relevant training and experience on a form provided by and returned to the Medical Staff Office. The review of such a request shall be processed in accordance with Article 5 of these Bylaws pertaining to review of applications for reappointment.

(b) Involuntary reduction, termination, or suspension of Clinical Privileges will be addressed by the Corrective Action process of Article 7 of these Bylaws.

(c) Clinical Privileges may not be relinquished solely for the purpose of removal from Department or Division on call responsibility.

6.5. Temporary Privileges

The Chief Executive Officer or the Chief Medical Officer may, with the written concurrence of the President, Vice-President, applicable Department Chair or their designee, grant temporary admitting and/or Clinical Privileges to a Provider currently holding Clinical Privileges who is requesting one (1) or more additional Clinical Privileges, is currently in the reappointment process and is requesting one (1) or more additional Clinical Privileges, and/or who is not a Member of the Medical or APP Staff. Temporary privileges shall only be granted in accordance with the criteria and under the circumstances set forth herein. The applicant granted temporary privileges shall act under the supervision of the Chair of the Department to which the applicant is assigned or the Chair's designee. The granting of temporary privileges is a courtesy extended by the Hospital and their termination does not entitle a Provider to any of the procedural rights afforded in these Bylaws.

6.5-1. Circumstances for Granting Temporary Privileges=

(a) After completion and verification of a clean application, which has been recommended for Staff Membership by the Credentials Committee, while awaiting review and approval of the Medical Executive Committee and the Board, an appropriately licensed and insured applicant may be granted temporary privileges for an initial period of no more than sixty (60) Days which such temporary privileges may be exercised immediately subject to §6.5-1-(d) and (e) below;

(b) To fulfill an important patient care need including when the Hospital's emergency management plan has been activated;

(c) Period of Temporary Privileges;

(d) Temporary privileges shall only be granted on a one-time basis and for a maximum period of sixty (60) Days without any extensions. Restriction of Temporary Privileges;

If the Executive Committee, based on its review of an application for Clinical Privileges, recommends Clinical Privileges more restricted than the scope of temporary privileges initially granted, then the applicant's temporary privileges shall be so restricted pending action by the Board of Governors. The Chief Medical Officer shall immediately provide Written Notice to the Provider of the limitations imposed; and

(e) Board Action: The decision of the Board upon the pending application shall supersede and extinguish any temporary privileges granted pursuant to this section. If there is a shortage of Providers within a Department, Division or Section, the CMO or the CMO's designee, after receipt of an application for Staff Membership, may grant temporary privileges, for a period not to exceed sixty (60) Days, to an appropriately licensed and insured applicant per the verification process of §6.5-5.

6.5-2. Care of a Specific Patient

Upon receipt of a written request for specific temporary privileges, an appropriately licensed and insured Practitioner who is not an applicant for Membership may be granted temporary privileges to care for a specific patient for a period not to exceed the length of the patient's hospitalization, and in no case more than sixty (60) Days.

6.5-3. Locum Tenens/Practitioner Coverage

An appropriately licensed and insured Provider who is serving locum tenens to provide coverage for a Member of the Medical Staff may be granted temporary privileges on a one-time basis, pursuant to the temporary privilege procedures set forth in §6.5, for a period not to exceed sixty (60) Days.

6.5-4. Visiting Clinical Privileges

Upon receipt of a request from a Staff Member, a visiting expert clinician, who will conduct a medical education activity approved by the CMO and the Chair of the applicable Department, may be granted temporary privileges for up to seven (7) Days.

6.5-5. New Privileges for Current Providers

Upon receipt of a written request for specific temporary privileges, an appropriately licensed and insured Provider who is a member of the Medical or APP Staff or in the reappointment process may be granted temporary privileges for one (1) or more additional Clinical Privileges.

6.5-6. Verification of Credentials

Prior to granting temporary privileges as set forth in §6.5-1, 6.5-2, 6.5-3 and/or 6.5-4, the application for initial appointment must be complete. There may be no current or previous successful challenges to licensure or registration, no prior involuntary terminations of Medical Staff or other healthcare organization membership and no prior involuntary reduction, denial or loss of Clinical Privileges. Verification of the applicant's medical license or other applicable professional license, DEA and CDS registration, malpractice insurance, malpractice claims or settlement history, education and training by reference to original sources, relevant training and experience for Clinical Privileges requested, current competence, and at least three (3) written professional references which meet the criteria in §5.2-1(b) will be completed as described in §5.3-1. The NPDB must be queried.

6.5-7. Conditions

Additional special requirements of supervision and reporting may be imposed by the Department Chair upon the granting of temporary privileges or at any time during the Provider's temporary privileges. Any Provider granted temporary privileges who exceeds the conditions of time established for the applicable category of privileges must thereafter apply for Medical Staff Membership.

6.5-8. Termination of Temporary Privileges

Temporary privileges shall be immediately terminated by the Department Chair upon notice of any failure by a Provider to comply with special conditions of temporary privileges. The Chief Executive Officer may at any time, upon the recommendation of the President of the Medical Staff or the Executive Committee, or upon the recommendation of the Board, terminate a Provider's temporary privileges.

(a) Where it is determined that the life or health of any patient(s) would be endangered by continued treatment by the Provider, the termination may be imposed by any person entitled to impose a precautionary suspension pursuant to these Bylaws, and the same shall be immediately effective.

(b) In the case of a termination of temporary privileges, the Department Chair shall assign a Member of the Medical or APP Staff to assume responsibility for the care of such terminated Provider's patient(s), taking into account the preferences of such patients.

(c) Termination of temporary privileges shall not entitle a Provider to any rights provided in Article 8 or pursuant to Article 5 of these Bylaws.

6.5-9. Transplant Teams Privileges

The Chief Executive Officer, President of the Medical Staff and the Chair of the Department of Surgery, or their designees, may permit members of recognized organ/tissue retrieval services to procure organs and tissues from donors at the Hospital.

6.5-10. Disaster Privileges

During a disaster, in which the emergency management plan has been activated, the CMO, Medical Staff President or their designees may grant disaster privileges to handle immediate patient care needs.

(a) Eligibility for Disaster Privileges;

Providers known to the CMO, Medical Staff President or their designees may be granted disaster privileges without further documentation. Providers not known to the CMO, Medical Staff President or their designees may be granted disaster privileges upon demonstration of a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following: A current hospital photo ID card that clearly identifies professional designation; current professional licensure with primary source verification of the appropriate license; or identification indicating the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC) or Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) or other recognized state or federal organization or group, or identification indicating that the Provider has been granted authority to render patient care, treatment and services in disaster circumstances (such authority having been granted by a federal, state or municipal entity).

(b) Identification;

Individuals granted disaster privileges shall be identified with a Hospital identification tag.

(c) Oversight of Professional Performance of Providers Granted Disaster Privileges;

The professional performance of those Providers who have been granted disaster privileges shall be supervised by a member of the Medical Staff by direct observation, retrospective chart review or mentoring.

(d) Verification of Credentials;

As soon as the immediate situation is under control the CMO or designee will verify credentials as described in §6.5-6; and

(e) Termination of Disaster Privileges;

When the emergency management plan has been deactivated and patients placed under the care of a Member of the Medical Staff, disaster privileges will terminate.

6.6. Emergency Privileges

In an emergency, any Provider, to the degree permitted by their license and regardless of service or Staff status or lack of it, shall be permitted and assisted to do everything the Provider deems necessary and appropriate to save the life of a patient, using every facility of the Hospital necessary including calling consultations. The Chief Executive Officer shall be notified promptly by any Provider who has exercised such privileges.

6.6-1. Conclusion of Emergency

When the emergency no longer exists, the emergency privileges of the Provider shall be extinguished.

6.6-2. Definition of Emergency

For the purpose of this section, an "emergency" is defined as a condition in which serious permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that harm or danger.

6.7. Telemedicine Privileges

6.7-1. Delineation of Clinical Services

The Executive Committee will recommend the clinical services to be provided by Telemedicine at the request of Department Chair. The clinical services to be provided by Telemedicine shall be held to the same standard of care or practice standards as are applicable to in-person settings. The Department Chair shall determine which electronic mediums are appropriate to Telemedicine services within their respective Departments. Prior to rendering Telemedicine services, members of the Telemedicine Staff shall ensure that a proper provider-patient relationship is established as required under applicable law.

6.7-2. Privileging Process

(a) Providers requesting privileges to provide Telemedicine services for the treatment and diagnosis of patients will be subject to the credentialing and privileging processes of these Bylaws, and will be assigned to a specific Department/Division.

(b) Providers will be required to complete the standard Medical/APP Staff application form. Telemedicine Providers will be required to have appropriate New Jersey professional licensure. Telemedicine Providers must maintain New Jersey malpractice insurance, and, if rendering treatment, CDS and DEA registration. The verification process may utilize credentialing information from a Joint Commission accredited institution so long as the Provider is privileged at the distant site for those clinical services to be provided at the Hospital and the distant site provides the Hospital with a current list of the Provider's privileges.

(c) Telemedicine privileges shall only be granted to Providers who are active members of the Medical or APP Staff and hold Medical Staff or APP Staff memberships at a distant site hospital or telemedicine entity, which has a written agreement with the Hospital that permits the Hospital to comply with all applicable CMS conditions of participation for the contracted services.

(d) The Hospital shall provide to the distant site information that is useful to assess the Provider's quality of care, treatment, and services for use in privileging and performance improvement which includes, at a minimum, all adverse outcomes related to sentinel events considered reviewable by the Joint Commission that results from the telemedicine services provided and complaints about the distant site licensed telemedicine Provider from patients, or staff at the Hospital.

6.8. Voluntary Leave of Absence

A Medical or APP Staff Member may obtain a voluntary leave of absence from the Medical Staff by applying through Written Notice to the Director of Medical Staff Services stating the approximate period of time of the leave, which may not exceed one (1) year, nor extend beyond the term of the then current appointment. The applicant shall state the reasons for the request. During the period of the leave, Provider's Clinical Privileges, prerogatives and responsibilities and access to the Hospital information systems shall be suspended. Notwithstanding the foregoing, the requirement for prior request and approval of a leave of absence by the Medical Executive Committee may be waived in the event of a medical or other emergency involving the Provider or their immediate family.

6.8-1. Acceptable Reasons for Leave of Absence

Acceptable reasons for a leave of absence include but are not limited to medical reasons, being physically absent from the area, or an educational sabbatical to participate in a significant educational program. Except in the case of an emergency, all leaves of absence are subject to approval by the Executive Committee. A Provider may request a leave of absence in anticipation of non-renewal or discontinuance of the Provider's malpractice insurance. A leave of absence may be granted to a Provider by the Executive Committee or an ad hoc committee appointed by it, following its review of an automatic suspension occurring because of loss of malpractice insurance.

6.8-2. Termination of Leave

No later than forty-five (45) Days prior to the desired or scheduled termination of the leave, the Provider may request reinstatement of their Clinical Privileges and prerogatives by submitting Written Notice to the Director of Medical Staff Services, who shall initiate review by the Credentials Committee. The request shall include a written summary of the Provider's relevant activities during the leave. The Credentials Committee shall make a report and recommendation to the Executive Committee. The Executive Committee shall recommend to the Board action concerning the reinstatement of the Member's Clinical Privileges and prerogatives. If the Executive Committee's recommendation is adverse to the Provider, the Provider shall be afforded the rights set forth in the Fair Hearing Plan. An individual on a leave of absence whose membership expires during the leave must complete the reappointment process prior to reinstatement. Notwithstanding the foregoing, the Department Chair, President or Chief Medical Officer may permit a Provider who has submitted a written summary that causes no concerns about the Provider's ability to safely exercise their Clinical Privileges and who meets other Medical Staff or APP requirements to temporarily exercise one (1) or more of the Provider's requested Clinical Privileges, at any time prior to the action of the Board while the Credentials Committee, Executive Committee and/or Board recommendations or actions are pending. The failure to permit the Provider to resume exercise of one (1) or more Clinical Privileges prior to full Board action shall not afford the Provider the right to exercise the rights afforded in the Fair Hearing Plan.

6.8-3. Failure to Request Reinstatement

Failure without good cause to request reinstatement shall be deemed a voluntary resignation from the Medical or APP Staff and shall result in automatic termination of Medical or APP Staff Membership or Clinical Privileges. A Provider whose Membership is so terminated shall not be entitled to the procedural rights provided in Article 7 or 8, as applicable. A request for Medical or APP Staff Membership subsequently received from a Provider so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

6.8-4. Impact on Adverse Actions and Recommendations

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

6.8-5. Arrangements for Advanced Practice Provider Staff

Each Practitioner must make alternate arrangements for the supervision or collaboration of APPs with which such Practitioner supervises or collaborates, for the duration of the Leave of Absence.

6.9. Assignment to Departments and Divisions

Each Member of the Medical Staff shall be assigned membership in at least one Department and may be granted membership and/or Clinical Privileges in one or more other

Departments. The exercise of Clinical Privileges within each Department and Division shall be subject to the Rules and Regulations therein and to the authority of the Department Chair.

6.10. Other Providers

Non-Physicians shall apply for Clinical Privileges in accordance with Article 4, and shall be assigned to the appropriate Department for the exercise of such Clinical Privileges.

6.11. Ongoing Professional Practice Evaluation

Each Member of the Medical and APP Staff shall be subject to an ongoing professional practice evaluation in accordance with policies adopted by the Executive Committee. Ongoing professional practice evaluation information shall be privileged and confidential in accordance with Article 13 of these Bylaws and New Jersey and federal laws, rules and regulations pertaining to confidentiality and non-discoverability. If there is uncertainty regarding a Staff Member's professional performance, the matter shall be referred to the Executive Committee for corrective action in accordance with Article 7 of these Bylaws.

6.12. Focused Professional Practice Evaluation

A period of focused professional practice evaluation shall be implemented for all initially requested Clinical Privileges during a Medical and APP Staff Member's initial appointment period and when a new privilege has been granted to a Provider currently serving on the Medical or APP Staff. The Executive Committee may also prescribe a period of focused professional practice evaluation, not to exceed ninety (90) days which such time period may be extended pursuant to applicable Medical Staff policy, to monitor a Medical or APP Staff Member's performance when issues affecting the provision of safe, high quality patient care are identified. The focused professional practice evaluation does not entitle the Provider to the procedural rights described in Article 8 of these Bylaws. The Focused Professional Practice Evaluation shall be performed in accordance with policies adopted by the Executive Committee.

6.12-1. APPs

If the period of focused professional practice evaluation identifies a basis for corrective action, the process identified in Article 7 of these Bylaws shall be followed.

6.13. History and Physical Examination

6.13-1. Generally

All patients undergoing surgery or any procedure requiring anesthesia (including but not limited to endoscopy or interventional radiologic procedures) must receive a history and physical examination (H&P). The H&P must be completed by a privileged attending Physician or their designee including an Advanced Practice Nurse, Physician Assistant, Certified Nurse Midwives, or by a Podiatrist for their patient if credentialed to do so and within the limitation set forth in §6.3-4 of these Bylaws, and appear on the chart in accordance with State law no more than thirty (30) days before, or within twenty-four (24) hours after, patient registration or admission to the Hospital but prior to surgery or any procedure requiring anesthesia. An H&P shall be either a

comprehensive H&P or a focused H&P, the definitions of which shall be set forth in a policy adopted by the Medical Staff. The Medical Staff, through a policy, shall establish the circumstances under which each type of H&P is utilized. Each comprehensive and focused H&P must be dictated or templated and may not, with the exception of H&Ps recorded by interns and residents in accordance with Section 6.13-6 below, be handwritten. The attending Physician or their designee including an Advanced Practice Nurse and Certified Nurse Midwives shall write an admission note within twenty-four (24) hours of admission, indicating the reason for hospitalization and the diagnostic/therapeutic plan. If a patient is admitted to one service and subsequently transferred to another service, the admitting service shall be responsible for the H&P and the admission note.

6.13-2. Pre-admission Evaluation

Pre-admission testing, and pre-anesthesia evaluation, are required on all elective surgical admissions (except procedures scheduled under local anesthetics only) and shall become part of the patient's permanent medical record. A Physician member of the Department of Anesthesia and Perioperative Medicine or APP Staff qualified to administer anesthesia shall perform the evaluation and management services for pre-anesthesia evaluation of pre-admission testing patients within forty-eight (48) hours prior to surgery or a procedure requiring anesthesia services. The Department of Anesthesia and Perioperative Medicine's "Pre-Anesthesia Diagnostic Testing Guidelines" shall be consulted for patients being admitted for surgery.

6.13-3. Use of H&Ps Prepared Prior to Current Admission

If a qualified Member of the Medical Staff or APP Staff has obtained a complete history and has performed a complete physical examination, which conforms with §6.13-1 for required content, within thirty (30) days prior to the patient's admission to the Hospital, a legible copy of the H&P may be used in the patient's Hospital medical record, provided that an interval admission note is recorded within twenty four (24) hours of admission but prior to the procedure that includes relevant additions to the history and pertinent changes in the physical findings performed during an examination subsequent to the original report.

6.13-4. H&Ps by Advanced Practice Nurses and Certified Nurse Midwives

An Advanced Practice Nurse including Advanced Practice Nurse in Anesthesia and Certified Nurse Midwives may document a history and physical examination in the medical record without countersignature when approved for that Clinical Privilege.

6.13-5. H&Ps by Physician Assistants

Physician Assistants may document a history and physical examination in the medical record when directed to do so by the Associated Physician. An Associated Physician's personal review and countersignature of the histories and physicals taken by a Physician Assistant are not required unless the Physician Assistant's delegation agreement provides otherwise.

6.13-6. H&Ps by Interns and Residents

All H&Ps recorded by interns and residents shall be reviewed and countersigned by the attending Physician or Physician Designee within twenty-four (24) hours but prior to the procedure.

6.13-7. Service On Call and Interpretation Rosters

The appropriate Department and/or Division Chairs shall make and administer on-call rosters, and rosters for the interpretation of tests, as required to meet the needs of the Hospital and patients and any criteria for service on such rosters. A Senior Medical Staff Member may not be relieved of their emergency on-call service, interpretation, and/or clinic duties unless such Senior Medical Staff Member applies for and receives approval from the Department Chair. A Senior Medical Staff Member requesting removal of their emergency on-call service obligations, interpretation, and/or clinic services must make an application for the same pursuant to §4.3. Any disputes or disagreements concerning on-call or interpretation rosters shall be submitted to the Executive Committee.

Requiring service on, or removal from, an emergency on-call roster or from any roster for the interpretation of tests or special procedures shall not be considered to be a reduction in privileges nor an adverse action concerning the Practitioner's Clinical Privileges or Medical Staff membership. No Practitioner shall be entitled to a hearing or any peer review procedures as a result of the failure of the Practitioner to be appointed to or the removal of the Practitioner from any roster for emergency on-call services or interpretation of tests or special procedures.

6.14. Rights Accorded on Temporary, Locum Tenens, Emergency and Disaster Privileges

The granting of Temporary, Locum Tenens, Emergency or Disaster Privileges shall not confer Medical or APP Staff membership on any Provider, nor shall Providers holding such privileges be considered to be part of the Medical or APP Staff or have any of the rights provided to Providers by these Bylaws or otherwise except as expressly stated herein. The refusal to grant, or termination or withdrawal of, Temporary, Locum Tenens, Emergency or Disaster Privileges shall not entitle the Provider to a hearing as set forth in Article 8 unless the action is reportable to the National Practitioner Data Bank.

Article 7

Corrective Action

7.1. Bases for Routine Corrective Action

It is the expectation of this Medical Staff that a wide variety of administrative issues among Medical and APP Staff Members, other members of the Hospital Staff and administration will be resolved informally by the Chief Medical Officer or by relevant Department Chairs. The circumstances set forth in this Article shall be the bases for corrective action against a Provider with Clinical Privileges. This Article shall provide the basis for corrective action against a

medico-administrative Providers only with respect to Medical or APP Staff Membership and Clinical Privileges and not administrative functions subject to an employment contract.

7.1-1. Collegial Intervention

(a) The use of progressive steps by Medical Staff leadership, beginning with collegial and educational efforts to address issues relating to a Provider's professional conduct and/or activities including clinical conduct is encouraged but is not mandatory;

(b) Collegial efforts shall include, but not be limited to, counseling, sharing of comparative data, monitoring, and additional training or education;

(c) All collegial intervention efforts by Medical Staff leadership are part of the hospital's performance improvement and professional and peer review activities;

(d) The Department Chair or designee(s) shall determine whether it is appropriate to include documentation of collegial intervention efforts in a Provider's confidential file. If documentation of collegial efforts is included in a Provider's file, the Provider will have the opportunity to review the information and respond in writing. The response will be maintained in the Provider's file along with the original documentation; and

(e) While collegial intervention is encouraged, it is not mandatory and shall be within the discretion of Medical Staff leadership.

7.1-2. Violations

A basis for corrective action exists whenever a Provider is believed to have violated these Bylaws or the Rules and Regulations of the Medical Staff.

7.1-3. Unprofessional or Unethical Conduct

A basis for corrective action exists whenever a Provider engages in acts, clinical or otherwise, makes statements, or exhibits demeanor or unprofessional or unethical conduct, either within or outside the Hospital, which action does not conform to professional standards as determined by the Medical Staff or is detrimental to patient safety or to the delivery of patient care, including a material misstatement or omission on any application for reappointment.

7.1-4. Disruptive Behavior

A basis for corrective action exists whenever a Provider engages in any action or behavior which is disruptive or is reasonably likely to be disruptive of Hospital operations or to be detrimental to patient safety or delivery of good patient care.

7.1-5. Breach of Confidentiality

The purposes of the Medical Staff set forth in these Bylaws and the responsibilities delegated to it by the Board shall be implemented through these Bylaws in all respects by all Providers in a manner which safeguards the confidentiality of the information considered, created or transmitted by an individual or committee operating pursuant to these Bylaws. Any breach of such confidentiality by any individual shall be considered a basis for corrective action.

7.1-6. Clinical Deficiencies

A basis for corrective action shall exist whenever a question arises regarding the clinical competence of any Provider, or the care or treatment of a patient or patients or management of a case or cases by any Provider.

7.1-7. Medicare or Medicaid Sanctions

A review of Medical or APP Staff Membership and Clinical Privileges may occur whenever the Medical Executive Committee determines that a Provider has been excluded from (including suspension, surrender, termination or limitation or withdrawal or relinquishment while under investigation or to avoid investigation) the Medicare or Medicaid or other federal payment programs or has otherwise become a "sanctioned person" within the meaning of the Social Security Act.

7.1-8. Violation of the Hospital Sexual, Racial and Ethnic Harassment Policy

All members of the Medical and APP Staff shall comply with the Hospital Sexual, Racial and Ethnic Harassment Policy. When the Hospital Administration receives a complaint of sexual, racial or ethnic harassment involving a member of the Medical or APP Staff the complaint shall be sent directly to the CMO. The complaint shall be promptly evaluated by the CMO, the President of the Medical Staff and a representative of Human Resources.

7.1-9. Actions by Board of Medical Examiners

A review of Medical or APP Staff Membership and Clinical Privileges may occur whenever the Executive Committee determines that a Provider has been sanctioned by the Board of Medical Examiners or other professional licensing body in this or any other jurisdiction, including the entry into a consent Order or the making of a reprimand.

7.1-10. Criminal Activity, Certain Misdemeanors

A review of Medical or APP Staff Membership and Clinical Privileges may occur whenever the Executive Committee determines that a Provider has been arrested, charged, or indicted for any felony, indictable crime or misdemeanor relating to controlled substances, illegal drugs, insurance or healthcare fraud or violence or to the Provider's fitness to practice medicine or practice as an APP.

7.2. Requests

A request for corrective action may be submitted by any of the officers of the Medical Staff, the Chief Executive Officer or Chief Hospital Executive after consultation with the President of the Medical Staff, by the Chief Medical Officer, the Chief Physician Executive, the Provider's Department Chair or Division Director, or by a member of the Executive Committee or the Executive Committee itself at any regular or special meeting. It shall be submitted to the Chief Medical Officer, and shall be supported by reference to the specific activities or conduct which constitute the grounds for the request. The Chief Medical Officer shall inform the Chief Executive Officer, the Chief Hospital Executive and the President of the Medical Staff as soon as possible of the request and shall transmit the request to the Executive Committee within ten (10) Days of its receipt by the CMO.

7.3. Formal Notice to Provider

All notices to be provided to a Provider under Articles 7 and 8 shall conform with the requirements for Written Notice.

The signature of the Provider's office staff or a delivery receipt from a third party service including, without limitation, USPS or FedEx, is sufficient evidence of delivery for these purposes.

7.4. Investigation

At the next regularly scheduled Executive Committee meeting after receipt of the request, the Executive Committee shall determine whether to investigate the matter and the scope of the investigation. If the Executive Committee decides to dismiss the matter without investigation, the Chief Medical Officer shall notify the requester in writing within ten (10) Days of the dismissal. If the Executive Committee determines the matter warrants an investigation, the President of the Medical Staff shall appoint an Investigating Committee of at least three (3) members (including the chair) within thirty (30) Days of the Executive Committee meeting. When the committee members have all been appointed, the President of the Medical Staff shall immediately notify the Chief Medical Officer and provide a written request for the investigation to the committee members. The members of the committee, insofar as possible, shall not include individuals in economic competition with the subject of the investigation, nor those likely to be financially advantaged or disadvantaged by the outcome of the Medical Staff process regarding the subject. The President shall determine the size of the committee based upon the scope of the issues involved.

7.4-1. Notice to Provider of Investigation

Should it be determined that an investigation will take place, the Executive Committee will immediately notify the Chief Medical Officer, who shall provide Written Notice within seven (7) Days to the individual who is the subject of the request for corrective action that such a request has been made and that a determination has been made that an investigation be

conducted. The Provider shall be advised of the identity of the committee members within seven (7) days of their appointment.

7.4-2. Conduct of Investigation

The Investigating Committee, whether the Executive Committee itself or others, shall seek to determine the facts in the matter and shall interview relevant individuals and/or obtain expert reports as necessary to the investigation. They shall consult with the Chief Medical Officer and the Medical Staff Office to obtain relevant information which such offices may have.

(a) The Investigating Committee shall invite the Provider to an interview, to be scheduled at the Investigating Committee's discretion taking into consideration the Provider's schedule. This interview shall not constitute a hearing, shall be preliminary in nature and none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto. No attorneys shall participate in the interview in an advisory or representative capacity.

(b) The Investigating Committee may require the Provider to supply office or other medical records of a patient that such Provider may have access to with respect to a review of particular case involving such patient.

(c) A written summary of such interview shall be made and included in the report to the Executive Committee.

(d) The failure of a Provider to participate in the interview shall be documented in the report, but no presumption shall attach to this fact.

(e) Members of the Medical and APP Staff agree as a condition of their Membership to respect the independence and objectivity of the processes provided for in these Bylaws. Consequently, any attempt to lobby, intimidate, or otherwise unduly influence the Investigating Committee, potential witnesses, and/or other committees including the Hearing Committee in a matter under review hereunder shall itself be an independent ground for corrective action.

7.4-3. Report of Investigating Committee

Within ninety (90) Days after the receipt of the Executive Committee's request for investigation, the Investigating Committee shall submit a written report of its investigation to the Executive Committee. If the Investigating Committee fails to submit a report within ninety (90) Days or if upon review of the report the Executive Committee seeks additional information, the Executive Committee may direct or conduct additional investigation which shall be concluded as expeditiously as possible and acted upon at the next regularly scheduled Executive Committee meeting.

7.5. Executive Committee Action

The Executive Committee shall act upon the report as soon as is feasible after the conclusion of the investigative process, if any, but in any event within one hundred twenty (120)

days after receipt of the request for corrective action unless deferred pursuant to these Bylaws. In connection with its evaluation, the Executive Committee shall examine the Provider's credentials file.

7.5-1. Types of Action

The Executive Committee may accept, reject, or modify the basis for the request for corrective action. If accepted, the Executive Committee shall recommend a specific sanction which may include but is not limited to the following:

(a) A written warning, admonition or reprimand;

(b) Time limited periods of probation, which shall require monitoring of the Provider's actions with additional episodes of the basis for corrective action necessitating further sanction or penalty;

(c) Requirement for remedial activity including additional or training education;

(d) Referral to the Professional Assistance Program of New Jersey and/or for a medical or psychiatric examination to determine "fitness" to exercise Clinical Privileges safely;

(e) Placement on probation or other conditional status;

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

(g) Fail to place a Provider on any on-call or interpretation roster or removal of any Provider from any such roster;

(h) Suspension of Clinical Privileges for less than fourteen (14) days;

(i) Suspension pending medical consultation;

(j) Involuntary reduction, suspension for more than fourteen (14) days or revocation of Clinical Privileges;

(k) Sustaining, terminating, expanding or otherwise modifying already imposed corrective action, including summary suspension of Clinical Privileges;

(l) Requirement for clinical supervision of care, consultation on categories of care, or co-privileges with another Provider;

(m) Suspension or revocation of Medical or APP Staff Membership; and

(n) Other specific sanctions as appropriate to the circumstances.

7.5-2. Procedural Rights

Except as otherwise provided in § 7.9, any Executive Committee recommendation set forth at §7.5-1 (i-m) or §5.3-8 with respect to appointments and reappointments shall entitle the affected Provider to the procedural rights provided in the Fair Hearing Plan. The affected Provider shall retain all responsibilities and prerogatives of Medical or APP Staff Membership and Clinical Privileges until such time as the Board has acted upon the recommendation of the Executive Committee.

7.5-3. Effect if No Hearing Right Pertains

If the action of the Executive Committee does not entitle the Provider to a hearing, it shall take effect immediately without action of the Board and without the right of appeal to the Board. A report of the action taken and reasons therefor shall be made to the Board through the CMO and the action shall stand unless modified by the Board. The Board may, but need not, take any action upon such report.

7.6. Board Intervention

If at any time in the corrective action process the Medical Staff through the Executive Committee fails to act in accordance with these Bylaws, including failure to meet established time frames, the Board may intervene and act in place of the Medical Staff. The Chief Medical Officer shall notify the Board of such failure. The Board shall then act in place of the Executive Committee, and any such action shall be in accordance with the procedures set forth in this Article 7.

7.7. Precautionary Suspension Pending Investigation

Whenever there are reasonable grounds to believe that the conduct or activities of a Provider poses a threat to the life, health or safety of any patient, employee or other person and that the failure to take prompt action may result in imminent danger to the health or safety of any person or when a Provider refuses to submit to evaluation or testing related to the Provider's mental or physical status including refusal to submit to any testing related to drug or alcohol use, any three (3) of the following, of which one must be a Physician: the Chair of the Board, the President of the Medical Staff, the Chief Medical Officer, the Chief Physician Executive, Chief Executive Officer, the Chief Hospital Executive, the Chair or Division Director of the subject Provider's Department or Division or the Chief Nursing Officer in the case of an APP, shall have the authority to impose a precautionary suspension of all or any portion of the Clinical Privileges and/or Medical or APP Membership status of a Provider, effective immediately, pending an investigation and review by the Executive Committee.

7.7-1. Notice

The Chief Medical Officer or designee shall provide immediate notice to the affected Provider (direct verbal notification is appropriate in the interests of time) and shall subsequently provide Written Notice to the Provider which states the scope of the suspension. The Chief Medical Officer or designee shall notify the President of the Medical Staff immediately of any precautionary suspension.

7.7-2. Provision of Patient Care

Immediately upon the imposition of a precautionary suspension, the Department Chair or Division Director shall have the authority to provide for alternative medical coverage for the patients of the suspended Provider still in the Hospital at the time of such suspension. To the extent feasible, the wishes of the patients shall be considered in the selection of such alternative Provider.

7.7-3. Executive Committee Review

The Executive Committee or a specifically delegated Ad Hoc Subcommittee of the Executive Committee as appointed by the President of the Medical Staff shall review any precautionary suspension as soon as practicable after imposition, but in no event more than fourteen (14) Days after imposition. The Committee must recommend modification, continuance or termination of the terms of the precautionary suspension no later than the end of the fourteen (14) Day period.

7.7-4. Provider Rights

Unless the Executive Committee or Subcommittee immediately lifts the suspension or ceases all corrective action, the suspension shall continue in effect and the Provider shall be notified of their rights, if any, pursuant to Article 8.

7.8. Automatic Suspensions or Limitations

A Provider's Clinical Privileges shall automatically be revoked, limited or suspended, as appropriate, upon the occurrence of the following circumstances.

7.8-1. Action as a Result of Automatic Suspension or Limitation

The Provider shall be notified of the basis of any automatic suspension or limitation as set forth in this §7.8 by certified or verified overnight mail as promptly as possible after the automatic suspension or limitation occurs. Automatic suspensions or limitations are not considered professional review actions, are not based on determinations of competence or unprofessional conduct, and are not entitled to the hearing or appeal procedures provided under these Bylaws.

7.8-2. Revocation Or Suspension Of License To Practice

(a) Revocation: Whenever a Provider's license, certificate or other legal credentials authorizing the Provider to practice in this State is relinquished or revoked, the Provider's Medical or APP Staff membership and Clinical Privileges shall be immediately and automatically revoked.

(b) Suspension: Whenever a Provider's license, certificate or other legal credentials in this or any other State are limited, restricted, suspended or placed on

probation, the Provider's Medical or APP Staff membership and Clinical Privileges shall be automatically suspended or placed on probation effective upon and for the term of the limitation, restriction, suspension or probation. Further action on the matter shall proceed pursuant to §7.8-14. During this time, the Provider will be considered ineligible for Medical or APP Staff Membership or Clinical Privileges and will not be entitled to the procedural due process rights provided in Article 8. If the licensing agency reinstates the Provider without any limitations or conditions, the suspension will be lifted. If the licensing agency reinstates the Provider's license with limitations or conditions, the suspension will remain in effect pending an interview with Credentials Committee and recommendation from the Executive Committee for action by the Board.

7.8-3. Drug Enforcement Administration Action/CDS Number

(a) Revocation: Whenever a Provider's DEA number/CDS is revoked, that Provider shall immediately and automatically be suspended. Further action on the matter shall proceed pursuant to §7.8-14.

(b) Relinquishment/Suspension: Whenever a Provider's DEA number is relinquished suspended, that Provider shall immediately and automatically be suspended and there will be no entitlement to the fair hearing and appeals procedures provided in Article 8. Further action on the matter shall proceed pursuant to §7.8-14.

(c) The Provider may request reinstatement during a period of ninety (90) calendar days following revocation or suspension upon presentation of proof of reinstatement. Thereafter, such Provider shall be deemed to have voluntarily resigned from the Medical or APP Staff and must reapply for Medical or APP Staff membership and/or Clinical Privileges and there will be no entitlement to the fair hearing and appeals procedures provided in Article 8.

(d) Probation: Whenever a Provider is placed on probation insofar as the use of the member's DEA number or CDS is concerned, action on the matter shall proceed pursuant §7.8-14.

(e) Expiration of DEA or CDS: An expiration of a Provider's DEA or CDS registration shall result in an automatic administrative suspension of the Provider's Clinical Privileges for the duration of the expired DEA or CDS registration. Such automatic administrative suspension is not considered a professional review action and does not entitle the Provider to the hearing or appeal procedures provided in Article 8.

7.8-4. Suspension Or Exclusion From Federal Or State Insurance Programs Or Conviction For Insurance Fraud

(a) Withdrawal/Exclusion: Whenever a Provider withdraws from or has been excluded from participation in the Medicare program, the Medicaid program, or any other Federal or State health care program, that Provider shall be considered to have automatically resigned their Medical or APP Staff Membership and/or

Clinical Privileges and there will be no entitlement to the fair hearing and appeals procedures provided in Article 8. Any Provider convicted of violations of the federal False Claims Act or of insurance fraud shall be considered to have automatically relinquished their Medical or APP Staff Membership and/or Clinical Privileges and there will be no entitlement to the fair hearing and appeals procedures provided in Article 8.

(b) Suspension: Whenever a Provider has been suspended from participation in the Medicare program, the Medicaid program, or both, the Provider's Clinical Privileges shall be automatically suspended for at least the term of such suspension and there will be no entitlement to the fair hearing and appeals procedures provided in Article 8. Further action on the Provider's general Medical or APP Staff Membership and Clinical Privileges shall proceed pursuant to §7.8-14.

(c) In the event of any such actions, the Provider's Medicare and/or Medicaid patients then in the Hospital shall be assigned to another Provider by the Department Chair or designee, provided such transfer shall not directly endanger patient care.

7.8-5. Medical Records

It is the policy of this Medical Staff that Providers at the Hospital shall complete medical records in an accurate, timely and legible manner. Providers who fail to conform with relevant requirements shall pay penalties in accordance with the process set forth in the Rules and Regulations.

(a) A Provider who fails to complete medical records and pay fines assessed for such incomplete medical records within fifteen (15) Days after the second notice of delinquency regarding such records, shall be sent a notice of Voluntary Relinquishment of Clinical Privileges, by Written Notice, by the President of the Medical Staff. Notwithstanding the foregoing, any medical record received at discharge without an H&P prepared in accordance with §6.13 hereof or an appropriate operative report shall be considered immediately delinquent without a second notice of delinquency regarding such records and the Provider at fault will be sent a notice of Voluntary Relinquishment of Clinical Privileges by Written Notice, by the President of the Medical Staff, on the next suspension cycle for such records.

(b) The President or designee shall provide simultaneous notification of the Provider's relinquishment of Clinical Privileges to the individual's Department, the admissions office, emergency room, labor and delivery room and operating room, where appropriate.

(c) Voluntary relinquishment of Clinical Privileges under this provision does not entitle a Provider to any the fair hearing and appeals procedures provided in Article 8.

(d) When the medical records are completed, the Provider's Clinical Privileges suspended upon that basis shall be reinstated, and the President of the Medical Staff shall send written notification of the individual's reinstatement to the Chair of the individual's Department, the admissions office, emergency room, labor and delivery room and operating room, where appropriate. Failure to pay relevant fines within twenty-four (24) hours of reinstatement will result in suspension as set forth in the Rules and Regulations.

7.8-6. Maintenance Of Professional Liability Insurance

Any member of the Medical or APP Staff who fails to maintain the professional liability insurance required as set forth in these Bylaws or fails to notify the Medical Staff Office in any event of lowering or malpractice limits shall be subject to automatic suspension of the member's Clinical Privileges, which shall be effective immediately upon receipt by the Hospital of notice of termination of such professional liability insurance coverage or lowering of limits below that amount required as contained in these Bylaws. Notice of such suspension shall be forwarded to the Provider as soon as possible after receipt of notice of such termination of such policy or lowering of such policy limits by the Hospital. Affected Providers may request reinstatement during a period of ninety (90) calendar days following suspension upon presentation of proof of adequate insurance. Thereafter, such Provider shall be deemed to have voluntarily resigned from the Staff and must reapply for Medical or APP Staff Membership and/or Clinical Privileges and there will be no entitlement to the fair hearing and appeals procedures provided in Article 8.

7.8-7. Failure To Pay Medical Staff Dues

(a) If dues are not paid by a Provider within sixty (60) days after notice has been sent, then the President or designee shall promptly provide a special notice to the delinquent Provider. The President or designee shall be free to suspend the Clinical Privileges of a delinquent Provider, if the Provider has not paid such dues within fourteen (14) days of being given notice of the delinquency.

(b) The President shall promptly reinstate a Provider's Clinical Privileges upon that Provider's payment of delinquent dues.

(c) A Provider shall be ineligible to apply for reappointment while any dues are delinquent.

7.8-8. Failure To Participate In An Evaluation Or Assessment

A Provider who fails or refuses to participate in an evaluation or assessment of their qualifications for Medical or APP Staff Membership and/or Clinical Privileges as required under these Bylaws shall be automatically suspended. Such evaluations or assessments can be to determine clinical competence, physical fitness to exercise Privileges, or to evaluate the Provider's behavioral/mental health and must be undertaken with professionals or organizations (e.g., the Professional Assistance Program of New Jersey) identified by or acceptable to the President or Executive Committee. If, within thirty (30) days of the suspension, the Provider agrees to and participates in the evaluation or assessment, the Provider shall be reinstated unless

the Medical Staff is in receipt of an evaluation or assessment that the Provider is not fit to practice. After thirty (30) days, the Provider will be deemed to have voluntarily resigned from the Medical or APP Staff and must reapply for Membership and/or Privileges and there will be no entitlement to the fair hearing and appeals procedures provided in Article 8.

7.8-9. Conviction Of A Crime

A Provider who has been convicted of, or entered a plea of guilty or no contest to a felony or indictable crime or misdemeanor relating to controlled substances, illegal drugs, insurance or healthcare fraud, or violence, or the Provider's fitness to practice medicine or as an APP will be immediately and automatically suspended from practicing in the Hospital. Such suspension shall not entitle the affected Provider to the fair hearing and appeals procedures provided in Article 8. A Provider's conviction of or entry of a plea of guilty or no contest to a motor vehicle/traffic violation involving drugs or alcohol (including but not limited to DUIs and refusal to consent to testing) shall not result in an automatic suspension of Medical or APP Staff Membership or Clinical Privileges. Instead, in accordance with §3.3-4 or §4.7-4, the Provider shall be required to notify the Medical Staff of any motor vehicle/traffic violation involving drugs or alcohol, which information may be used as the basis for corrective action, which may include suspension.

7.8-10. Failure To Comply with Required Screenings and Vaccinations as Determined by the Medical Staff

A Provider who has failed to provide evidence of compliance with required health screenings and mandatory vaccinations as determined by the Medical Staff, except excused for health or religious reasons as permitted by applicable law or Hospital policy, will be automatically suspended from practicing in the Hospital effective upon written notice. If, within thirty (30) days after the suspension, the Provider agrees to and obtains the screening or vaccination, or provides satisfactory evidence as to why they need be excused from obtaining the screening and/or mandatory vaccination, the Provider shall be reinstated. After thirty (30) days, the Provider will be deemed to have voluntarily resigned from the Medical or APP Staff and must reapply for membership and/or Privileges and there will be no entitlement to the fair hearing and appeals procedures provided in Article 8.

7.8-11. Failure To Become Board Certified Or To Maintain Board Certification

Where applicable under these Bylaws, whenever a Provider's time period in which to become board certified expires without achieving certification or the Provider fails to maintain board certification as required in §3.2-6, that individual will be deemed to have voluntarily resigned from the Staff and must reapply for Medical or APP Staff Membership and/or Clinical Privileges and there will be no entitlement to the fair hearing and appeals procedures provided in Article 8. This provision shall not be applicable to Providers granted a lifetime exemption from recertification pursuant to the requirements of the applicable certifying board. This §7.8-11 applies to APPs with respect to maintenance of a national specialty or certification, if applicable.

7.8-12. Failure To Notify Hospital Of Certain Actions

(a) A Provider who fails to notify the President in writing within five (5) days of any of the following shall be automatically suspended:

(i) if the Provider's privileges in any hospital or health care institution have been revoked, suspended or limited in any way;

(ii) if proceedings have been initiated to revoke, suspend or limit privileges in any way at any hospital or health care institution such as ambulatory surgery centers;

(iii) if a professional malpractice action has been resolved in an adverse outcome;

(iv) if the Provider has been suspended or excluded from Federal (including without limitation Medicare, Medicaid and Champus) or State insurance programs or convicted of insurance fraud;

(v) if the Provider has been charged with, indicted for, convicted of, entered a plea of guilty or no contest to a felony, indictable crime or misdemeanor related to controlled substance, illegal drugs, insurance or health fraud violence or fitness to practice medicine;

(vi) if the Provider has been charged with, indicted for, convicted of, entered a plea of guilty or no contest to a motor vehicle/traffic violation involving drugs or alcohol (including but not limited to DUIs and/or refusal to consent to testing);

(vii) if there is a change in licensure (including, without limitation, suspension or revocation) to practice medicine or prescribe drugs in any jurisdiction;

(viii) if there is a change in professional licensure (including, without limitation, suspension or revocation) in any jurisdiction;

(ix) if the Provider resigns from the medical or APP staff at any hospital or health care institution in any state while under investigation;

(x) if the Provider fails to maintain liability insurance as required in these Bylaws;

(xi) if the Provider is removed from or not renewed for participation in an insurance plan due to quality of care issues; or

(xii) if the Provider fails to notify the Hospital of any action taken by any state medical or professional board against the Provider (including but not

limited to probation, suspensions, or revocations or entry into a consent agreement which is not a private reprimand or private consent order).

(b) Unless the information provided by the Provider results in automatic action pursuant to these Bylaws, the suspension shall be lifted by the Executive Committee when the Provider provides adequate documentation to the Executive Committee of the circumstances that triggered the suspension. Failure to provide this information in fourteen (14) days after requested to do so will be considered a voluntary resignation from Medical or APP Staff Membership and/or Privileges and there will be no entitlement to a fair hearing or appeals as provided in Article 8.

7.8-13. Failure To Return From A Leave Of Absence

If a Provider granted a leave of absence does not request reinstatement or an extension before the Leave of Absence expires, the Provider will be considered to have voluntarily resigned their Medical or APP Staff Membership and/or Clinical Privileges.

7.8-14. Executive Committee Deliberation

As soon as feasible, but no longer than thirty (30) days after action is taken as described in §7.8-2, the Executive Committee shall convene to review and consider the facts under which such action was taken. The Executive Committee may then recommend such further peer review as is appropriate to the facts disclosed in its investigation, including limitation of Privileges and/or prerogatives. Thereafter, except as otherwise provided in §7.9, the procedure to be followed shall be provided in Article 8.

7.9. Right to Fair Hearing and Appellate Review

(a) An APP employed by a Medical Staff Member shall be entitled to a Fair Hearing and Appellate Review as described in Article 8. APPs who are employed by the Hospital or Hospital affiliates, including without limitation AtlantiCare Physician Group, shall not be entitled to a Fair Hearing and Appellate Review as described in Article 8.

(b) The definition of "Practitioner" in Article 8 only shall include an APP employed by a Medical Staff Member.

Article 8

Fair Hearing Plan

8.1. Right to Hearing and to Appellate Review

When any Practitioner receives notice of a recommendation of the Executive Committee, that, if ratified by decision of the Board, would adversely affect their appointment to or status as a Member of the Medical Staff or their exercise of Clinical Privileges, as provided for in these

Bylaws, the Practitioner shall be entitled to a hearing before a Fair Hearing Committee of the Medical Staff which shall make its recommendations to the Executive Committee.

8.1-1. Appellate Review from Executive Committee Decision

If the recommendation of the Executive Committee following such hearing is still adverse to the affected Practitioner, the Practitioner shall then be entitled to an appellate review by the Board before the Board makes a final decision on the matter.

8.1-2. Hearing and Appellate Review by the Board

When any Practitioner receives notice of an adverse decision by the Board that will affect their appointment to or status as a Member of the Medical Staff or their exercise of Clinical Privileges, and such decision is not based on a prior adverse recommendation by the Executive Committee with respect to which the Practitioner was entitled to a hearing and appellate review, the Practitioner shall be entitled to a hearing by a committee appointed by the Board. If such hearing does not result in a favorable recommendation, the Practitioner shall be entitled to an appellate review by the Board before it makes a final decision on the matter.

8.2. Bases for Action

The Fair Hearing Plan shall apply only to adverse actions which are enumerated below.

8.2-1. Adverse Recommendations Defined

A recommendation or action listed in §8.2-2 below shall be deemed adverse only in the following circumstances:

(a) when it has been recommended by the Executive Committee;

(b) when it is taken by the Board contrary to a favorable recommendation by the Executive Committee under circumstances where no right to hearing existed; or

(c) when it is taken by the Board on its own initiative without benefit of a prior recommendation by the Executive Committee.

8.2-2. Adverse Actions Enumerated

The following recommendations or actions shall, if deemed adverse, entitle the Practitioner affected thereby to a hearing, upon the Practitioner's timely request for the same. The determination of the scope of Clinical Privileges available to be exercised or the category of Practitioner permitted to practice in the Hospital is not a basis for a Fair Hearing.

(a) Initial appointment denied;

(b) Reappointment denied;

(c) Involuntary reduction, suspension for more than fourteen (14) days, termination or revocation of Clinical Privileges;

(d) Requirement for clinical supervision of care, consultation on categories of care, or co-privileges with another Practitioner;

(e) Denial of request for Clinical Privileges or additional Clinical Privileges when those Clinical Privileges are available to other similar Practitioners on a non-exclusive basis;

(f) Sustaining, terminating, expanding or otherwise modifying an already imposed corrective action, including precautionary suspension of Clinical Privileges, that entitles the Practitioner to a hearing as set forth at §7.5-2;

(g) Suspension, termination or revocation of Staff Membership.

8.3. Procedural Rights

All hearings and appellate reviews shall be in accordance with the procedural safeguards set forth in this section to assure that the affected Practitioner is accorded all rights to which they are entitled. Notwithstanding any other provision of these Bylaws, no Practitioner shall be entitled as a right to more than one hearing and one appellate review on any matter which shall have been the subject of an adverse action. No other actions except those specified in §8.2-2 shall give rise to any Practitioner's right to a hearing or an appellate review. Any Practitioner entitled to the procedural rights in this Fair Hearing Plan shall exhaust such remedies before proceeding in any other forum.

8.4. Notice, Request and Waiver for Hearing

The Chief Medical Officer shall give Written Notice of an adverse recommendation or decision to any affected Practitioner who is entitled to request a hearing. The Written Notice shall include the reasons for the action, the right to a hearing, the time limit of thirty (30) Days to request a hearing, and a summary of hearing rights found in this Article at §8.8-6.

8.4-1. Request

A Practitioner shall submit a request for hearing within thirty (30) Days of receipt of notice to the Chief Medical Officer whether in response to an action by the Executive Committee, or in response to an action by the Board. Such request shall be accompanied by the name and address of any attorney or other representative for the Practitioner, the name and address of any and all witnesses to be called to testify at the hearing on behalf of the Practitioner. A witness not listed may be called at the hearing provided that the Practitioner provides reasonable advance notice prior to the witness's testimony.

8.4-2. Waiver

The failure of a Practitioner to timely request a hearing to which they are entitled by these Bylaws in the manner herein provided shall be deemed a waiver of the right to such hearing or other further review to which the Practitioner might otherwise have been entitled on the matter.

8.4-3. Effect of Waiver

When a hearing is waived, the adverse recommendation of the Executive Committee or of the Board which created the right to hearing shall become or remain effective against the Practitioner pending the Board's decision on the matter.

(a) When the waived hearing relates to an adverse decision by the Board, that decision shall thereupon become and remain effective against the Practitioner in the same manner as a final decision of the Board provided for in §8.10.

(b) In any waiver under this provision, the Chief Medical Officer shall notify the affected Practitioner within ten (10) Days by verified overnight delivery or certified mail, return receipt requested, of their status.

8.5. Notice of Hearing

After receipt of a request for hearing from a Practitioner entitled to the same, the Executive Committee or the Board, whichever is appropriate, shall schedule and arrange for such a hearing and shall notify the Chief Medical Officer who shall give Written Notice to the Practitioner of the time, place, and date so scheduled.

8.5-1. Date of Hearing

The hearing date shall be not less than thirty (30) Days nor more than sixty (60) Days from the date of notice of the hearing. However, a Practitioner who is under suspension which is then in effect may request that an expedited hearing be held as soon as arrangements therefore may reasonably be made, but not later than thirty (30) Days from the date of receipt of such Practitioner's request for hearing unless another date is otherwise stipulated by the affected Practitioner. Such request for an expedited hearing must be set forth in the Practitioner's request for a hearing.

8.5-2. Contents of Notice

The notice of hearing shall state in concise language: the acts or omissions with which the Practitioner is charged, the specific medical records or other data, if any, which provide the basis for the adverse recommendation or the other reasons or subjects that were considered in making the adverse recommendation or decision; the Practitioner's rights at the hearing or on appeal; a list of the members of the Fair Hearing Committee panel and the Practitioner's right to challenge any of them; and a list of the witnesses, including expert witnesses, if any, expected to testify in support of the adverse recommendation or decision. A witness not listed may be called at the hearing provided that the Practitioner is given reasonable notice prior to the witness's testimony.

8.5-3. Access to Information

Prior to the hearing, the affected Practitioner shall have the right to copies of all relevant material and medical records or other data which were considered in making the adverse recommendation or decision. The Fair Hearing Committee or the Board shall be permitted to

produce or rely upon other data or information at the hearing provided, however, the affected Practitioner shall be given adequate notice and opportunity to review and challenge the new information. The provision of this information is not intended to waive any privilege under the State peer review protection statutes. The Practitioner shall also supply to the Executive Committee or the Board, as the case may be, relevant material and medical records and/or other data which such Practitioner intends to rely upon during the hearing and the Executive Committee or the Board shall have the opportunity to review and challenge the material, medical records and/or other data. The Practitioner will have no right to discovery beyond the above information. No information will be provided regarding other practitioners or APPs.

8.5-4. Confidentiality

All confidential documentation is provided to the Practitioner under the express provisions that such documentation and information is confidential, will be maintained as confidential and will not be disclosed or used for any purpose outside of the hearing processes contained in Article 8 of the Bylaws. The Practitioner shall require their counsel and all experts to execute a HIPAA compliant Business Associates Agreement with respect to any patient health information contained in any document, record or information provided, prior to providing access to the same. The Practitioner shall provide a written representation that the Practitioner has obtained such executed Business Associates Agreement at any time upon request.

8.5-5. Effect of Hearing

The Practitioner, by requesting a hearing, authorizes any and all professional societies or associations, licensure, certifying and examining boards of any states or foreign countries, hospitals, other health care providers and their employees and Medical Staffs to furnish any and all information in their possession (including copies of documents) concerning the affected Practitioner, and to render an opinion which might have a bearing upon the adverse recommendation or decision, for use in the proceedings conducted pursuant to these Bylaws.

8.5-6. Hospital Employees

Neither the Practitioner, nor any other person acting on behalf of the Practitioner, may contact Hospital employees whose names appear on the Executive Committee’s witness list or in documents provided pursuant to this section concerning the subject matter of the hearing, until the Hospital has been notified and has contacted the employees about their willingness to be interviewed. The Hospital will advise the Practitioner once it has contacted such employees and confirmed their willingness to meet. Any employee may agree or decline to be interviewed by or on behalf of the Practitioner who requested a hearing.

8.5-7. Pre-Hearing Conference

The Hearing Officer will require the affected Practitioner or a representative (who may be legal counsel) for the individual and for the Executive Committee to participate in a pre-hearing conference. At the pre-hearing conference, the Hearing Officer will resolve all procedural questions, including any objections to exhibits or witnesses. The Hearing Officer will establish the time to be allotted to each witness’s testimony and cross-examination. It is expected that the hearing will last no more than fifteen (15) hours, with each side being afforded

approximately seven and a half (7 ½) hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their case so that a hearing will be concluded after a maximum of fifteen (15) hours. The Hearing Officer may, after considering any objections, grant limited extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

8.6. Composition of Medical Staff Fair Hearing Committee

When a hearing relates to an adverse recommendation of the Executive Committee such hearing shall be conducted by a Fair Hearing Committee of not less than three (3) members of the Medical Staff appointed by the President of the Medical Staff with the concurrence of the Chief Executive Officer. One of the members so appointed shall be designated as Chair. There also may be appointed one or more alternate members of the Fair Hearing Panel who meet the qualifications set forth in §8.6-1.

8.6-1. Qualifications

Insofar as possible, no Staff Member who has actively participated in the consideration of the adverse recommendation, or the initiation or investigation of the underlying matter at issue at any earlier stage of the proceedings, shall be appointed a member of this Fair Hearing Committee; nor shall any individual who is in direct economic competition with the Practitioner nor anyone who will be financially advantaged or disadvantaged by the outcome of the hearing be appointed to this committee. Knowledge of the underlying matter, in and of itself, and/or employment by, or other contractual arrangement with, the Hospital or an affiliate will not preclude an individual from serving on the Fair Hearing Committee. If three (3) members of the Staff who meet these requirements cannot be identified, then one or more members of the Fair Hearing Committee may be appointed from New Jersey licensed physicians or retired New Jersey physicians not currently having Medical Staff privileges or membership at this Hospital, but qualified to serve by training, experience, and similar considerations. Notwithstanding the foregoing, nothing in these Bylaws shall prohibit the Fair Hearing Committee from being comprised of one or more persons who previously served as a panelist in a hearing on the same underlying facts. Solely as means of example, a panelist who served on a Fair Hearing Committee to consider a member's appeal of a precautionary suspension shall not be prohibited from serving as a member of a Fair Hearing Committee with respect to a member's subsequent appeal of an adverse recommendation to terminate or permanently suspend privileges arising from the action that was the basis of the precautionary suspension.

8.6-2. Additional Panelists

If a qualified panel cannot be constituted solely with Medical Staff Members, in the discretion of the President of the Medical Staff with the concurrence of the Chief Executive Officer, individuals unaffiliated with the Medical Staff may be appointed to serve with Members of the Medical Staff on the Fair Hearing Committee. In any instance, a majority of the panel shall be Physicians. If, because of the qualifications set forth herein, no Members of the Medical Staff can serve, the President of the Medical Staff, with the concurrence of the Chief Executive Officer, may request the Board to appoint the Fair Hearing Committee.

8.6-3. Hearing Officer

The Fair Hearing Committee or the President of the Medical Staff may request that the Chief Executive Officer of the Hospital, or designee, appoint a Hearing Officer who shall be an attorney of the State of New Jersey. The Hospital attorney may serve as Hearing Officer. Either the Hearing Officer, if appointed, or the Chair of the Fair Hearing Committee or the Chair's designee, shall preside over the hearing to determine the order or procedure during the hearing, to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum. The Hearing Officer shall advise the Fair Hearing Committee but shall not participate in the decision of the Fair Hearing Committee although the Hearing Officer may attend deliberations. The Hearing Officer shall be available to the members of the Fair Hearing Committee after the conclusion of the hearing to advise them on procedural or legal matters and to assist the panel with the drafting of its report and recommendations. The Hearing Officer may, in their discretion, require attendance of the affected Practitioner and a member of the body whose adverse recommendation is the subject of the hearing, along with their attorneys or other representatives, to attend a pre-hearing conference for the purpose of delineating issues, witnesses, exchanging exhibits, and resolving any other issues that may expedite the conduct of the hearing.

8.7. Board Hearing

When a hearing relates to an adverse decision of the Board that is contrary to the recommendation of the Executive Committee, the Board shall appoint a Board Fair Hearing Committee of not less than three (3) of its members.

8.7-1. Qualifications

No Board member who is in direct economic competition with the Practitioner or who has a stake in the outcome of the proceedings shall be appointed to such committee.

8.7-2. Alternates

If a qualified committee cannot be constituted from Board membership, the Board may in its discretion appoint an outside hearing officer unaffiliated with the Hospital to conduct the hearing; the Board may appoint unaffiliated individuals who are not in economic competition with the Practitioner to serve on a panel with Board members to conduct such hearing; or the Board may appoint a panel of unaffiliated individuals to conduct the hearing.

8.8. Conduct of Hearing

The hearing, whether by the Medical Staff Fair Hearing Committee or the Board Fair Hearing Committee, shall be conducted in accordance with the rules set forth herein. If in the course of the hearing a matter arises which these Bylaws do not address, the Fair Hearing Committee Chair shall be authorized to determine how to proceed.

8.8-1. Committee Presence

There shall be at least a majority of the members of the Fair Hearing Committee present when the hearing takes place. Any member of the Fair Hearing Committee, including any alternate, who participates in the entire hearing and reviews the transcript of any portion of the hearing for which the panel member is not in personal attendance, may be permitted to participate in the deliberations and to vote on the recommendations of the hearing panel.

8.8-2. Practitioner Presence

The personal presence of the Practitioner for whom the hearing has been scheduled shall be required. A Practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived their rights in the same manner and with the same effect as provided in §8.4-2.

8.8-3. Record of Proceedings

An accurate record of the hearing shall be kept by transcription by a court stenographer or reporter, the cost of which shall be borne by the Hospital.

8.8-4. Hearing Postponement

Postponement of a hearing beyond the time set forth in these Bylaws shall be made only with the approval of the Fair Hearing Committee. Granting of such postponements shall only be for good cause shown and in the sole discretion of the Fair Hearing Committee.

8.8-5. Evidence

The hearing need not be conducted strictly according to the rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objection in civil or criminal action. The Fair Hearing Committee shall have the right to consider any pertinent material contained on file in the Hospital and any other information which might be considered in the decision on initial appointment and reappointment. The Fair Hearing Committee shall have the right to question any witness in the course of the hearing. The Practitioner shall have notice of and an opportunity to rebut any such information considered. Evidence unrelated to the reasons for the recommendations or the Practitioner's qualifications for appointment, reappointment or the relevant Clinical Privileges will be excluded.

8.8-6. Hearing Rights

All parties to the hearing shall at any time prior to or during the hearing, or no later than three (3) Days after the closing of the hearing be entitled to submit memoranda concerning any issue of procedure or of fact and such memoranda shall become a part of the hearing record. The affected Practitioner and the Executive Committee or Board, as the case may be, shall have the following rights:

(a) To be represented by an attorney or other person of the participant's choice;

(b) To call, examine and cross-examine witnesses. Notice is hereby given to the participants that no party has the legal power of subpoena;

(c) To introduce evidence or exhibits determined to be relevant by the Chair of the Fair Hearing Committee, regardless of its admissibility in a court of law;

(d) To challenge any witness and to rebut any evidence;

(e) To obtain a copy of the transcript of the hearing upon payment of reasonable charges associated with its preparation;

(f) If the Practitioner does not testify in their own behalf, they may be called and examined as if under cross-examination;

(g) To submit a written statement at the commencement of the hearing which shall not exceed ten (10) pages in length; and

(h) To submit a written statement at the close of the hearing which shall not exceed ten (10) pages in length.

8.8-7. Chair of the Fair Hearing Committee

The Chair of the Fair Hearing Committee, or the Fair Hearing Officer shall preside over the hearing to determine the order of procedure during the hearing, to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum. The Chair shall have the authority to decide matters of procedure during the course of the hearing.

8.8-8. Representation

The affected Practitioner shall be entitled to be represented at the hearing by a representative of their choice. The Executive Committee or Board, as appropriate, shall appoint representatives as follows:

(a) When its action has prompted the hearing, the Executive Committee shall appoint one of its members, some other Medical Staff Member and/or an attorney to represent it at the hearing, to present the facts in support of its adverse recommendation and to examine witnesses.

(b) When its action has prompted the hearing, the Board shall appoint one of its members and/or an attorney to represent it at the hearing, to present the facts in support of its adverse decision and to examine witnesses.

8.8-9. Burden of Proof

It shall be the obligation of the Executive Committee or Board representative to go forward and present evidence in support of the adverse recommendation or decision. In response the affected Practitioner shall have the burden of proof. The affected Practitioner shall thereafter be responsible for supporting their challenge to the adverse recommendation or decision by demonstrating by clear and convincing evidence that the adverse recommendation was unsupported by the evidence, arbitrary, unreasonable or capricious. After all the evidence has been submitted by both sides, the Fair Hearing Committee shall recommend in favor of the Executive Committee and/or the Board unless it finds that the individual who requested the hearing has proved by clear and convincing evidence that the recommendation or decision that prompted the hearing was unsupported by the evidence, arbitrary, unreasonable or capricious.

8.8-10. Deliberations, Recesses and Adjournment

The Fair Hearing Committee may, 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, the hearing shall be closed. The Fair Hearing Committee may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the Practitioner for whom the hearing was convened, and any representatives of any of the parties.

8.8-11. Written Report

Within thirty (30) Days after final adjournment of the hearing, the Fair Hearing Committee shall make a written report and recommendation and shall forward the same together with the hearing record and all other documentation to the Executive Committee or to the Board, whichever appointed it with a copy to the Chief Medical Officer. The report may recommend confirmation, modification or rejection of the original adverse recommendation of the Executive Committee or decision of the Board.

8.8-12. Notice

The Chief Medical Officer or designee shall within ten (10) Days of receipt of the report of the Fair Hearing Committee give Written Notice of the result to the Practitioner accompanied by a copy of the written report and recommendation, with copies to the President of the Medical Staff and to the body making the initial adverse recommendation.

8.8-13. Action on Fair Hearing Committee Report

At its next regular meeting after receipt of the Fair Hearing Committee Report, the Executive Committee or the Board, as appropriate, shall act to affirm, modify or reverse the original adverse recommendation.

8.8-14. Effect of Favorable Action

If the Executive Committee's action on the Fair Hearing Committee report is favorable to the Practitioner, the Chief Medical Officer shall transmit the result within seven (7) Days to the Board for final action. The CMO or designee shall provide Written Notice within ten (10) days to the Practitioner of the result, the requirement of final action by the Board and the date of the Board meeting. At its next regularly scheduled meeting, the Board shall act. If the Board takes action favorable to the Practitioner it shall be final action and the matter shall be closed. If the Board takes action adverse to the Practitioner it shall proceed as set forth in §8.8-15, below. The Chief Medical Officer shall give the Practitioner Written Notice of the Board's decision within ten (10) Days.

8.8-15. Effect of Adverse Action

If the Executive Committee, or Board in the event of a favorable action as set forth in §8.8-14, takes action on the Fair Hearing Committee report which is adverse to the Practitioner as set forth at §8.2-1, the Chief Medical Officer or designee shall within ten (10) Days notify the Practitioner of their right to appellate review in accordance with §8.9.

8.8-16. Board Remand

If the Board decides to remand the matter to the Executive Committee for either review of the matter in total, or consideration of specific issues, the Chief Medical Officer shall notify the Practitioner and Executive Committee within ten (10) Days. The notice shall state the matter to be determined and a deadline for a decision which shall in no event exceed thirty (30) Days from the date of the notice.

8.9. Appeal to the Board

The notice of an adverse action provided to the Practitioner under §8.8-15 shall state the action taken, the right to appellate review, time limits to request review and a summary of appellate review rights. Within ten (10) Days after receipt of a notice to an affected Practitioner of an adverse recommendation or decision made or adhered to after a hearing as above provided, the Practitioner may, by Written Notice to the Board delivered through the President of the Hospital, request an appellate review by the Board. The grounds for appellate review shall be limited to the following: the adverse recommendation or decision against the Practitioner was unsupported by the evidence, arbitrary, unreasonable or capricious and/or there was substantial failure to comply prior to the hearing with the provisions in the Bylaws so as to deny basic fairness or reasonable due process.

8.9-1. Waiver of Appeal

If such appellate review is not requested within ten (10) Days, the affected Practitioner shall be deemed to have waived their right to the same, and to have accepted such adverse recommendation or decision and the same shall become effective immediately as provided in §8.4-3 of this Fair Hearing Plan. In any waiver under this provision, the Chief Medical Officer shall notify the affected Practitioner within five (5) Days of their status by certified mail, return receipt requested.

8.9-2. Notification to Practitioner

Within thirty (30) Days after receipt of a request for appellate review, the Board shall appoint the Appellate Review Committee and shall, through the Chief Medical Officer or designee, by Written Notice, notify the affected Practitioner of the same along with the notice set forth in §8.9-4.

8.9-3. Composition of the Appeals Panel

The appellate review shall be conducted by the Board or by a duly appointed Appellate Review Committee of the Board of not less than three (3) members none of whom shall be either in direct economic competition with the affected Practitioner or financially advantaged or disadvantaged by the outcome of the proceedings. The Appellate Review Committee may request the appointment of counsel to assist them in determining order and procedure and to maintain decorum. Counsel shall advise the Appellate Review Committee but shall not participate in its deliberations. Counsel to the Appellate Review Committee may assist in the drafting of the Committee's report and recommendations. The Hospital attorney may serve as such counsel.

8.9-4. Scheduling the Appeal

Within thirty (30) Days after receipt of a request for appellate review, the Appellate Review Committee shall select a date for such review and shall, through the Chief Medical Officer or designee, by Written Notice, notify the affected Practitioner of the same. The date of the appellate review meeting shall not be less than thirty (30) Days from the date of notification to the Practitioner of the meeting date nor more than seventy five (75) Days, from the date of receipt of the request for appellate review.

8.9-5. Rights of Parties

The parties shall have access to the report and transcript of the Fair Hearing Committee and all other material, favorable or unfavorable, that was considered in making the adverse recommendation or decision against the Practitioner.

8.9-6. Written Submissions

Each party to the review, as determined by the Board, shall have the right to submit a written statement to the Chief Executive Officer setting forth the factual and procedural positions each advocates within the scope described in §8.9-7. Any such written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may participate in its preparation.

(a) Any party making such a submission shall provide it to the Appellate Review Committee within ten (10) Days after notice of the date of the appeal is received.

(b) Any party making any submission to the Appellate Review Committee under this section shall simultaneously provide a copy of the submission to the other party.

(c) Any party receiving a written submission may submit a written rebuttal to the Board within ten (10) Days of receipt of the initial submission to be rebutted. No other written submissions will be accepted unless requested by the Board in its sole discretion.

(d) The failure of any party to timely submit a statement under this section shall constitute a waiver of such right.

8.9-7. Scope of Review

The Board or its appointed review committee acting as the appellate body shall review the report and transcript of the Fair Hearing Committee and all other material, favorable or unfavorable, that was considered in making the adverse recommendation and shall consider the written statements submitted pursuant to the preceding section, for the purpose of determining whether the adverse recommendation or decision against the affected Practitioner was unsupported by the evidence, arbitrary, unreasonable or capricious. The review committee shall not hear testimony of witnesses.

8.9-8. Oral Argument

Review shall be on the record unless the affected Practitioner requests, and the Appellate Review Committee in its sole discretion grants, permission for oral argument or if the Board or Appellate Review on its own motion determines that oral argument is appropriate.

(a) A request for oral argument must be submitted with an initial written statement, if any, by the Practitioner or, if no initial submission is made, with the Practitioner's written rebuttal submission, if any. If the Practitioner makes no written submissions, a request for oral argument must be received by the Chief Medical Officer no later than twenty (20) Days from receipt of notice of the date of appellate review.

(b) A request for oral argument shall indicate with specificity why oral argument would enhance consideration of the appeal.

(c) The Appellate Review Committee shall rule on the request for oral argument within five (5) Days of its receipt by the Chief Medical Officer, and shall provide Written Notice of its determination to the Practitioner.

(d) The Appellate Review Committee shall have the right on its own motion, without Practitioner request, to require oral argument. If it makes such a motion, it shall notify the parties of its decision no later than five (5) Days prior to the date of the appellate review.

(e) If oral argument is permitted or required, the Practitioner shall be present, shall be permitted to speak against the adverse decision or recommendation, and shall answer questions presented by any member of the appellate review body.

(f) The failure of the Practitioner to appear shall be deemed a waiver of all rights associated with, related to, or arising out of such appearance.

(g) With Board approval, a representative designated by the Committee making the adverse recommendation or decision and subject to Board approval, shall be permitted to speak in favor of the adverse recommendation or decision and shall answer questions presented by members of the Appellate Review Committee.

(h) Attorneys at law shall be permitted to be present and to advise any party in an oral argument, but shall not be permitted to make any statements unless the Appellate Review Committee in its discretion waives this provision and permits attorneys at law to make statements.

8.9-9. Appellate Review Committee Determinations

The Appellate Review Committee shall issue its determination within ten (10) Days of the adjournment of its proceedings and shall present its findings in writing to the Board with a copy to the Parties. It may recommend that the Board affirm, modify or reverse the prior decision, or refer the matter back to the Executive Committee for further review and recommendation including a request for a further hearing to resolve specified disputed issues pertaining to the Medical Staff determination. Such further action shall be concluded within thirty (30) Days. If the Board acts as the Appellate Review Committee, instead of appointing a review committee to act as the appellate body as permitted in §8.9-7, the determination of the Appellate Review Committee shall be the final decision of the Board.

8.9-10. Exhaustion of Appellate Review

Appellate review shall be deemed concluded only when all the procedural steps provided herein have been completed or waived. Any failure of the affected Practitioner to timely exercise their procedural rights shall be deemed a waiver of such rights. Any actions required of the review panel shall not be delayed except for good cause which shall be documented in the record of the appeal.

8.10. Final Decision by Board

Within thirty (30) Days after the conclusion of the appellate review, the Board shall make its decision in the matter, providing Written Notice to the parties, whatever the scope of the final decision, through the Chief Medical Officer or designee. If the Board denies a Practitioner initial Medical Staff appointment or reappointment or revokes such Practitioner's Staff Membership or Clinical Privileges and the Practitioner has exhausted their rights under this Article 8, such Practitioner may not apply for appointment or reappointment to the Medical Staff or for the affected Clinical Privileges for a period of two (2) years following the final action or decision of the Board, unless set forth to the contrary by the Board in rendering its final decision in the matter.

8.11. One Hearing on Each Matter

No applicant or member of the Medical Staff shall be entitled as a matter of right to more than one hearing and one appellate review on any matter which has been the subject of an action by the Executive Committee, the Board of Governors or a duly authorized committee of either the Medical Staff, Board or both. For purposes of this provision, the matter shall be defined as the underlying action of the applicant or the Medical Staff member which was the basis of the corrective action recommended. Solely as means of example, the termination of a Member's clinical privileges after a precautionary suspension which has been appealed by the Practitioner and ultimately approved by the Board shall entitle the Practitioner to an appeal as to the propriety of the termination only and not the underlying facts that gave rise to the adverse recommendation to precautionarily suspend.

8.12. Confidentiality

All confidential documentation is provided to the Practitioner under the express provisions that such documentation and information is confidential, will be maintained as confidential and will not be disclosed or used for any purpose outside of the hearing processes contained in these Bylaws. The Practitioner shall require their counsel and all experts to execute at HIPAA compliant Business Associate's Agreement with respect to any patient health information contained in any document, record or information provided, prior to providing access to the same. The Practitioner shall provide a written representation that they have obtained such executed Business Associates Agreement at any time upon request.

Article 9

Officers of the Medical Staff

9.1. Officers of the Medical Staff

The officers of the Medical Staff shall be:

- President
- Vice-President
- Immediate Past President
- Secretary
- Treasurer

9.2. Qualifications for Elective Office

All candidates for elective office shall be Members of the Active or Senior Staff at the time of nomination and election and shall remain voting Members of the Active or Senior Staff in good standing during their term of office. Good standing includes current payment of dues, no dues, fines or fees in arrears, compliance with meeting attendance requirements and no current medical records or other suspension. Failure to maintain such status shall immediately terminate an officer's tenure in office and shall create a vacancy in the office involved. Nominees for the offices of President and Vice-President must have been a member of the Active or Senior Staff and have served on the Medical Staff for at least three (3) years at the time of the election. In

addition, each nominee for the offices of President or Vice President must have previously served as an officer of the Medical Staff, a member of the Executive Committee, a Department Chair, a Division Director, or as the chair of one of the Medical Staff Committees listed in Article 11 of these Bylaws. No officer shall serve concurrently as a medical executive committee member, officer of or leader in any medical staff and/or department or division of any other hospital or health system including its affiliated entities, or be employed by another hospital or its affiliated entities including a captive physician practice. Notwithstanding the forgoing, at-large members of the Executive Committee may be employed by another hospital or its affiliated entities if the individual is employed through a contracted service.

9.3. Nominations

Nominations for Medical Staff offices, members-at-large positions and the APP member of the Executive Committee shall be made as follows:

9.3-1. By the Nominating Committee

The Nominating Committee or its designee shall advise the voting members of the Medical Staff of the date it will convene and request those interested in serving who meet the qualifications for office as described in §9.2 of these Bylaws to notify the Nominating Committee of their interest. The Nominating Committee or its designee shall also advise the members of the APP Staff of the date it will convene and request those interested in serving as an APP member of the Executive Committee to notify the Nominating Committee of their interest. The Nominating Committee shall convene no earlier than the date provided to the voting members to consider one or more nominees for each office except for the office of immediate Past President, and members-at-large positions which may, but need not, include those Members and APPs who have advised the Nominating Committee of their interest in serving, and shall submit the nominations to the Executive Committee no later than September 1st. The slate of nominees shall be provided to voting members of the Medical Staff no later than October 1st.

9.3-2. By the Membership

Additional nominations for officers (except for the immediate Past President), the APP representative to the Executive Committee and/or members-at-large to serve on the Executive Committee may be made by petition signed by at least ten (10%) percent of the Members of the Active Medical Staff and filed with the Director of Medical Staff Services no later than seven (7) days before the annual meeting of the Medical Staff scheduled to conduct the election. All nominees must meet the qualifications for office as described in §9.2 of these Bylaws.

9.4. Elections

The President, Vice-President, Secretary and Treasurer, as well as the members-at-large who will serve on the Executive Committee, including the APP representative to the Executive Committee, shall be elected at the meeting of the Medical Staff where the quorum described in §13.4 has been met, held in the 4th quarter of the calendar year, by a majority of votes cast by Members present at the meeting and eligible to vote. The outgoing President shall automatically succeed to the office of Immediate Past President upon the completion of their term as President. Proxy voting is not permitted. Unless uncontested, voting shall be done by secret written ballot

counted by the Secretary of the Medical Staff and one (1) additional person appointed by the President.

9.5. Term of Office

All elected officers shall serve for a two (2) year term beginning on January 1 following the date in which the officer was elected. The President may not serve more than one (1) consecutive two (2) year term without a break in service of at least one (1) year. The Immediate Past President shall serve in that office for so long as their successor shall remain President of the Medical Staff. Notwithstanding the foregoing, any officer's service while filling a vacancy as described in §9.6 below, will not be counted in determine the officer's elected term and/or any term limitation set forth herein.

9.6. Vacancies

In the event of a vacancy in the office of President, the Vice-President, shall assume the vacant office through the balance of the President's term. Vacancies in other offices during the Medical Staff year shall be filled by the Executive Committee through the unexpired balance of the term of office.

9.7. Removal of Officers

Officers may be removed as follows:

9.7-1. Failure to Maintain Qualification

An officer who ceases to be a Member in good standing of the Active or Senior Staff or who otherwise no longer meets the qualifications specified in §9.2 shall be automatically removed from office. For the purposes of this Section, an officer shall cease to be a member in good standing of the Active or Senior Staff if their dues, fees or fines are in arrears, they fail to maintain meeting attendance requirements and/or they are currently suspended including suspension for failure to complete medical records for more than fourteen (14) consecutive days.

9.7-2. Other Good Cause

Any officer may be removed for good cause, which shall mean that the elected individual either has neglected their duties, has performed their duties in an incompetent manner or has performed in such a manner as to bring discredit upon the Medical Staff of the Hospital.

(a) Removal shall be initiated by written petition signed by at least fifty (50) Members of the Active and Senior Staff; and

(b) Approval of the removal shall require the affirmative votes of not less than two-thirds (2/3) of the entire Membership of the Active and Senior Staff present at a regular or special meeting of the Medical Staff where a quorum is present.

9.8. Duties of Officers

The officers of the Medical Staff shall perform the duties set forth in these Bylaws and such other functions as may be from time to time assigned by the President of the Medical Staff or the Executive Committee. Designated officers shall serve on the Board of Governors as delineated in the Bylaws of Board of Governors of the AtlantiCare Regional Medical Center.

9.8-1. President

The duties of the President shall be:

(a) To act in coordination and cooperation with the Chief Executive Officer or designee with regard to issues of mutual concern within the Hospital;

(b) To preside at all general meetings of the Medical Staff;

(c) To serve as Chair of the Executive Committee;

(d) To serve as ex-officio member of all other Medical Staff committees, except the Nominating Committee, where the President serves without vote;

(e) To be responsible for the enforcement of the Medical Staff Bylaws, Rules and Regulations and Policies of the Medical Staff, for implementation of sanctions and for the Medical Staff's compliance with procedural safeguards when corrective action has been requested against a Practitioner;

(f) To appoint committee members to all Medical Staff committees, except the Executive Committee;

(g) To represent the views, policies, needs and grievances of the Medical Staff to the Chief Executive Officer of the Hospital and the Board.

(h) To receive and interpret the policies of the Board to the Medical Staff and report to the Board on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care; and

(i) To be the spokesman for the Medical Staff in its external professional and public relations.

9.8-2. Vice-President

In the absence of the President, the Vice-President shall assume all the duties and have the authority of the President. The Vice President shall be a member of the Executive Committee and shall be an ex-officio member of all other Medical Staff committees without vote, except the Nominating Committee, where the Vice President does not serve. The Vice-President shall succeed to the office of` President if the office of President becomes vacant for any reason.

9.8-3. Immediate Past President

The Immediate Past President acts as an advisor to the President and shall serve as a voting member of the Executive Committee.

9.8-4. Secretary

The Secretary shall be a member of the Executive Committee. The Secretary shall keep accurate and complete minutes of all Medical Staff meetings and Executive Committee meetings, call Medical Staff meetings on order of the President, attend to all correspondence, tally the votes for any elections and perform such other duties as ordinarily pertain to the office.

9.8-5. Treasurer

The Treasurer shall be accountable for collection and disbursement of Staff funds.

Article 10

Departments

10.1. Departments, Divisions and Sections

The Medical Staff shall be organized into Departments, each of which shall have a Chair who has the authority, duties and responsibilities specified in these Bylaws. A Department may be divided into Divisions and Sections.

10.1-1. Departmental Organization

The Departments, Divisions and Sections of the Medical Staff are:

(a) Department of Anesthesiology and Perioperative Medicine

(b) Department of Critical Care

(c) Department of Emergency Services

(d) Department of Medicine

(i) Division of Cardiology

(ii) Division of Family Medicine

(iii) Division of Gastroenterology

(iv) Division of General Internal Medicine

(A) Section of Allergy

(B) Section of Dermatology

(C) Section of Endocrinology

(D) Section of Gerontology

(E) Section of Neurology

(F) Section of Palliative Care

(G) Section of Rheumatology

(v) Division of Hematology and Oncology

(vi) Division of Infectious Diseases

(vii) Division of Nephrology

(viii) Division of Physical Medicine and Rehabilitation

(ix) Division of Pulmonary Diseases

(x) Division of Radiation Oncology

(e) Department of Neurosciences

(i) Division of Neurology

(ii) Division of Neurosurgery

(f) Department of Obstetrics and Gynecology

(i) Section of Female Pelvic Medicine and Reconstructive Surgery

(ii) Section of Maternal and Fetal Medicine

(iii) Section of Ob/Gyn Oncology

(iv) Section of Reproductive Endocrinology

(g) Department of Pathology and Laboratory Services

(h) Department of Pediatrics

(i) Division of General Pediatrics

(A) Section of Pediatric Allergy

(B) Section of Pediatric Pulmonary Medicine

(C) Section of Pediatric Subspecialties

(ii) Division of Neonatology

(i) Department of Psychiatry

(i) Section of Addiction Medicine

(ii) Section of Psychology

(j) Department of Radiology

(i) Division of Diagnostic Imaging

(A) Section of Angiography and Interventional Procedures

(B) Section of Computed Tomography

(C) Section of Magnetic Resonance Imaging

(D) Section of Mammography

(E) Section of Nuclear Medicine

(F) Section of Ultrasonography

(k) Department of Surgery

(i) Division of Cardiac Surgery

(ii) Division of General Surgery

(A) Section of Bariatric Surgery

(B) Section of Pediatric Surgery

(C) Section of Thoracic Surgery

(iii) Division of Vascular Surgery

(A) Section of Podiatric Surgery

(B) Section of Wound Care

(iv) Division of Ophthalmology

(v) Division of Oral and Maxillofacial Surgery

(vi) Division of Orthopedic Surgery

(A) Section of Hand Surgery

(vii) Division of Otolaryngology- Head and Neck Surgery

(viii) Division of Plastic and Reconstructive Surgery

(A) Section of Hand Surgery

(ix) Division of Spine Surgery

(x) Division of Trauma Surgery

(xi) Division of Urology

10.1-2. Changes in Departments, Divisions and Sections

Departments, Divisions and Sections may be created, eliminated, or combined upon recommendation of the Executive Committee and approval by the Board.

10.1-3. Department, Division and Section Meetings

Each Department shall meet at least quarterly at the call of the Department Chair. Divisions shall meet according to the rules of the applicable Department or, if such rules do not specify the number of Division meetings, each Division shall meet no less than one (1) time per year at the call of the Division Director. Each Section shall meet no less than one (1) time per year at the call of the Section Chief. Each Department, Division and Section shall maintain minutes of its proceedings, actions and recommendations which shall be submitted to the Executive Committee. No less than fourteen (14) days advance written or email notice of a meeting(s) shall be provided to members of the Department, Division or Section.

10.1-4. Functions of Departments

The primary responsibility of each Department is to continuously monitor and evaluate activities of the Department in order to improve the quality and efficiency of patient care. In fulfillment of that responsibility each Department, through the involvement of its members, shall:

(a) Establish criteria to be used to monitor the quality of care within the Department;

(b) Conduct ongoing monitoring, assessment and improvement of the quality of patient care and services provided, including the quality of medical histories and physical examinations, and the clinical performance of individuals with delineated Clinical Privileges within the Department;

(c) Participate in the Hospital's Quality Assurance Plan and establish a written Quality Assurance Plan which describes the methods to be used in performing such activities, and which delineates Staff responsibilities for accomplishing all tasks in a timely fashion;

(d) Draw conclusions, formulate recommendations, and initiate actions as a result of evaluating the care provided by the Department and communicate such conclusions, findings, recommendations and actions to Department members;

(e) Establish criteria for the granting of Clinical Privileges within the Department for review and recommendation by the Credentials Committee subject to approval by the Executive Committee and the Board;

(f) Responsible for mechanisms to establish and enforce criteria to delegate oversight responsibilities to Practitioners;

(g) Report to Executive Committee on a periodic basis concerning:

(i) Findings of the Department's review and evaluation activities, actions taken thereon, and the results of such action;

(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 Executive Committee;

(h) Responsible for mechanisms to establish and maintain patient care standards; and

(i) To provide leadership in patient safety activities, oversight in analyzing and improving patient satisfaction and mechanisms to ensure patients receive appropriate and uniform care, treatment and services.

10.1-5. Functions of Divisions

Divisions participate in credentialing, privilege delineation, and establishment of service obligations for their members, under the authority of the applicable Department. Divisions may perform such other duties as shall be assigned by the applicable Department.

10.2. Department Chairs, Division Directors and Section Chief

Each Chair of a Department, each Director of a Division and each Section Chief shall be a Member in good standing of the Active or Senior Medical Staff, who is board-certified in the Department, Division or Section primary area of practice (as applicable) based on privilege delineation. Department Chairs shall be board-certified in the primary areas of practice of the Department or at least one (1) Division falling under it. The Division Director and Section Chief shall be Board certified in the primary area of practice of the applicable Division or Section. There is no length of service requirements for Department Chairs, Division Directors, or Section Chiefs. Each Chair, Director, and Chief shall be qualified by training, experience and demonstrated current ability in the clinical area of the Department, Division or Section and shall be willing and able to discharge the administrative responsibilities of their office. Department Chairs are selected and appointed by the Chief Executive Officer. Division Directors shall be appointed by their respective Department Chair. Section Chiefs shall be appointed by their

respective Division Director in consultation with the applicable Department Chair. Associate Chairs of Departments shall be appointed by their respective Department Chair.

No Department Chair, Associate Chair, Division Director, or Section Chief may serve concurrently as an officer or leader of any department or division of any other hospital, as a medical executive committee member, officer of or leader in any medical staff of any other hospital or health system including its affiliated entities, or be employed by another hospital or its affiliated entities including a captive physician practice. Notwithstanding the foregoing, Department Chairs, Associate Chairs, Division Directors, and Section Chiefs may be employed by another hospital or its affiliated entities if the individual is employed through a contracted service.

10.2-1. Removal

A Department Chair, Division Director, or Section Chief who ceases to be a Member in good standing of the Active or Senior Staff or meet the other qualifications contained in these Bylaws shall be automatically removed from office. Department Chairs, Division Directors, and/or Section Chiefs may be removed by: the individual with authority to make appointments to the specified office. In addition, by two-thirds (⅔) of the voting members of the Executive Committee present at a meeting, the Executive Committee may recommend to the Chief Executive Officer the removal of a Department Chair, Division Director and/or Section Chief. If the Chief Executive Officer fails to remove such individual, the matter shall be referred to the Board or the applicable Board committee for final determination.

10.2-2. Duties of Chairs

Each Chair shall be administratively responsible for the functions of their Department. The Chair shall be accountable for all clinically related and administratively related activities within the Department including:

(a) Coordinating and integrating services within the Department, among Departments and Divisions, and with other hospital functions;

(b) Developing and implementing policies and procedures that guide and support the provision of services within the Department;

(c) Recommending to the Credentials Committee the criteria for Clinical Privileges in the Department;

(d) Making recommendations to the Credentials Committee concerning a sufficient number of qualified and competent persons to provide care, treatment and services, appointment and classification, reappointment and delineation of Clinical Privileges relevant to the care provided in the Department and Practitioners and APP Staff in the Department;

(e) Continuing surveillance of the professional performance of all individuals who have delineated Clinical Privileges in the Department;

(f) Assuring that the quality and appropriateness of patient care within the Department are maintained and evaluated through quality control programs, including the continuous assessment and improvement of the quality of care and services provided;

(g) Establishing Departmental Rules and Regulations consistent with those of the Medical Staff and Hospital, and enforcing the Hospital and Medical Staff Bylaws, Rules, Regulations and Policies within the Department, including initiating corrective action and investigating clinical performance;

(h) Coordinating and overseeing in-service training, orientation and continuing education of all persons in the Department;

(i) Recommending the space, personnel and other resources needed by the Department;

(j) Recommending off-site sources for needed patient care, treatment and services not provided by the Department or by the Hospital;

(k) Recommending a sufficient number of qualified and competent persons to provide care;

(l) Determining qualifications and competence of Department or service personnel who are not Providers who provide patient care, treatment and services;

(m) Orienting and continuing education of staff in the Department; and

(n) Integrating of the Department into the primary functions of the Hospital.

10.2-3. Duties of Division Directors

Each Division Director shall perform such duties as are assigned pursuant to the Departmental rules which apply to the Division. In addition, the Division Director shall recommend to the Department Chair criteria for Clinical Privileges in the Division and shall make recommendations concerning, appointment and classification, reappointment, delineation of Clinical Privileges and corrective action with respect to Practitioners in the Division.

10.2-4. Associate Chairs and Directors

Each Department Chair shall appoint an Associate Chair to serve in the absence of the Chair and the Associate Directors to serve in the absence of the Directors of those Divisions within the Department. The qualifications and term of office of Associate Chair and Associate Directors shall be the same as those of the Chairs and Directors.

Article 11

[Reserved]

Article 12

Committees

12.1. Medical Staff Committees

Medical Staff Committees are those committees which are part of the Medical Staff organization. Except for the Executive Committee and the Nominating Committee, the President of the Medical Staff shall appoint committees and committee chairs from the Membership of the Medical Staff. Appointments shall be for one year. Members and chairs may be reappointed. The President of the Medical Staff shall be a voting member of the Executive Committee and an ex-officio member of all other committees, unless otherwise provided herein.

12.1-1. Minutes

Each Committee Chair shall appoint a secretary to keep written minutes. Minutes shall be submitted to the Executive Committee with the originals retained in the Medical Staff Office.

12.1-2. Membership

Each committee shall consist of at least five (5) members, except as otherwise provided in these Bylaws. Vacancies in the membership of any committee except the Executive Committee and the Nominating Committee may be filled by the President of the Medical Staff. Vacancies in the at-large membership of the Executive Committee may be filled by the Executive Committee, unless such vacancy occurs during the regular election cycle and shall be filled through those processes.

12.1-3. List of Medical Staff Committees

The Medical Staff Committees are:

(a) Executive Committee;

(b) Officers' Council;

(c) Bylaws Committee;

(d) Continuing Medical Education Committee;

(e) Credentials Committee;

(f) Nominating Committee;

(g) Medical Staff Excellence Committee;

(h) Patient Care and Resource Management Committee;

(i) Focused Professional Practice Evaluation Committee.

12.2. Institutional Committees Chaired by Physicians

The following institutional committees shall be composed of Members of the Staff and other Hospital representatives and shall be chaired by a Member of the Staff. The chair and the Physician members of these committees shall be appointed by the President. Other committee members shall be appointed by the Chief Executive Officer.

(a) Blood Usage and Transfusion Committee;

(b) Emergency Committee;

(c) Infection Control Committee

(d) Critical Care Committee;

(e) Medical Ethics Committee;

(f) Cancer Committee;

(g) Nutrition Committee;

(h) Perinatal Committee;

(i) Pharmacy and Therapeutics Committee;

(j) Trauma Committee;

(k) Perioperative Committee; and

(l) Institutional Review Board

12.3. Other Institutional Committees

The President shall appoint the Physician members of other institutional committees established by the Hospital.

12.4. Executive Committee

The Executive Committee shall consist of between eighteen (18) and twenty-eight (28) fully licensed members of the Active or Senior Staff, the majority of whom are actively practicing in the Hospital, along with one APP. Medical Staff members on the Active and Senior Staff are eligible for Executive Committee membership. No member of the Executive Committee shall concurrently serve as an officer of or leader in any medical staff and/or department or

division of any other hospital or health system including its affiliated entities, or be employed by another hospital or its affiliated entities including a captive physician practice. Notwithstanding the forgoing, at-large members of the Executive Committee may be employed by another hospital or its affiliated entities if the individual is employed through a contracted service.

The composition of the Executive Committee is as follows:

(a) The President, Vice-President, Immediate Past President, Secretary and Treasurer of the Attending Medical Staff. The Chairs of the Departments of Medicine, Surgery, Obstetrics and Gynecology, Neurosciences, Pediatrics, Radiology, Pathology, Anesthesiology, Emergency Services, Critical Care and Psychiatry.

(b) The Chair of the Credentials Committee and the Bylaws Committee with vote and the Chair of the Medical Staff Excellence Committee, Medical Director of Academic Affairs, and the Chief Medical Quality Officer without vote.

(c) The Hospital Chief Medical Officer.

(d) The System Chief Medical Officer.

(e) The Chief Physician Executive.

(f) One (1) APP appointed by the Chief Executive Officer or designee.

(g) Five (5) members-at-large elected from the entire Active Staff. . If the President is Chair of a Clinical Department, then the Associate Chair shall fill an at large seat for the President's term.

(h) The Chief Executive Officer, Chief Hospital Executive, hospital administrators, Chief Medical Officer of Quality and Population Health, Trauma Medical Director, and corporate nurse executive shall be ex-officio members of the Executive Committee without voting privileges.

12.4-1. Duties

The duties of the Executive Committee shall be:

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

(b) To regularly receive and act upon reports and recommendations from Medical Staff Committees and from clinical Departments and Divisions;

(c) To approve and implement policies of the Medical Staff;

(d) To provide liaison between the Medical Staff and the Board;

(e) To recommend action to the Chief Executive Officer on matters of a medico-administrative nature;

(f) To review the credentials of all applicants and to make recommendations directly to the Board for Staff Membership, reappointment and delineation, renewal or changes in Clinical Privileges;

(g) To review the quality of medical care as it relates to the delivery of both medical and institutional services and to evaluate utilization review activities;

(h) To serve as the review body for all Medical Staff performance improvement matters and to fulfill the Medical Staff's accountability to the Board;

(i) To make recommendations to the Board concerning:

(i) the structure of the Medical Staff;

(ii) the mechanisms used to review credentials and delineate individual Clinical Privileges;

(iii) individuals applying for Medical Staff Membership, and regarding delineated Clinical Privileges for each eligible individual privileged through the Medical Staff;

(iv) the organization of the performance improvement and utilization review activities of the Medical Staff and the mechanism used to conduct, evaluate and revise such activities;

(v) the mechanisms by which Medical Staff Membership may be terminated; and

(vi) the mechanism for fair hearing procedures.

(j) to take a leadership role in Hospital performance improvement activities to improve quality of care, treatment and services and patient safety and to provide leadership for measuring, assessing and improving processes that primarily depend on the activities of the Medical Staff and the APP Staff;

(k) to be actively involved in the measurement, assessment and improvement of the following:

(i) medical assessment and treatment of patients;

(ii) use of information about adverse privileging decisions for any Member of the Medical Staff;

(iii) use of medications;

(iv) use of blood and blood components;

(v) operative and other procedures;

(vi) appropriateness of clinical practice patterns;

(vii) significant departures from established patterns of clinical practice; and

(viii) the use of developed criteria for autopsies.

Information used as part of the performance improvement mechanisms, measurement or assessment shall include sentinel event data and patient safety data;

(l) To report at each general Staff meeting;

(m) To coordinate the activities and general policies of the various Departments;

(n) To ensure that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the Hospital; and

(o) To take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all Members of the Medical Staff, including the request of evaluations of Practitioners privileged through the Medical Staff where there is doubt about its Member's ability to perform privileges requested.

12.4-2. Meetings

The Executive Committee shall meet at least ten (10) times a year on a monthly basis. The President of the Medical Staff may call a special meeting of the Executive Committee at any time, and shall call a special meeting upon the request of any five (5) members of the Executive Committee. The presence of fifty (50%) percent of the Executive Committee shall constitute a quorum for action requiring a vote.

12.5. Officers' Council

The Officers' Council shall consist of the President, Immediate Past President, Vice-President, Secretary and Treasurer of the Medical Staff.

12.5-1. Duties

The duties of the Officers' Council shall be:

(a) To meet and act for the Executive Committee when a matter requires urgent action and a timely meeting, if the Executive Committee cannot be convened, subject to ratification of any such action at the next meeting, of the Executive Committee;

(b) To act as a liaison among Departments of the Medical Staff, and to mediate differences among Departments and among Staff Members; and

To perform such other duties may be assigned by the Executive Committee.

12.5-2. Meetings

The Officers' Council shall meet on the call of the President as needed.

12.6. Bylaws Committee

The Bylaws Committee shall include the Chief Medical Officer as a voting member.

12.6-1. Duties

The duties of the Bylaws Committee are:

(a) To review the Medical Staff Bylaws and Rules and Regulations at least every two (2) years, and to propose to the Medical Staff revisions or additions to the Bylaws and Rules and Regulations, in accordance with legal and accreditation requirements and Medical Staff needs;

(b) To receive and act upon recommendations from the Medical Staff regarding amendments to the Bylaws and Rules and Regulations; and

(c) To report to the Executive Committee regarding proposed amendments to the Bylaws, Rules and Regulations in accordance with Article 14.

12.6-2. Meetings

The Bylaws Committee shall meet at least every two (2) years or more often at the discretion of the Chair.

12.7. Continuing Medical Education Committee

The Continuing Medical Education Committee shall consist of a physician Chair appointed by the Chief Medical Officer, Director of Medical Education; the Continuing Medical Education/Library Services Supervisor; Physician Members of the Medical Staff representing a range of medical subspecialties; and one or more representative(s) from the Department of Quality Management.

12.7-1. Duties

The Continuing Medical Education Committee shall have the following duties:

(a) To offer programs of quality continuing medical education to Members of the Medical Staff, which programs shall relate, at least in part, to the type and nature of care, treatment and services offered by the Hospital;

(b) To assess the need for education in specific areas through the quality assessment and performance improvement process;

(c) To perform an annual survey to determine the continuing medical education needs of the Medical Staff;

(d) To facilitate the documentation of CME credits for Staff Members; and

(e) To maintain the accreditation of the Hospital's Continuing Medical Education program with accrediting organizations.

12.7-2. Meetings

The Continuing Medical Education Committee shall meet at least quarterly, and more frequently as necessary.

12.8. Credentials Committee

The Credentials Committee shall consist of the Department Chairs, the Immediate Past President, the President and Vice President of the Medical Staff, the Chief Medical Officer, the Chair of the Bylaws Committee, the Corporate Nurse Executive and up to two (2) additional members appointed by the President of the Medical Staff.

12.8-1. Duties

The duties of the Credentials Committee are:

(a) To review the credentials of each applicant for appointment, reappointment and Clinical Privileges and to make recommendations to the Executive Committee for membership and delineation of Clinical Privileges, including specific consideration of the recommendations from the Departments in which such applicant requests Clinical Privileges; and

(b) To review the credentials of each APP who performs clinical functions in the Hospital for the delineation of Clinical Privileges to provide patient care activities in the Hospital.

12.8-2. Meetings

The Credentials Committee shall meet at least eight (8) times a year, including all months in which there are meetings of the Board of Governors.

12.9. Medical Staff Excellence Committee

The duties of the Medical Staff Excellence Committee shall be: Evaluation of Individual Cases, Evaluation of Rate and Rule Indicators, Improvement Opportunities and Measurement System Management and to oversee Department/Division and clinical service related peer review activities. The composition, operation, and duties of the Medical Staff Excellence Committee shall be set forth in its Charter.

12.10. Nominating Committee

The Nominating Committee shall consist of the five (5) most recent past Presidents of the Medical Staff, and the current President ex-officio without vote.

12.10-1. Duties

The duties of the Nominating Committee are:

(a) To consider the qualifications of the Members of the Active and Senior Medical Staff for Staff offices, and to prepare a slate containing one or more nominees for each position to be filled for presentation to the Executive Committee in accordance with §9.3; and

(b) To nominate members-at-large to the Executive Committee from among the Members of the Active and Senior Staff.

12.10-2. Meetings

The Nominating Committee shall meet at least once a year at a time which will permit it to meet its reporting responsibility.

12.11. Cancer Committee

The composition, operation and duties of the Cancer Committee shall be set forth in its Cancer Committee Membership and shall comply with Standard Volume 1.2.1 (ACOS).

12.12. Patient Care and Resource Management Committee

The composition, operation, and duties of the Patient Care and Resource Management Committee shall be set forth in its Charter.

12.13. Ad Hoc Committees

Ad Hoc Committees may be established by the Executive Committee or the President of the Medical Staff for a specific and time-limited purpose as the need arises.

Article 13

Medical Staff Meetings

13.1. Regular Medical Staff Meetings

There shall be at least four (4) regular meetings of the Medical Staff held in a calendar year. These shall include an annual meeting at which officers shall be elected and installed. The purpose of Medical Staff meetings shall be to review issues of concern to the Medical Staff, to conduct continuing medical education, to conduct town meetings with the Hospital and System administration, and to perform required Medical Staff functions. Communication between meetings will occur via periodic communications to all Medical Staff Members.

13.2. Special Meetings

The Secretary of the Medical Staff shall call a special meeting upon request of the Board, the President, or the Executive Committee, or upon written petition signed by ten (10%) percent of the Members of the Active and Senior Staff. Upon receipt of such a request, the Secretary shall give notice by mail to all Members of the Medical Staff, stating the nature of the business to be transacted at the meeting. No other business shall be transacted at the meeting except that stated in the notice.

13.3. Quorum

The presence of fifty (50) Members of the Medical Staff eligible to vote shall constitute a quorum for the transaction of business of the Medical Staff. Once a quorum is present at the start of a meeting, the failure to maintain a quorum throughout the meeting shall not inhibit any subsequent action at that meeting.

13.4. Attendance Requirements.

Each Member of the Active and Senior Staff shall observe the following attendance requirements for Medical Staff, Department and Division meetings. Each such Staff Member shall attend at least fifty percent (50%) of the Division meetings in the previous twelve (12) month period, or such greater amount as may be established by the Division, in order to vote in the Division when such meeting requirements are met and shall attend at least fifty (50%) percent of the Department meetings in the previous twelve (12) month period, or such greater amount as may be established by the Department, in order to vote in the Department when such meeting requirements are met. Members of the Active and Senior Staff are only permitted to vote in matters that come before the Medical Staff if they have met their respective meeting attendance requirements as set forth in this Section. Medical Staff members are also encouraged to attend at least one (1) Medical Staff meeting in each twelve (12) month period. Members of the Medical Staff are required to participate in Hospital mandated educational programs (i.e., annual reviews). Only those Members of the Staff who have complied with such requirements and who have attended at least one (1) Medical Staff meeting during the previous twelve (12) month period are eligible to run for any leadership position, including Medical Staff Officer, Department or Committee Chairs, Division Director or Section Chiefs.

13.5. Administrative Involvement

The CEO or designee shall attend all Medical Staff meetings. Administrative personnel may be invited to attend Department and Division meetings.

13.6. Minutes

The Secretary of the Medical Staff or designee shall keep minutes of all Medical Staff meetings reflecting the actions taken and recommendations made at the meetings. The original of such minutes shall be filed in the Medical Staff Office.

13.7. Voting

Proxy voting is not permitted in any meeting of the Medical Staff, any Medical Staff Committee, and/or in any meeting of a Department, Division or Section. Only Practitioners in good standing (no dues, fees or fines in arrears), compliance with meeting attendance requirements and/ or are not subject to a suspension including a current medical records suspension) shall be eligible to vote.

Article 14

Confidential, Immunity and Releases

14.1. Special Definitions

For the purpose of this Article only, the following definitions shall apply:

(a) Information means records of proceedings, minutes, records, reports, interviews, investigations, memoranda, statements, recommendations, conclusions, actions, data and other disclosures, whether in written, oral or electronic form, relating to any of the subject matter specified in this Article;

(b) Malice means the dissemination of a knowing falsehood or of information with a reckless disregard for whether it is true or false;

(c) Representative means the Board of Governors, any Board member or committee thereof, the Hospital Chief Executive or designee, registered nurses and other employees of the Hospital, the Executive Committee, the Medical Staff organization and any Member, officer, Department or committee thereof, a credentialing verification organization and any individual authorized by any of the foregoing to perform specific information gathering analysis, use or disseminating functions provided that such individual has been trained in confidentiality requirements and has signed a written acknowledgement of such obligation; and

(d) Third Parties means both individuals and organizations providing Information to any Representative.

14.2. Authorization and Conditions

By applying for or exercising Clinical Privileges a Provider:

(a) Authorizes and directs Representatives of the Hospital and the Medical Staff to solicit, provide and act upon Information which may bear on their professional ability, utilization practices and qualifications;

(b) Agrees to be bound by the provisions of this Article and not to sue and to waive all legal claims against any Representative or Third Party who acts in accordance with the provisions of this Article;

(c) Acknowledges that the provisions of this Article are express conditions to the application for or acceptance of Staff Membership, or the exercise of Clinical Privileges at the Hospital; and

(d) Authorizes the Hospital to consult with and query the New Jersey Division of Consumer Affairs Health Care Professional Information Clearing House, the National Practitioner Data Bank, and other sources for the purpose of evaluating the Provider for hiring, continued employment or new or continued privileges and otherwise in connection with any application, reappointment application and exercise of Clinical Privileges.

14.3. Confidentiality of Information

Information with respect to any Provider which is submitted, collected or prepared by a Representative of the Hospital or Medical Staff or any other health care facility or organization or medical staff, for the purpose of achieving and maintaining quality patient care, reducing morbidity and mortality, contributing to medical research, or other peer review activities pursuant to state or federal law shall, to the fullest extent permitted by law, be confidential and shall not be disseminated to anyone other than a Representative of the Hospital or Medical Staff nor used in any way except as provided herein. Such confidentiality shall also extend to Information of like kind that may be provided by Third Parties. This Information shall not become part of any particular patient's file or of the general Hospital records. A breach of this provision by a Representative who is a Provider shall be grounds for corrective action under §7.1-4.

14.4. Immunity from Liability for Action Taken

No Representative of the Hospital or Medical Staff shall be liable to a Provider in any proceeding for damages or other relief for any action taken or statement or recommendation made within the scope of their duties as a Representative, if such Representative acts after a reasonable effort under the circumstances to ascertain the truthfulness of the facts and in the reasonable belief that the action, statement, or recommendation is warranted by such facts. Regardless of the provisions of state law, truth shall be an absolute defense in all circumstances.

14.5. Immunity from Liability for Providing Information

No Representative of the Hospital or Medical Staff shall be liable to a Provider in any proceeding for damages or other relief by reason of providing Information, including otherwise privileged or confidential Information, to a Representative of the Hospital or Medical Staff or to any other hospital, organization of health professionals or other health-related organization concerning a Provider who is or has been an applicant to or Member of the Medical or APP Staff or who did or does exercise Clinical Privileges at the Hospital, provided that such Representative or Third Party undertakes a reasonable effort under the circumstances to ascertain the truthfulness of the facts and in the reasonable belief that the action, statement, or recommendation is warranted by such facts.

14.6. Activities and Information Protected

The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health-related institutions or organizations activities concerning:

(a) Applications for appointment, Clinical Privileges or specified services;

(b) Periodic reappraisals for reappointment or Clinical Privileges;

(c) Corrective or disciplinary action including precautionary suspensions or automatic suspensions or limitations;

(d) Hearings and appellate reviews;

(e) Medical care evaluations;

(f) Quality Review Program activities including Utilization reviews; and

(g) Other Hospital Staff, Department or committee activities related to monitoring and maintaining quality patient care and appropriate professional conduct and other acts including any otherwise protected by law.

14.7. Information Protected

The acts, communications, reports, recommendations, disclosures and other Information referred to in this Article may relate to a Provider's professional activities, professional qualifications, clinical ability, judgment, character, current physical and mental health as they relate to a Provider's ability to exercise Clinical Privileges, emotional stability, professional ethics or any other matter that might be relevant to patient care.

14.8. Releases

Each Provider shall, upon request of the Medical Staff, APP Staff or the Hospital, execute general and specific releases in accordance with the tenor and import of this Article, subject to such requirement, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of the State of New Jersey. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

14.9. Cumulative Effect

Provisions in these Bylaws and in application forms relating to authorizations, confidentiality of information and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof.

Article 15

Rules and Regulations

15.1. Medical Staff Rules and Regulations

The Medical Staff shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found within these Bylaws subject to the approval of the Board of Governors. These shall relate to the proper conduct of Medical Staff organizational activities as well as the standards of practice that are required of each Provider at the Hospital. These Rules and Regulations shall be reviewed at least annually and more often as needed to reflect the Hospital's current practice.

15.1-1. Adoption and Amendment

Such Rules and Regulations shall be part of these Bylaws, except that they may be amended or repealed in the manner set forth in 15.2-3, below. Amendments to the Rules and Regulations may also be proposed directly to the Board of Governors upon a petition of twenty (20) voting members of the Medical Staff. Any proposed amendments made by petition shall also be submitted to the Bylaws Committee and Executive Committee for review and comment. Urgent Amendments may be made pursuant to Section 15.2-5, below. The Bylaws Committee shall consider each proposed amendment and make a report to the Executive Committee or if the Bylaws Committee fails to act in a timely manner, the Executive Committee may consider such proposed amendment without a recommendation from the Bylaws Committee. The Executive Committee shall consider the proposed amendment and Bylaws Committee report and shall make a recommendation which, if such recommendation results in a proposed change to the Rules and Regulations, shall be voted on as set forth in Section 15, below. Amendments shall be effective upon approval by the Board. The Medical Staff Rules and Regulations may not be unilaterally amended by the Medical Staff or the Board of Governors.

15.1-2. Effect of Rules and Regulations

The Rules and Regulations of the Medical Staff are intended to implement these Bylaws and shall have the same force and effect. In the event of any actual or apparent conflict between these Bylaws and the Rules and Regulations, these Bylaws shall control.

15.2. Departmental Rules and Regulations

Subject to the approval of the Executive Committee and the Board of Governors, each Department shall formulate its own rules and regulations for the conduct of its affairs and the discharge of its responsibilities. Such rules and regulations shall not be inconsistent with these Bylaws, the Rules and Regulations of the Medical Staff or other policies of the Hospital. In the case of inconsistencies among Departments, the Executive Committee shall resolve conflicts or may utilize the conflict resolution process contained in Article 16.

Article 16

Adoption and Amendment of Bylaws

16.1. Review

These Bylaws shall be reviewed at least every two (2) years and more often as is needed to reflect the Hospital's current practices.

16.2. Medical Staff Responsibility and Authority

The Medical Staff shall have the initial responsibility and delegated authority to formulate, adopt and recommend to the Board of Governors, Bylaws and amendments thereto which shall be effective when approved by the Board. These Bylaws may not be unilaterally amended by the Medical Staff or the Board of Governors.

16.2-1. Request for a Bylaws Amendment

Proposed amendments to these Bylaws may be submitted to the Executive Committee or to the Bylaws Committee by any Staff Member, by the Chief Executive Officer, or by the Board. Amendments to these Bylaws may also be proposed directly to the Board of Governors upon a petition of twenty (20) voting members of the Medical Staff. Any proposed Bylaws amendments made by petition shall also be submitted to the Executive Committee and Bylaws Committee for review and comment. Thereafter, the procedures contained in these Bylaws shall govern. The Bylaws Committee shall consider each proposed amendment and make a report to the Executive Committee or if the Bylaws Committee fails to act in a timely manner, the Executive Committee may consider such proposed amendment without a recommendation from the Bylaws Committee. The Executive Committee shall consider the proposed amendment and Bylaws Committee report and shall make a recommendation which, if such recommendation results in a proposed change to the Bylaws, shall be voted on as set forth in §16.2-3, below.

16.2-2. Notice of Proposed Bylaws and/or Rules and Regulations Amendments

Following any affirmative vote of the Executive Committee, all voting members of the Medical Staff shall receive a description of the proposed amendment(s) by regular or electronic mail.

16.2-3. Adoption of Amendments

At least thirty (30) days following this dissemination of the proposed amendment(s), all voting members of the Medical Staff will be eligible to vote on the proposed amendment(s). This vote may be conducted via printed and/or electronic ballot in a manner determined by the Executive Committee. Ballots that are not returned will be considered abstentions. To be adopted, the proposed amendment(s) must be affirmed by a majority of the members of the voting members of the Medical Staff who voted and the Board of Governors must subsequently ratify the amendment(s).

16.2-4. Adoption of Technical Amendments

The Executive Committee shall have the power to adopt such amendments to the Bylaws as are, in the committee's judgment, technical or regulatory modifications or clarifications, reorganization or renumbering, or amendments made necessary because of punctuation, spelling or other errors of grammar or expression. Such amendments shall be effective immediately upon notice to the Board. The action to amend may be taken by a motion acted upon in the same manner as any other motion before the Executive Committee

16.2-5. Adoption of Urgent Amendments

In the event there is a documented need for an urgent amendment to the Bylaws and/or Rules and Regulations or the adoption of a new rule, regulation, or policy to comply with a law or regulation, the Executive Committee may provisionally adopt, and the Board of Governors may provisionally approve, an urgent amendment to the Bylaws and/or Rules and Regulations without prior notification to the Medical Staff. In such event, the Medical Staff shall be immediately notified of the amendment and its purpose and members of the Medical Staff may, within thirty (30) calendar days, submit to the Executive Committee any comments regarding the provisional amendment. Upon petition signed by twenty (20) voting Members of the Medical Staff entitled to vote, the provisional amendment may be submitted to the conflict management process set forth in Article 16 of these Bylaws. The results of the conflict management process shall be communicated to the Executive Committee, the voting members of the Medical Staff and the Board. Any repeal or revision of a provisional amendment shall be subject to approval by the Board of Governors.

16.3. Recording

The text of each amendment to or repeal of these Bylaws shall be attached hereto with a notation of the date of such amendment or repeal.

Article 17

Conflict Resolution

17.1. Conflict Resolution Process

In the event of a conflict between members of the Organized Medical Staff and the Executive Committee regarding the adoption of any bylaw, rule, regulation or policy, or any amendment thereto, or with regard to any other matter, upon a petition signed by twenty (20) members of the Medical Staff entitled to vote, or a majority of members of a Section, Division or Department if the matter involves a Department, Division or Section, the matter shall be submitted to the conflict resolution process set forth herein.

17.2. Conflict Resolution Committee

An Ad hoc Conflict Resolution Committee shall be formed consisting of up to five (5) representatives of the voting Medical Staff designated by the Medical Staff members submitting the petition and an equal number of representatives of the Executive Committee appointed by the President of the Medical Staff. The Chief Executive Officer or designee shall be an ex-officio non-voting member of any Conflict Resolution Committee.

The members of the Conflict Resolution Committee shall gather information regarding the conflict, meet to discuss the disputed matter, and work in good faith to resolve the differences between the parties in a manner consistent with protecting safety and quality.

Any recommendation which is approved by a majority of the voting Medical Staff representatives and a majority of the Executive Committee representatives shall be submitted to the Board of Governors for consideration. If agreement cannot be reached, the members of the Conflict Resolution Committee shall individually or collectively report to the Board of Governors regarding the unresolved differences for consideration by the Board in making its final decisions regarding the matter in dispute.

17.3. Conflicts within the Medical Staff

In the event of a dispute between leaders or segments of the Medical Staff, the matter in dispute shall be considered by a Conflict Resolution Committee composed of equal number of members representing opposing viewpoints who are appointed by the President or the Executive Committee. The members of the Conflict Resolution Committee shall proceed in accordance with §17.2.

17.4. Conflicts with the Board

In the event of a dispute between the Board of Governors and the Organized Medical Staff or the Board of Governors and the Executive Committee, the matter in dispute shall be submitted to a Joint Conference of an equal number of the Medical Staff appointed by the Medical Staff President and non-Medical Staff members of the Joint Conference/Medical Affairs Committee appointed by the Chair of the Board for review and recommendation before making its final decision and giving notice of the final decision utilizing the processes contained in the Board of Governors Bylaws. The Executive Committee or the Board may also request the convening of a Joint Conference to discuss any matter of controversy or concern that would benefit from enhanced dialogue between Medical Staff and Board leaders.

17.5. Resolution Techniques

If deemed appropriate by the President of the Medical Staff and the Chief Executive Officer, an outside mediation or facilitator may be engaged to assist with the resolution of any disputed issues.

Article 18

Parliamentary Authority

In all matters not covered by the Bylaws, the Medical Staff shall be governed by the spirit of Robert's Rules of Order.

Reviewed and Approved by Board of Trustees

June 1996
November 1998
September 1999
December 2000
September 2001
March 2002
October 2004
April 30, 2008
October 27, 2010
February 17, 2011
October 25, 2011
November 12, 2013
October 8, 2014
December 2, 2015
March 18, 2016
May 25, 2017
January 26, 2018
May 31, 2019
June 10, 2020
December 8, 2022
September 18, 2025