# MEDICAL STAFF CREDENTIALING PROCEDURES MANUAL

Martin Memorial Medical Center, Inc.
Stuart, Florida

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DEFINITIONS

The definitions applicable in this Credentialing Procedures Manual are those stated in the Medical Staff Bylaws.
PART ONE. APPOINTMENT PROCEDURES

1.1 APPLICATION
An application for Staff membership must be submitted by the applicant in writing and on such form as approved by the Board, the Medical Executive Committee (MEC), and the Credentials Committee or as otherwise required by law. Prior to the application being submitted, the applicant will be provided a copy or summary of, or access to a copy of, the Corporate Bylaws, the Medical Staff Bylaws and related manuals, the Rules and Regulations of the Staff and its Departments/Services, and summaries of other Hospital and Staff policies and resolutions relating to clinical practice in the Hospital.

1.2 APPLICATION CONTENT
Every application must furnish complete information concerning at least the following:

(a) Undergraduate, graduate, and postgraduate training, including the name of each institution, degrees granted, program completed, dates attended, and names of practitioners monitoring the applicant's performance. The applicant must account for all activities during all periods of time from undergraduate training to the present time.

(b) All past and currently valid medical, dental, podiatric, psychological, and other professional licensures or certifications, and Federal Drug Enforcement Administration registration for the State of Florida and any other controlled substances registration, with the date and number of each.

(c) Specialty or sub-specialty board certification, recertification, or eligibility status to sit for the examination.

(d) Information on malpractice claims history and experience (suits and settlements made, concluded and pending).

(e) Any pending or completed action involving denial, revocation, suspension, reduction, limitation, probation, non-renewal or voluntary relinquishment (by resignation or expiration) of: license or certificate to practice any profession in any state or country; Drug Enforcement Administration or other controlled substances registration; membership or fellowship in local, state or national professional organizations; faculty membership at any medical or other professional school; staff membership status, prerogatives or clinical privileges at any other hospital, clinic or health care institution; professional liability insurance.

(f) Location of offices; names and addresses of other practitioners with whom the applicant is or was associated and inclusive dates of such association; names and locations of any other hospital, clinic or health care institution where the applicant provides or provided clinical services with the inclusive dates of each affiliation, status held, and general scope of clinical privileges.

(g) Department/Service assignment, Staff category, and specific clinical privileges requested.
Any current felony criminal charges pending against the applicant and any past charges including their resolution.

References as required by Section 1.3 below.

Statements that the applicant has been notified of and agrees to the scope and extent of the authorization, confidentiality, immunity, and release provisions of the Medical Staff Bylaws and this Credentialing Procedures Manual.

1.3 REFERENCES

The application must include the names of at least two (2) practitioners, not newly associated or about to become partners with the applicant in professional practice or personally related to him/her, who have personal knowledge of the applicant's current clinical ability, ethical character, health status and ability to work cooperatively with others and who will provide specific written comments on these matters upon request from Hospital or Medical Staff authorities.

The named individuals must have acquired the requisite knowledge through recent observation of the applicant's professional performance over a reasonable period of time.

1.4 EFFECT OF APPLICATION

The applicant must sign the application and in so doing:

(a) attests to the correctness and completeness of all information furnished and acknowledges that any material misstatement in or omission from the application constitutes grounds for denial of appointment or for dismissal from the Staff;

(b) signifies his/her willingness to appear for interviews in connection with his/her application;

(c) agrees to abide by the terms of the Bylaws and related manuals, rules, policies and procedure manuals of the Medical Staff and those of the Hospital if granted membership and/or clinical privileges, and to abide by the terms thereof in all matters relating to consideration of the application without regard to whether or not membership and/or privileges are granted;

(d) agrees to maintain an ethical practice and to provide continuous care to his/her patients;

(e) agrees to keep Hospital representatives up to date on any change made or proposed in the status of his/her professional license to practice, DEA or other controlled substances registration, professional liability insurance coverage, and membership or clinical privileges at other institutions, and on the status of current or initiation of new malpractice claims;

(f) authorizes and consents to Hospital representatives consulting with prior associates or others who may have information bearing on professional or ethical qualifications and competence and consents to their inspecting all records and documents that may be material to evaluation of said qualifications and competence;
releases from any liability all those who, in good faith and without intentional fraud, review, act on or provide information regarding the applicant's competence, professional ethics, utilization practice patterns, character, health status, and other qualifications for Staff appointment and clinical privileges.

For purposes of this Section, the term "Hospital representative" includes: the Board of Directors, its individual directors and committees; the Chief Executive Officer and his/her designees; the Medical Staff organization and all Medical Staff members, clinical units and committees which have responsibility for providing information about or collecting and evaluating the applicant's credentials or acting upon his/her applications; and any authorized representative of any of the foregoing.

1.5 PROCESSING THE APPLICATION

1.5-1 APPLICANT'S BURDEN
The applicant has the burden of producing adequate information for a proper evaluation of and of resolving any doubts about his/her experience, training, current competence, utilization practice patterns, ability to work cooperatively with others, and health status, and any other qualifications required for Staff membership or the requested Staff category, Department/Service assignment, or clinical privileges, and of satisfying any reasonable requests for information or clarification (including health examinations) made by appropriate Medical Staff or Board authorities. Any intentional misrepresentation in or omission from the application shall constitute sufficient grounds for rejection of the application and request for clinical privileges.

1.5-2 VERIFICATION OF INFORMATION
The completed application shall be submitted to the Chief Executive Officer or his/her designee. Representatives of Medical Staff Services, working with the Credentials Committee Chairperson, shall organize and coordinate the collection and verification of the references, licensure and other qualification evidence submitted and promptly notify the applicant of any problems in obtaining the information required. This must be a special notice and must indicate the nature of the additional information the applicant is to provide, if any, and the time frame for response. Failure, without good cause, to respond in a satisfactory manner by that date is deemed a voluntary withdrawal of the application.

Verification shall include sending a copy of the list of clinical privileges requested by the applicant to at least his/her most recent affiliations and a request for specific information regarding his/her competence in exercising those privileges. When collection and verification is accomplished, Medical Staff Services shall transmit the application and all supporting materials to the Chairperson of each Department/Chief of each Service in which the applicant seeks privileges.

1.5-3 MEDICAL STAFF INPUT
The name of each applicant and a brief summary of his/her credentials shall be made available to members of the Staff. Any Medical Staff member may submit in writing to the applicable Department Chairperson/Service Chief or to the Credentials Committee a written statement containing relevant information regarding an applicant’s qualifications for membership or the privileges requested. Any such
member may request or may be requested to confer with the Department Chairperson/Service Chief or the Credentials Committee to discuss his/her statement.

1.5-4 DEPARTMENT/SERVICE EVALUATION
The Chairperson of each Department/Chief of each Service in which the applicant seeks privileges shall review the application and its supporting documentation and forward to the Credentials Committee a written report as required by Section 1.5-9 within ten (10) days of being informed that the application is complete and ready for review. All information sought or acquired by the Chairperson/Chief as part of his/her evaluation must be included with his/her report.

A Department Chairperson/Service Chief or his/her designee may conduct an interview with the applicant. If a Department Chairperson/Service Chief requires further information, he/she may defer transmitting his/her report but for not more than thirty (30) days beyond the ten (10) day limit except for good cause. In case of a deferral, the applicable Department Chairperson/Service Chief must notify the Credentials Committee and obtain the additional information he/she needs to process the application. At his/her discretion, the Department Chairperson/Service Chief may communicate verbally with the applicant in order to expedite the acquisition of any additional information required. A written record of the verbal communication, including the date, nature of requested information and expected time for receipt of the information, shall be kept with the credentials file. If the verbal request is not productive, or the Department Chairperson/Service Chief chooses not to communicate verbally, then the applicant is to be notified in writing of the deferral and the grounds. If the applicant is to provide the additional information or a specific release/authorization to allow Hospital representatives to obtain information, the notice to him must so state, must be a special notice, and must include a request for the specific data/explanation or release/authorization required and the time frame for response. Failure, without good cause, to respond in a satisfactory manner by that date is deemed a voluntary withdrawal of the application.

1.5-5 CATEGORIZING APPLICATIONS
After the application and its supporting documentation have been reviewed by the Chairperson of each Department/Chief of each Service in which the applicant seeks privileges, the application will be placed into one (1) of three (3) categories by the Director of Medical Staff Services, based on the following criteria:

(a) **Category One Applications**: To be considered a Category One application, the application must satisfy all of the following criteria:

1. all application information is promptly verified; if an applicant cannot satisfy this requirement as a result of completing graduate or postgraduate training overseas and subsequently completed postgraduate training in the United States, the application may be considered a Category One so long as all other Category One criteria are satisfied;

2. all references are fully positive;

3. a) there is no history of any prior malpractice settlements or judgments, or b) there is a history of one (1) prior malpractice
settlement or judgment not exceeding $10,000, or c) a history of one (1) malpractice settlement or judgment in excess of $10,000 that occurred more than 10 years prior to the date of application for appointment privileges;

(4) there is no history of prior disciplinary actions, licensure restrictions, or any other professional investigations;

(5) all requested privileges are consistent with the applicant's specialty, established criteria, and privileges generally requested by physicians in that specialty, and the training, experience, and current clinical competence of the applicant;

(6) all input received from the Medical Staff under Section 1.5-3 above is fully positive; and

(7) the evaluation of each applicable Department Chairperson/Service Chief is fully positive.

(b) Category Two Applications: Applications which do not satisfy the requirements to be considered a Category One application, but otherwise satisfy each of the following criteria, shall be considered Category Two applications:

(1) all application information is promptly verified, or difficulties occur in the verification of application information, but all such information is verified;

(2) all references are fully positive, or are generally positive but contain some information suggesting minor problems;

(3) the application satisfies the malpractice settlement/judgment criteria for a Category One application, or there is a history of one (1) malpractice settlement or judgment in excess of $10,000 that occurred within the immediate past 10 years;

(4) no prior disciplinary action, licensure restrictions or any other professional investigations, or a history including professional investigations which have been fully and completely resolved and which resulted in no disciplinary action or restrictions of any kind;

(5) all requested privileges are consistent with the specialty, established criteria and privileges generally requested by physicians in that specialty, or the requested privileges vary from those generally requested by physicians in the specialty, but which have been approved without any recommended restrictions by the appropriate Department Chairperson/Service Chief and, under either circumstance, are consistent with the training, experience, and current clinical competence of the applicant;

(6) all input from the Medical Staff under Section 1.5-3 above is fully positive or is generally positive but contains some information suggesting minor problems; and

(7) the evaluation of each applicable Department Chairperson/Service Chief is fully positive, or is generally positive but contains some information suggesting minor problems.
(c) **Category Three Applications**: All applications which do not satisfy the criteria for being considered Category One applications or Category Two applications shall be considered Category Three applications.

### 1.5-6 PROCESSING CATEGORY ONE APPLICATIONS

(a) **Credentials Committee Evaluation**: The Credentials Committee Chairperson shall assign a member of the Credentials Committee to review the application, the supporting documentation, the reports from the Department Chairpersons/Service Chiefs, and any other relevant information and forward to the Medical Staff President a written report as required by Section 1.5-9 within ten (10) days after receiving the Department Chairpersons/Service Chiefs’ reports, unless the Credentials Committee member determines that the application should be considered a Category Two or Category Three application, in which event the application shall automatically be referred to the Credentials Committee as a whole, to be processed in accordance with the provisions of this Manual. All Category One applications will be submitted to the Credentials Committee for information purposes, provided that no formal recommendation of the Credentials Committee shall be required on any such application, and further provided that the Credentials Committee may make any recommendation it deems appropriate on any such application.

(b) **Medical Executive Committee Evaluation**: Upon receipt of a Category One application, the Medical Staff President or designee (who must be a member of the MEC who has not previously reviewed the application as a Department Chairperson/Service Chief), shall review the application, the supporting documentation, the reports from the Department Chairpersons/Service Chiefs, the Credentials Committee members’ report, and any other relevant information available to him/her and forward to the Chief Executive Officer a written report as required by Section 1.5-9 within ten (10) days after receiving the application from the Credentials Committee, unless the Medical Staff President or designee determines that the application should otherwise be considered a Category Two or Category Three application, in which event the application shall automatically be referred to the Credentials Committee as a whole, to be processed in accordance with the provisions of this Manual. All Category One applications will thereafter be submitted to the MEC at its next regular meeting for ratification of action taken. The MEC may make any recommendation it deems appropriate on any such application.

(c) **Action by the Chief Executive Officer and MSARC/Report to the Board**: Upon receipt of the Category One application, the Chief Executive Officer shall review the application, the supporting documentation, the reports from the Department Chairperson/Service Chiefs, and the Medical Staff President or designee, and any other relevant information. If the Chief Executive Officer determines that the application should be considered a Category Two or Category Three application, the application shall automatically be referred to the Credentials Committee as a whole, to be processed in accordance with the provisions of this Manual. So long as the Chief Executive Officer...
determines that the application should be considered a Category One application, the Chief Executive Officer may call a meeting of the Medical Staff Application Review Committee (MSARC), acting on behalf of and as a subcommittee of the Board. The MSARC shall grant Medical Staff appointment and requested clinical privileges unless it determines that the application should be considered a Category Two or Category Three application, in which event the application shall automatically be referred to the Credentials Committee as a whole, to be processed in accordance with the provisions of this Manual. The Chief Executive Officer shall report to the Board at its next regularly scheduled meeting regarding all Staff appointments and clinical privileges granted by the MSARC pursuant to this Section. The Board shall not be required to take any action on such applications, further provided that they may take such action as they deem appropriate.

1.5-7 PROCESSING CATEGORY TWO APPLICATIONS

(a) Credentials Committee Evaluation: The Credentials Committee shall review all Category Two applications, together with the supporting documentation, the reports from the Department Chairpersons/Service Chiefs, and any other relevant information available to it, and forward to the MEC a written report as required by Section 1.5-9 within thirty (30) days after receiving the Department Chairpersons/Service Chiefs reports.

The Credentials Committee may, at its discretion, conduct an interview with the applicant or designate one (1) or more of its members to do so. If the Credentials Committee requires an interview, the application shall automatically be considered a Category Three application.

(b) Medical Executive Committee Evaluation: If the report of the Department Chairpersons/Service Chiefs and Credentials Committee on the Category Two application are fully positive, the Medical Staff President or designee (who must be a member of the Medical Executive Committee who has not previously reviewed the application as a Department Chairperson/Service Chief) shall review the application, the supporting documentation, the reports from the Department Chairpersons/Service Chiefs, the reports of the Credentials Committee, and any other relevant information available to him/her and forward to the Chief Executive Officer a written report as required by Section 1.5-9 within ten (10) days after receiving the Credentials Committee’s report, unless the Medical Staff President or designee determines that the application should be considered a Category Three application, in which event the application shall automatically be referred to the MEC as a whole, to be processed in accordance with the provisions of this Manual. All Category Two applications will thereafter be submitted to the MEC at its next regular meeting for ratification of action taken. The MEC may make any recommendation it deems appropriate.

(c) Action by the Chief Executive Officer and MSARC/Report to the Board: Upon receipt of the Category Two application, the Chief Executive Officer shall review the application, the supporting documentation, the reports from
the department chairpersons/service chiefs, the Credentials Committee, and
the Medical Staff President or designee, and any other relevant information.
If the Chief Executive Officer determines that the application should be
considered a Category Three application, the application shall automatically
be referred to the Medical Executive Committee as a whole, to be processed
in accordance with the provisions of this Manual. So long as the Chief
Executive Officer determines that the application should be considered a
Category Two application, the Chief Executive Officer may call a meeting of
the Medical Staff Application Review Committee (MSARC), acting on behalf
of and as a subcommittee of the Board. The MSARC shall grant Medical
Staff appointment and requested clinical privileges unless it determines that
the application should be considered a Category Three application, in which
event the application shall automatically be referred to the Medical Executive
Committee as a whole, to be processed in accordance with the provisions of
this Manual. The Chief Executive Officer shall report to the Board at its next
regularly scheduled meetings regarding all Staff appointments and clinical
privileges granted by the MSARC pursuant to this Section. The Board shall
not be required to take any action on any such applications, further provided
that they may take such action as they deem appropriate.

1.5-8 PROCESSING CATEGORY THREE APPLICATIONS

(a) Credentials Committee Evaluation: The Credentials Committee shall review
the Category Three application, the supporting documentation, the reports
from the Department Chairpersons/Service Chiefs, and any other relevant
information available to it and forward to the MEC a written report as required
by Section 1.5-9 within thirty (30) days after receiving the Department
Chairpersons/Service Chiefs’ reports.

The Credentials Committee may, at its discretion, conduct an interview with
the applicant or designate one (1) or more of its members to do so. If the
Credentials Committee requires further information, it may defer transmitting
its report but generally for not more than forty (40) days, except for good
cause and must notify, through the Medical Staff Services, the President of
the Staff of the deferral and the grounds. The Credentials Committee must
then obtain the additional information it needs to process the application. At
its discretion, the Credentials Committee may communicate verbally with the
applicant in order to expedite the acquisition of any additional information
required. A written record of the verbal communication, including the date,
nature of requested information and expected time for receipt of the
information, shall be kept with the credentials file. If the verbal request is not
productive, or the Credentials Committee chooses not to communicate
verbally, then the applicant is to be notified in writing of the deferral and the
grounds. If the applicant is to provide the additional information or a specific
release/authorization to allow Hospital representatives to obtain information,
the notice to him/her must so state, must be a special notice, and must
include a request for the specific data/explanation or release/authorization
required and the time frame for response. Failure, without good cause, to
respond in a satisfactory manner by that date is deemed a voluntary
withdrawal of the application.
(b) **Action by the Medical Executive Committee:** The MEC, at its next regular meeting after receiving a report of the Credentials Committee shall review it as well as the reports and recommendations from the Department Chairpersons/Service Chiefs, and any other relevant information made available to or requested by it. The MEC may, at its discretion, conduct an interview with the applicant or designate one (1) or more of its members to do so. The MEC shall defer action on the application or prepare a written report with recommendations as required by Section 1.5-9, with the effect as described in Section 1.5-8(c).

(c) **Effect of Medical Executive Committee Action:**

1. **Deferral:** Action by the MEC to defer the application for further consideration must, except for good cause, be followed up within forty (40) days with its report and recommendations. The MEC shall then obtain the additional information it needs to process the application. At its discretion, the MEC may communicate verbally with the applicant in order to expedite the acquisition of any additional information required. A written record of the verbal communication, including the date, nature of requested information and expected time for receipt of the information, shall be kept with the credentials file. If the verbal request is not productive, or the MEC chooses not to communicate verbally, then the applicant is to be notified in writing of the deferral and the grounds. If the applicant is to provide the additional information or a specific release/authorization to allow Hospital representatives to obtain information, the notice to him/her must so state, must be a special notice, and must include a request for the specific data/explanation or release/authorization required and the time frame for response. Failure, without good cause, to respond in a satisfactory manner by that date is deemed a voluntary withdrawal of the application.

2. **Favorable Recommendations:** An MEC recommendation that is favorable to the applicant in all respects is forwarded, together with all supporting documentation, to the Board.

3. **Adverse Recommendation:** An adverse MEC recommendation is forwarded to the Chief Executive Officer who informs the applicant by special notice of the recommendation, and he/she is then entitled to the procedural rights as provided in the Fair Hearing Plan. For purposes of this Section 1.5-8(c)(3), an "adverse recommendation" by the MEC is as defined in Section 1.1 of the Fair Hearing Plan.

(d) **Board Action:** The Board shall review the application, the supporting documentation, the reports from the Credentials Committee, the MEC, the Department Chairpersons/Service Chiefs, and any other relevant information available to it. The Board may, at its discretion, conduct an interview with the applicant or designate one (1) or more of its members to do so. If, in its deliberations, the Board determines that it needs additional information, it may defer its action but generally for not more than sixty (60) days except for good cause. If the applicant is to provide additional information or a specific
release and/or authorization to allow Hospital representatives to obtain information, the applicant must be so notified. This may be a verbal communication with a written record created showing the date, nature of the requested information and expected time for receipt. If the verbal request is not productive or if the Board chooses not to communicate verbally, a written request shall be sent to the applicant. This shall be a special notice and shall include a specific request for the information/release required and the time frame for response. Failure, without good cause, to respond in a satisfactory manner by the time specified is deemed a voluntary withdrawal of the application.

(1) **On Favorable Medical Executive Committee Recommendation**: The Board may adopt or reject, in whole or in part, a favorable recommendation or refer the recommendation back to the MEC for further consideration stating the reasons for such referral and setting a time limit within which a subsequent recommendation must be made back to the Board. If the Board's action is favorable to the applicant, it is effective as the final decision. If the Board's action, after complying with the requirements of Section 1.5-10, is adverse to the applicant in any respect, the Chief Executive Officer shall inform the applicant by special notice as provided in Section 1.2 of the Fair Hearing Plan, and the applicant is then entitled, upon proper and timely request, to the procedural rights provided in said Plan. For purposes of this Section 1.5-8(d)(1), "adverse action" by the Board is as defined in Section 1.1 of the Fair Hearing Plan.

(2) **After Adverse Medical Executive Committee Recommendation**: In the case of an adverse MEC recommendation, the Board takes final action in the matter as provided in the Fair Hearing Plan.

1.5-9 **CONTENT OF REPORTS AND BASIS FOR RECOMMENDATIONS AND ACTIONS**

The report of each individual or group required to act on an application must include recommendations as to approval or denial of, and any special limitations on, Staff appointment, category of Staff membership and prerogatives, Department/Service affiliation, and scope of clinical privileges. All documentation and information received by any individual or group during or as part of the evaluation process must be included with the application as part of the applicant's central credentials file and, as appropriate or requested, transmitted with reports and recommendations. The reasons for each recommendation or action to deny, restrict or otherwise limit must be stated, with reference to the completed application and all other documentation considered. Any minority views at any point in the process may also be documented in a minority report which states the reason for the differing view and the information on which it is based and the alternative recommendation, if any. Any minority report must be transmitted with the majority report.

1.5-10 **CONFLICT RESOLUTION**

Whenever the Board determines that it will decide a matter contrary to the recommendation of the MEC, the matter will be submitted to a joint advisory council, composed of three (3) members each from the Medical Staff and the Board appointed respectively by the President of the Staff and the Chairperson of the Board, for review and report before the Board makes its decision.
1.5-11 NOTICE OF FINAL DECISION

(a) Notice of the final decision is given through the Chief Executive Officer and goes to the applicant by special notice and to the Medical Staff President, the MEC, and the applicable Department Chairpersons and Service Chiefs.

(b) A decision and notice to appoint includes: (1) the Staff category to which the applicant is appointed; (2) the Department/Service to which he is assigned; (3) the clinical privileges he/she may exercise; and (4) any special conditions attached to the appointment.

1.5-12 TIME PERIODS FOR PROCESSING

All individuals and groups required to act on an application for Staff appointment must do so in a timely and good faith manner.

The time periods as set forth in the various provisions in Section 1.5 are to be deemed guidelines and are not directives such as to create any rights for a practitioner to have an application processed within these precise periods. If the provisions of the Fair Hearing Plan are activated, the time requirements provided there govern the continued processing of the application. If action does not occur at a particular step in the process and the delay is without apparent cause, the next higher authority may immediately proceed to consider the application and all the supporting information or may be directed by the President of the Medical Staff on behalf of the MEC or by the Chief Executive Officer on behalf of the Board to so proceed.

1.6 REAPPLICATION AFTER ADVERSE CREDENTIALS DECISION

Except as otherwise provided in the Medical Staff Bylaws or this manual or as determined by the Credentials Committee in light of exceptional circumstances, an applicant or Staff member who has received a final adverse decision regarding or who has voluntarily resigned or withdrawn an application for appointment, Staff category or Department/Service assignment is not eligible to reapply to the Medical Staff or for the denied/resigned/withdrawn category or Department/Service for a period of two (2) years from the date of the notice of the final adverse decision or the effective date of the resignation or application withdrawal. Any such Staff member may reapply for appointment to the Staff and privileges at any time after such voluntary resignation, as specified in Section 1.1 of this Manual subject to any Board policy governing new appointments to the Staff in general. Any applicant or Staff member who has received a final adverse decision regarding clinical privileges, who has voluntarily withdrawn an application for a new clinical privilege or has voluntarily withdrawn an existing clinical privilege may reapply for such a privilege(s) providing the applicant or Staff member can demonstrate to the satisfaction of the Credentials Committee adequate additional training, experience, or education, as appropriate.

Except as otherwise provided herein, any reapplication pursuant to this Section is processed in accordance with the procedures set forth in Section 1.5 of this Credentialing Procedures Manual, and the applicant or Staff member must submit such additional information as the applicable authorities of the Staff and the Board may reasonably require in demonstration that the basis for the earlier adverse action no longer exists. If such information is not
provided, the reapplication will be considered incomplete and voluntarily withdrawn and will not be further processed. No applicant or Staff member may submit or have in process at any given time more than one application for initial appointment, reappointment, Staff category, a particular Department or Service assignment, or the same clinical privileges.

1.7 **TELEMEDICINE CREDENTIALING**

A physician or other practitioner who prescribes, renders a diagnosis or otherwise provides clinical treatment to a patient via Telemedicine (the "Telemedicine Practitioner") must be credentialed and be granted privileges in accordance with the Hospital's credentialing and privileging procedures set forth in the Medical Staff Bylaws and Credentialing Procedures Manual.

If, however, the Telemedicine Practitioner provides Telemedicine services through a contract between the Hospital and a distant-site entity or distant-site hospital and (a) the Telemedicine Practitioner is credentialed and granted privileges by the distant-site entity or distant-site hospital, and (b) the distant-site entity or distant-site hospital is accredited, or conducts credentialing and privileging in accordance with standards established, by the Joint Commission, the Telemedicine Practitioner may be credentialed and recredentialed as follows, notwithstanding any other provisions of this Credentialing Procedures Manual.

The Medical Staff and the Board may rely, in whole or in part, on the credentialing decision of the distant-site entity or distant-site hospital regarding the Telemedicine Practitioner if the Hospital's written agreement with the distant-site entity or distant-site hospital complies with the Telemedicine credentialing provisions of the Joint Commission and the Medicare Conditions of Participation.

No later than thirty (30) business days before the addition of any new Telemedicine Practitioner, the contracted Telemedicine provider shall provide the following to the Medical Staff:

(a) Copies of the complete application, credentialing materials, and other relevant evidence of the distant-site entity's or distant-site hospital's compliance with Hospital standards for each Telemedicine Practitioner;

(b) The distant-site entity's or distant-site hospital's approved delineation of privileges; and

(c) Evidence of current professional liability insurance coverage for the Telemedicine Practitioner.

In addition, the Hospital will also verify the Telemedicine Practitioner's Medicare/Medicaid eligibility and will conduct a National Practitioner Data Bank query.

The denial of an application for credentialing or recredentialing pursuant to this Section 1.7 will not be subject to the Fair Hearing procedures set forth in the Medical Staff Fair Hearing Plan or the Medical Staff Bylaws or any other appeal, and will not be reportable to the National Practitioner Data Bank or any State licensing agency.
PART TWO. REAPPOINTMENT PROCEDURES

2.1 INFORMATION COLLECTION AND VERIFICATION

2.1-1 FROM STAFF MEMBER

On or about five (5) months prior to the date of expiration of a Medical Staff member's appointment, Medical Staff Services shall notify him/her in writing of the date of expiration and send him/her an application for reappointment to be completed, with the due date for the return of the completed application clearly stated on the notice. The due date shall not be less than one (1) month from the date of the notice. If the completed application is received on or prior to the due date, processing fees shall be waived. In order for the application to be considered completed, the practitioner must furnish, in writing, on the application for reappointment or in such other format as is required by law: (a) complete information and all documents necessary to bring his/her file current on the items listed in Section 1.2 of this Manual, including current license and DEA or other controlled substances registration, malpractice claims, suits and judgments, other institutional affiliations and status thereat, Board certification status, disciplinary actions pending/completed, health status changes; (b) continuing training and education external to the Hospital during the preceding period; (c) specific request for additions to or deletions from the clinical privileges presently held, with any basis for changes; (d) requests for changes in Staff category or Department or Service assignments.

If Medical Staff Services has not received a completed application within two (2) weeks from the date the application for reappointment is sent, Medical Staff Services shall send a Written Notice to the practitioner restating the due date and notifying the Medical Staff member once again of the date on which their current appointment will lapse.

If a completed application for reappointment is not received by the due date, the practitioner shall begin incurring processing fees for the application. A memorandum outlining the processing fee structure shall be included with the initial notice sent to the practitioner. The processing fees for delinquent applications for reappointment shall be as follows: (a) if the completed application for reappointment is received not more than one (1) month after the due date, the processing fee shall be fifty dollars ($50); and (b) if the completed application for reappointment is received more than one (1) month but less than two (2) months after the due date, the processing fee shall be one hundred dollars ($100). If the practitioner provides a completed application more than two (2) months but not more than three (3) months after the due date, the processing fee shall be two hundred dollars ($200) and, in addition, the Medical Staff member shall be required to appear before the Credentials Committee to demonstrate good cause for failure to timely complete the reappointment application. If the Credentials Committee finds that the Medical Staff member has demonstrated good cause, the Medical Staff member shall pay the two hundred dollar ($200) processing fee and the application shall be thereafter processed. If the Credentials Committee concludes that the Medical Staff member has not demonstrated good cause, the Medical Staff member’s appointment and clinical privileges shall automatically lapse at the expiration of the current appointment term, and he/she will need to apply for Medical Staff membership as a new member.
If a Medical Staff member does not provide a completed application within three (3) months of the due date, fails to submit processing fees as required above, or fails to attend a required meeting with the Credentials Committee to demonstrate good cause, then in any such event the Medical Staff member’s Staff appointment and clinical privileges shall automatically expire at the end of the current appointment term, and the practitioner will need to apply for Medical Staff membership and clinical privileges as a new member.

Medical Staff Services shall diligently attempt to verify the information provided on the reappointment application, and notify the Staff member of any information inadequacies or verification problems. The Staff member then has the burden of producing adequate information and resolving any doubts about the data. Medical Staff Services shall transmit the reappointment application and all the supporting information and the member's credentials file, or relevant portions thereof, with the information required by Section 2.1-2 below to the Chairperson of each Department/Chief of each Service in which the member exercised privileges during the last period of appointment and to the Chairperson of each Department/Chief of each Service in which he/she requests privileges.

2.1-2 FROM INTERNAL SOURCES
The Chairperson of the Credentials Committee, or his/her designee, shall collect for each Staff member's credentials file all relevant information regarding the individual's professional and collegial activities, performance and conduct in this Hospital. Such information, which together with the information obtained under Section 2.1-1 above shall form the basis for recommendations and action, shall include, without limitation: patterns of care and utilization as demonstrated in the findings of quality assessment and improvement, risk management and utilization management activities; participation in relevant internal teaching and continuing education activities; level/amount of clinical activity (patient care contacts) at the Hospital; sanctions imposed or pending and other problems; health status; attendance at required Medical Staff, Department/Service and committee meetings; participation as a Staff official, committee member/chairperson, and in specialty coverage for the emergency department; timely and accurate completion and preparation of medical records; cooperativeness in working with other practitioners and Hospital personnel; general attitude toward his/her patients and the Hospital; compliance with all applicable bylaws, policies, rules, and procedures of the Hospital and Staff.

2.2 DEPARTMENT/SERVICE EVALUATION
Each Chairperson of each Department and Chief of each Service in which the Staff member requests or has exercised privileges shall review the reappointment application and its supporting information and pertinent aspects of the member's file and evaluate the information for continuing satisfaction of the qualifications for Staff membership, the category of assignment and the privileges requested. If the Staff member being reviewed is a Department Chairperson/Service Chief, the Staff member's reappointment application, supporting information and file shall be reviewed and evaluated by the immediate past Chairperson/Chief of the applicable Department/Service.

If a Chairperson/Chief requires further information he/she shall notify the Credentials Committee, and proceed to acquire the needed information. If this information is required
from the Staff member, the Department Chairperson/Service Chief may, at his/her discretion, communicate verbally with the Staff member in order to expedite the acquisition of any additional information required. A written record of the verbal communication, including the date, nature of the requested information, and expected time for receipt of the information shall be kept with the credentials file. If the verbal request is not productive, or the Department Chairperson/Service Chief chooses not to communicate verbally, then a written request for the information shall be sent to the Staff member. The notice to him/her must be a special notice and must include a request for the specific information required and the time frame for response. Failure without good cause to respond in a satisfactory manner by the time specified is deemed a voluntary resignation of membership and all clinical privileges.

Each applicable Chairperson and Chief shall forward to the Credentials Committee a written report, including a statement as to whether he/she has observed or been informed of any conduct which indicates significant present or potential physical, alcohol or drug dependence, or behavioral problems affecting the practitioner’s ability to perform professional and Medical Staff duties appropriately and with recommendations for, and any special limitations on, reappointment or non-reappointment and Staff category or status, Department/Service assignment, and clinical privileges. Included in a report must be any actions or information contained in the Department's/Service's files that were not previously transmitted to Medical Staff Services concerning the member's clinical performance, fulfillment of Medical Staff membership obligations, or satisfaction of any other qualifications for membership or clinical privileges.

2.3 CATEGORIZING REAPPOINTMENT APPLICATIONS

After the reappointment application and its supporting documentation have been reviewed by the Chairperson of each Department/Chief of each Service in which the Staff member requests or has exercised privileges, the application will be placed in one (1) of three (3) categories by the Director of Medical Staff Services, based on the following criteria:

(a) Category One Applications: To be considered a Category One reappointment application, the application must satisfy all of the following criteria:

(1) all application information must be promptly verified;
(2) there is no history of any malpractice settlements or judgments which have not been previously reviewed at the time of appointment or reappointment or there is a history of one (1) such settlement or judgment not exceeding $10,000;
(3) there is no history of disciplinary actions, licensure restrictions, or any other professional investigations which have not previously been reviewed at a time of appointment or reappointment;
(4) all requests for new privileges are consistent with the applicant’s specialty, established criteria, privileges generally requested by Practitioners in that specialty and the training, experience and current clinical competence of the applicant;
(5) all information gathered pursuant to Section 2.1-2 above is fully positive; and
(6) the evaluation of each applicable Department Chairperson/Service Chief is fully positive.
(b) **Category Two Applications**: Applications which do not satisfy the requirements to be considered a Category One application, but otherwise satisfy each of the following criteria, shall be considered Category Two applications:

1. All application information is promptly verified, or difficulties occur in the verification of application information, but all such information is verified;
2. Either (1) the application satisfies the malpractice settlement/judgment criteria for a Category One application, or (2) there is a history of no more than two (2) such settlements or judgments not exceeding $10,000, or one (1) such settlement or judgment exceeding $10,000, which settlement(s) or judgment(s) has not previously been reviewed at a time of appointment or reappointment, but which has been reviewed as part of the Hospital's quality assessment and improvement or risk management activities and a conclusion has been reached that the circumstances did not give rise to a sufficient factual basis to warrant the initiation of any corrective action;
3. There is no history of disciplinary actions, licensure restrictions, or any other professional investigations which have not previously been reviewed at a time of appointment or reappointment, or a history including one (1) such investigations which has been fully and completely resolved and which resulted in no disciplinary action or restrictions of any kind;
4. All new clinical privileges requested are consistent with the specialty, established criteria and privileges generally requested by Practitioners in that specialty, or the newly requested privileges vary from those generally requested by Practitioners in the specialty, but which have been approved without any recommended restrictions by the appropriate Department Chairperson/Service Chief and under either circumstance, are consistent with the training, experience, and current clinical competence of the applicant;
5. All information gathered pursuant to Section 2.1-2 above is fully positive or is generally positive but contains some information suggesting minor problems; and
6. The evaluation of each applicable Department Chairperson/Service Chief is fully positive, or is generally positive but contains some information suggesting minor problems.

(c) **Category Three Applications**: All reappointment applications which do not satisfy the criteria for being considered Category One reappointment applications or Category Two reappointment applications shall be considered Category Three reappointment applications.

2.4 **PROCESSING CATEGORY ONE REAPPOINTMENT APPLICATIONS**

(a) **Credentials Committee Evaluation**: The Credentials Committee Chairperson shall assign a member of the Credentials Committee to review the reappointment application, the supporting documentation, the reports from the Department Chairperson/Service Chiefs, and any other relevant information and forward to the Medical Staff President a written report as required by Section 2.7 within ten (10) days after receiving the Department Chairpersons/Service Chiefs' reports, unless the Credentials Committee member determines that the application should be considered a Category Two or Category Three reappointment application, in which
event the application shall automatically be referred to the Credentials Committee as a whole, to be processed in accordance with the provisions of this Manual. All Category One applications will be submitted to the Credentials Committee for information purposes, provided that no formal recommendation of the Credentials Committee shall be required on any such application, and further provided that the Credentials Committee may make any recommendation it deems appropriate on any such application.

(b) **Medical Executive Committee Evaluation:** Upon receipt of a Category One application, the Medical Staff President or designee (who must be a member of the MEC who has not previously reviewed the application as a Department Chairperson/Service Chief), shall review the application, the supporting documentation, the reports of the Department Chairpersons/Service Chiefs, the Credentials Committee members’ report, and any other relevant information available to him/her and forward to the Chief Executive Officer a written report as required by Section 2.7 within ten (10) days after receiving the application from the Credentials Committee, unless the Medical Staff President or designee determines that the application should be considered a Category Two or Category Three application, in which event the application shall automatically be referred to the Credentials Committee as a whole, to be processed in accordance with the provisions of this Manual. All Category One applications will thereafter be submitted to the MEC at its next regular meeting for ratification of action taken. The MEC may make any recommendation it deems appropriate on any such application.

(c) **Action by Chief Executive Officer and MSARC/Report to the Board:** Upon receipt of the Category One application, the Chief Executive Officer shall review the application, the supporting documentation, the reports from the Department Chairperson/Service Chiefs, and the Medical Staff President or designee, and any other relevant information. If the Chief Executive Officer determines that the application should be considered a Category Two or Category Three application, the application shall automatically be referred to the Credentials Committee as a whole, to be processed in accordance with the provisions of this Manual. So long as the Chief Executive Officer determines that the application should be considered a Category One application, the Chief Executive Officer may call a meeting of the Medical Staff Application Review Committee (MSARC), acting on behalf of and as a subcommittee of the Board. The MSARC shall grant Medical Staff appointment and requested clinical privileges unless it determines that the application should be considered a Category Two or Category Three application, in which event the application shall automatically be referred to the Credentials Committee as a whole, to be processed in accordance with the provisions of this Manual. The Chief Executive Officer shall report to the Board at its next regularly scheduled meetings regarding all Staff reappointments and clinical privileges granted by the MSARC pursuant to this Section. The Board shall not be required to take any action on any such applications, further provided that they may take such action as they deem appropriate.
2.5 PROCESSING CATEGORY TWO REAPPOINTMENT APPLICATIONS

(a) Credentials Committee Evaluation: The Credentials Committee shall review all Category Two applications, together with the supporting documentation, the reports from the Department Chairpersons/Service Chiefs, and any other relevant information available to it, and forward to the MEC a written report as required by Section 2.7 within thirty (30) days after receiving the Department Chairpersons/Service Chiefs’ reports.

The Credentials Committee may, at its discretion, conduct an interview with the applicant or designate one (1) or more of its members to do so. If the Credentials Committee requires an interview, the application shall automatically be considered a Category Three application.

(b) Medical Executive Committee Evaluation: If the report of the Department Chairpersons/Service Chiefs and Credentials Committee on the Category Two application for reappointment are fully positive, the Medical Staff President or designee (who must be a member of the MEC who has not previously reviewed the application as a Department Chairperson/Service Chief), shall review the application, the supporting documentation, the reports from the Department Chairpersons/Service Chiefs, reports of the Credentials Committee, and any other relevant information available to him/her and forward to the Chief Executive Officer a written report as required by Section 2.7 within ten (10) days after receiving the Credentials Committee report, unless the Medical Staff President or designee determines that the application should be considered a Category Three application, in which event the application shall automatically be referred to the MEC as a whole, to be processed in accordance with this Manual. All Category Two reappointment applications will thereafter be submitted to the MEC at its next regular meeting for ratification of action taken. The MEC may make any recommendation it deems appropriate.

(c) Action by Chief Executive Officer and MSARC/Report to the Board: Upon receipt of the Category Two application, the Chief Executive Officer shall review the application, the supporting documentation, the reports from the department chairpersons/service chiefs, the Credentials Committee, and the Medical Staff President or designee, and any other relevant information. If the Chief Executive Officer determines that the application should be considered a Category Three application, the application shall automatically be referred to the Medical Executive Committee as a whole, to be processed in accordance with the provisions of this Manual. So long as the Chief Executive Officer determines that the application should be considered a Category Two application, the Chief Executive Officer may call a meeting of the Medical Staff Application Review Committee (MSARC), acting on behalf of and as a subcommittee of the Board. The MSARC shall grant Medical Staff appointment and requested clinical privileges unless it determines that the application should be considered a Category Three application, in which event the application shall automatically be referred to the Medical Executive Committee as a whole, to be processed in accordance with the provisions of this Manual. The Chief Executive Officer shall report to the Board at its next regularly scheduled meeting regarding all Staff reappointments and clinical privileges granted by the MSARC pursuant to this Section. The Board shall not be required to take any action on any
such applications, further provided that they may take such action as they deem appropriate.

2.6 PROCESSING CATEGORY THREE REAPPOINTMENT APPLICATIONS

(a) Credentials Committee Evaluation: The Credentials Committee shall review and evaluate the Category Three reappointment application and its supporting information, other pertinent aspects of the member's file, the Chairperson's/Chief's reports and all other relevant information available to it. If the Credentials Committee requires further information (including an impartial physical, mental, or laboratory examination, which shall be obtained in the manner specified in Section 5.1-2) it shall notify, through Medical Staff Services, the President of the Medical Staff and proceed to acquire the needed information. If this information is required from the Staff member, the Credentials Committee may, at its discretion, communicate verbally with the Staff member in order to expedite the acquisition of any additional information required. A written record of the verbal communication, including the date, nature of the requested information, and expected time for receipt of the information shall be kept with the credentials file. If the verbal request is not productive, or the Credentials Committee chooses not to communicate verbally, then a written request for the information shall be sent to the Staff member. The notice to him/her must be a special notice and must include a request for the specific information required and the time frame for response. Failure without good cause to respond in a satisfactory manner by the time specified is deemed a voluntary resignation of membership and all clinical privileges.

The Credentials Committee shall prepare a written report with recommendations for, and any special limitations on, reappointment or non-reappointment and Staff category, status, Department/Service assignment, and clinical privileges. The Credentials Committee's report is transmitted with the Chairperson's/Chief's reports and supporting documentation as required to the MEC.

If a current member of the Credentials Committee is a candidate for reappointment, the process of review of the reappointment application and supporting documentation will be reviewed by the appropriate Department Chairperson and one (1) member of the MEC (preferably the Past President) and will provide recommendation to the MEC. The reappointment application and supporting documentation will not be presented to Credentials Committee for review.

(b) Action by the Medical Executive Committee:

The MEC shall review the report and recommendations of the Credentials Committee as well as the reports and recommendations from the Department Chairpersons/Service Chiefs, and any other relevant information made available to or requested by it. The MEC shall defer action on the reappointment or prepare a written report with recommendations as required by Section 2.6. The effect of MEC action is as follows:

(1) Deferral: Action by the MEC to defer the application for further consideration must, except for good cause, be followed up generally within thirty (30) days with its report and recommendations. The MEC shall proceed to acquire the further information needed. If this information is required from the Staff
member, the MEC may, at its discretion, communicate verbally with the Staff member in order to expedite the acquisition of the information. A written record of the verbal communication, including the date, nature of the requested information, and expected time for receipt of the information shall be kept with the credentials file. If the verbal request is not productive, or the MEC chooses not to communicate verbally, then a written request for the information shall be sent to the Staff member. The notice to him/her must be a special notice and must include a request for the specific information required and the time frame for response. Failure, without good cause, to respond in a satisfactory manner by the time specified is deemed a voluntary resignation of membership and all clinical privileges.

(2) Favorable Recommendation: An MEC recommendation that is favorable to the applicant in all respects is forwarded, together with all supporting documentation, to the Board.

(3) Adverse Recommendation: An adverse MEC recommendation is forwarded to the Chief Executive Officer who informs the applicant by special notice of the recommendation, and he/she is then entitled to the procedural rights as provided in the Fair Hearing Plan. For purposes of this Section 2.6(b)(3), an "adverse recommendation" by the MEC is as defined in Section 1.1 of the Fair Hearing Plan.

(c) Board Action: The Board shall review the reappointment application, the supporting documentation, the reports from the Credentials Committee, the MEC, the Department Chairpersons/Service Chiefs, and any other relevant information available to it. If in its deliberations the Board determines that it needs additional information, it may defer its action but generally for not more than sixty (60) days except for good cause. If the Staff member is to provide additional information or a specific release and/or authorization to allow Hospital representatives to obtain information, the Staff member must be so notified. This may be a verbal communication with a written record created showing the date, nature of the requested information, and expected time for receipt. If the verbal request is not productive or if the Board chooses not to communicate verbally, a written request shall be sent to the Staff member. This shall be a special notice and shall include a specific request for the information/release required and the time frame for response. Failure, without good cause, to respond in a satisfactory manner by the time specified is deemed a voluntary withdrawal of the application.

(1) On Favorable Medical Executive Committee Recommendation: The Board may adopt or reject, in whole or in part, a favorable recommendation or refer the recommendation back to the MEC for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation must be made back to the Board.

If the Board's action is favorable to the Staff member, it shall be effective as its final decision. If the Board's action, after complying with the requirements of Section 1.5-10, is adverse to the Staff member in any respect, the Chief Executive Officer shall inform the Staff member by special notice as provided in Section 1.2 of the Fair Hearing Plan, and he/she is then entitled to the procedural rights provided in said Plan. For the purposes of this Section
2.6(c)(1), "adverse action" by the Board is as defined in Section 1.1 of the Fair Hearing Plan.

(2) After Adverse Medical Executive Committee Recommendation: In the case of an adverse MEC recommendation, the Board takes final action in the matter as provided in the Fair Hearing Plan.

2.7 BASIS FOR RECOMMENDATIONS AND ACTION
The report of each individual or group required to act on a reappointment shall state the reasons for each adverse recommendation made or action taken, with specific reference to the Staff member's credentials file and all other documentation considered. In addition to any other information contained in a credentials file that may support a non-reappointment recommendation or action, any individual or group required to act on a reappointment may consider no or very minimal involvement at the Hospital by a Staff member over the last period of appointment in patient care, teaching or other such activities as grounds for a recommendation/action to not reappoint. Any minority views at any point in the process may be documented in a minority report which states the reason for the differing view and the information on which it is based and the alternative recommendation, if any. Any minority report must be transmitted with the majority report.

2.8 TIME PERIODS FOR PROCESSING
Transmittal of the notice to a Staff member and his/her providing updated information is to be carried out in accordance with Section 2.1-1 of this Manual. Thereafter and except for good cause, all persons and groups required to act must complete such action so that all reappointment reports and recommendations are acted on by the Board prior to the expiration date of Staff membership of the member whose reappointment is being processed.

The time periods specified are to guide the acting parties in accomplishing their tasks. If reappointment processing has not been completed by an appointment expiration date, through no fault of the Staff member, the member shall be temporarily reappointed by the Board with current status and clinical privileges, with such reappointment to be effective until the time that processing is completed, unless corrective action is taken with respect to all or any part thereof. If delay without good cause occurs at any step in the processing and is attributable to a Staff or Hospital authority, the next higher authority may immediately proceed to consider the reappointment application and all the supporting information or may be directed by the President of the Medical Staff on behalf of the MEC or by the Chief Executive Officer on behalf of the Board to so proceed.

If the delay is attributable to the practitioner's failure to provide information required by Section 2.1-1, his/her Staff membership terminates on the expiration date as provided in Section 2.1-1.

2.9 REQUESTS FOR MODIFICATION OF MEMBERSHIP STATUS OR PRIVILEGES
A Staff member may, either in connection with reappointment or at any other time, request modification of his/her Staff category or status, Department/Service assignment, or clinical privileges by submitting a written request to Medical Staff Services. A modification request is processed according to the procedures outlined in Section 1.5 of this Manual, is otherwise subject to the provisions of the relevant Medical Staff Bylaws and the related manuals, and must contain all pertinent information supportive of the request.
PART THREE. SYSTEMS AND PROCEDURES FOR DELINEATING CLINICAL PRIVILEGES

3.1 DEPARTMENT/SERVICE RESPONSIBILITY
Each Department/Service must define, in writing, the operative, invasive and other special procedures, the conditions and the problems that fall within its clinical area, including different levels of severity or complexity when appropriate and the requisite training, experience or other qualifications required. These definitions are to be coordinated as necessary and approved by the Credentials Committee and the MEC, must be periodically reviewed and revised, and must form the basis for delineating privileges within the Department/Service.

3.2 CONSULTATION AND OTHER CONDITIONS
There may be attached to any grant of privileges, in addition to requirements for consultation in specified circumstances provided for in the Bylaws and related manuals, or in the rules, regulations and policies of the Staff, any of its clinical units or the Hospital, special requirements for consultation as a condition to the exercise of particular privileges. As part of his/her request for and exercise of clinical privileges, each practitioner pledges that in dealing with cases outside his/her training and usual area of practice he/she will seek appropriate consultation or refer to a practitioner who has expertise in such cases and acknowledges that his/her request for and exercise of privileges are circumscribed by Hospital and Staff policies as may from time to time be in force.

3.3 PROCEDURE FOR DELINEATING PRIVILEGES
3.3-1 REQUESTS
Each application for appointment and reappointment to the Medical Staff must contain a request for the specific clinical privileges desired by the applicant or Staff member.

Specific requests must also be submitted for temporary privileges and for modifications of privileges in the interim between reappraisals.

3.3-2 PROCESSING REQUESTS
All requests for clinical privileges, except those for temporary privileges, are processed according to the procedures outlined in Parts One and Two of this Manual, as applicable. Requests for temporary privileges are processed according to Section 8.7 of the Medical Staff Bylaws. All applications for additional clinical privileges between reappointments by current members of the Medical Staff shall be processed according to the procedures outlined in Part Two of this Manual, except that the criteria for categorizing such applications shall be as follows:

(a) Category One Applications: To be considered a Category One application, the application must satisfy all of the following criteria:

(1) the applicant must be a member of the Medical Staff in good standing and must have successfully completed the provisional period;
(2) two (2) or more members of the Medical Staff must be currently privileged to exercise the privilege(s); or familiar with the specialty area of the privileges;
(3) all application information is promptly verified;
(4) all references are fully positive;
(5) there is no history of prior malpractice claims or actions in any way involving the requested clinical privilege(s);
(6) there is no history of prior disciplinary actions, licensure restrictions, or any other professional investigations in any way involving the requested clinical privilege(s);
(7) the requested privilege(s) is consistent with the applicant's specialty, established criteria, and privileges generally requested by physicians in that specialty, and the training, experience, and current clinical competence of the applicant; and
(8) the evaluation of each applicable Department Chairperson/Service Chief is fully positive.

(b) **Category Two Applications:** Applications which do not satisfy the requirements to be considered a Category One application, but otherwise satisfy each of the following criteria, shall be considered Category Two applications:

(1) the applicant must be a member in good standing of the Medical Staff;
(2) one (1) or more members of the Medical Staff must be currently privileged to exercise the privilege(s); or familiar with the specialty area of the privileges;
(3) all application information is promptly verified, or difficulties occur in the verification of the information, but all such information is verified;
(4) all references are fully positive, or are generally positive but contain some information suggesting minor problems;
(5) no history of prior malpractice claims or actions in any way involving the requested clinical privilege(s);
(6) no history of prior disciplinary action, licensure restrictions or any other professional investigations in any way involving the requested clinical privilege(s);
(7) the requested privilege(s) is consistent with the specialty, established criteria and privileges generally requested by physicians in that specialty, or the requested privileges vary from those generally requested by physicians in the specialty, but which has been approved without any recommended restrictions by the appropriate Department Chairperson/Service Chief and, under either circumstance, is consistent with the training, experience, and current clinical competence of the applicant; and
(8) the evaluation of each applicable Department Chairperson/Service Chief is fully positive, or is generally positive but contains some information suggesting minor problems.

(c) **Category Three Applications:** All applications which do not satisfy the criteria for being considered Category One applications or Category Two applications shall be considered Category Three applications.
PART FOUR. CONCLUSION AND EXTENSION OF PROVISIONAL PERIOD

4.1 REQUIREMENTS FOR SUCCESSFUL CONCLUSION

4.1-1 REVIEW AND OBSERVATION REQUIRED
The requirement for, applicability and duration of, and status of the practitioner in the provisional period are set forth in Section 7.4 of the Medical Staff Bylaws. Each Department/Service shall establish, subject to approval of the Credentials and MECs, the review requirements for concluding the provisional period in the Department/Service. The Chairperson of the Credentials Committee, or his/her designee, will prepare, as part of the process for reviewing the provisional member, a summary for the member's file of the same type of information as is collected under Section 2.1-2 of this Manual in connection with reappointments.

4.1-2 CREDENTIALS COMMITTEE ACTION
At the end of a practitioner's first year of appointment to the Staff or at the end of a previously defined provisional period assigned to a practitioner with increased privileges, the Credentials Committee shall review the performance of the practitioner as required by Section 4.1-1 above. The Credentials Committee shall formulate a written report and provide supporting documentation or recommend an extension of the provisional period within three (3) months after the conclusion of the provisional period, or notify the MEC and the Board of the reasons for the delay. Final processing follows the procedures set forth in the reappointment process.

4.2 EXTENSION
If, at the discretion of the Credentials Committee, additional time beyond the appropriate provisional period is required to fairly evaluate a practitioner, the Credentials Committee may extend the provisional period as it sees fit, but under no circumstances shall the total provisional period assigned by the Credentials Committee be more than twenty-four (24) months. At the conclusion of the extended provisional period, or sooner at the discretion of the Credentials Committee, the Credentials Committee shall evaluate the practitioner as set forth in Sections 4.1-1 and 4.1-2 except that a recommendation must be made if the total provisional period has reached twenty-four (24) months. As stated in Section 4.1-2, the Credentials Committee shall have three months (3) after conclusion of the extended provisional period to complete its evaluation and formulate a recommendation, even if this is in addition to the twenty-four (24) month provisional period. Extension of the provisional period as set forth in this Section specifically does not entitle the practitioner to any rights of hearing or appeal. In addition, no practitioner is entitled to request advancement in Staff category or status or termination of provisional status during the provisional period or any extension of that period. The limit of twenty-four (24) months of provisional status does not apply should such a requirement be placed as a result of action of the Board.

4.3 PROCEDURAL RIGHTS
Whenever a provisional period, including any period of extension, concludes with an adverse recommendation or action, the Chief Executive Officer shall provide the practitioner with special notice of the adverse result and of his/her entitlement to the procedural rights provided in the Fair Hearing Plan. For purposes of concluding the provisional period, an "adverse recommendation" by the MEC or an "adverse action" by the Board is as defined in Section 1.1 of the Fair Hearing Plan. The decision to continue provisional status shall not be deemed a denial of advancement.
PART FIVE. CORRECTIVE ACTION PROCEDURES

5.1 CORRECTIVE ACTION

5.1-1 INITIATION, REQUESTS AND NOTICES
The criteria for initiating corrective action other than a summary or automatic suspension and procedures for conducting an interview prior to initiating such action are contained in Sections 9.1 and 9.2 of the Medical Staff Bylaws. All requests for corrective action must be in writing, submitted to the MEC, and supported by reference to the specific activities or conduct which constitute the grounds for the request.

5.1-2 INVESTIGATION
After deliberation, the MEC may either act on the request or direct that investigation concerning the grounds for the corrective action request be undertaken. The MEC may conduct such investigation itself or may assign this task to a Medical Staff general or Department/Service officer, a Department/Service, a standing or ad hoc committee, or any other organizational component. This investigative process is not a "hearing" as that term is used in the Fair Hearing Plan. If the investigation is accomplished by a group or individual other than the MEC, that group or individual must forward a written report of the investigation to the MEC as soon as is practicable after the assignment to investigate has been made. The MEC may at any time within its discretion, and shall at the request of the Board or its designee, terminate the investigative process and proceed with action as provided in Section 5.1-3 below. The MEC or other investigating group or individual shall have available to them the full resources of the Medical Staff and the Hospital as well as the authority to use outside consultants as deemed necessary. As part of the investigation, the MEC or other investigating group or individual may require the practitioner involved to procure an impartial physical, mental, or laboratory evaluation within a specified time and pursuant to the guidelines set forth below. Failure to provide such an evaluation, without good cause, shall result in immediate suspension of Medical Staff membership and all clinical privileges until such time as the evaluation is obtained and the results are reported to the MEC or other investigating group or individual. The practitioner who will conduct the evaluation shall be named by the MEC or other investigating group or individual. If a psychiatric evaluation is required, it shall be performed by at least two (2) psychiatrists who are not members of the Attending Staff. One (1) psychiatrist may be chosen by the individual under investigation. Fees for an evaluation shall be paid by the Hospital.

5.1-3 MEDICAL EXECUTIVE COMMITTEE ACTION
As soon as practicable after the conclusion of the investigative process, if any, but in any event within six (6) months after receipt of the request for corrective action unless deferred, the MEC acts upon such request. Its action may include, without limitation:

(a) Recommending rejection of the request for corrective action;

(b) Recommending a verbal warning;

(c) Recommending additional education and/or training;
(d) Recommending individual medical/psychiatric treatment;

(e) Recommending a probationary period of prescribed duration with retrospective review of cases and/or other review of professional behavior but without special requirements of prior or concurrent consultation or direct supervision;

(f) Recommending suspension of appointment prerogatives that do not affect clinical privileges;

(g) Recommending a formal letter of reprimand;

(h) Recommending an individually imposed requirement of prior or concurrent consultation or direct supervision;

(i) Recommending an individually specific limitation of the right to admit patients where such limitation is not related to the adoption or implementation of an administrative or Medical Staff policy within the Hospital as a whole or within one (1) or more specific Departments/Services;

(j) Recommending reduction, suspension or revocation of all or any part of the clinical privileges granted; or

(k) Recommending suspension or revocation of Staff membership.

5.1-4 PROCEDURAL RIGHTS
An MEC recommendation pursuant to Section 5.1-3 (h), (i), (j), or (k) or any combination thereof is deemed adverse and entitles the practitioner to the procedural rights contained in the Fair Hearing Plan.

5.1-5 OTHER ACTION
An MEC recommendation pursuant to Section 5.1-3(a), (b), (c), (d), (e), (f) or (g) any combination thereof is transmitted to the Board together with all supporting documentation. Thereafter, the procedure in Section 2.6(c) of this Manual is applicable.

5.2 SUMMARY SUSPENSION
5.2-1 CRITERIA FOR IMPOSING
The criteria for imposing a summary suspension and the parties authorized to do so are designated in Section 9.3 of the Medical Staff Bylaws.

5.2-2 SUBSEQUENT ACTION
If the MEC, acting in concert with one (1) or more authorized individuals or committees, initiates a summary suspension, the MEC may, but need not, conduct an additional investigation into the matter. If it elects not to conduct an additional investigation, the MEC, together with the other person or committee initiating the summary suspension, shall forward their findings and recommendations to the Board of Directors. If a summary suspension is initiated by authorized committees and/or individuals other than the MEC, then within seventy-two (72) hours after the
summary suspension is imposed, the MEC shall convene to review and consider the action taken for the purpose of making a recommendation to the Board of Directors. It may recommend modification, continuation or termination of the terms of the suspension. Such an investigation shall be completed within a reasonable time period not to exceed thirty (30) days unless good cause for the delay exists, in which case the factual basis constituting good cause shall be transmitted to the Board so that the Board may consider whether the suspension should be lifted. Upon completion of its investigation, the MEC shall forward its findings, along with its recommendation, to the Board of Directors.

An MEC recommendation to continue the suspension or to take any other adverse action as defined in Section 1.1 of the Fair Hearing Plan entitles the practitioner to the procedural rights contained in the Fair Hearing Plan. An MEC recommendation to terminate or to modify the suspension to a lesser sanction not triggering procedural rights is transmitted, together with all supporting documentation, to the Board. The terms of the summary suspension as originally imposed remain in effect pending a final decision by the Board.

A summary suspension which extends beyond thirty (30) days pending an MEC investigation and recommendation to the Board shall not be deemed a professional review action for purposes of reporting to the National Practitioner Data Bank under Title IV of Public Law 99-660. ("The Health Care Quality Improvement Act of 1986") unless and until the MEC makes a recommendation to the Board to continue the suspension on the terms that are otherwise reportable to the National Practitioner Data Bank.

5.3 AUTOMATIC SUSPENSION
5.3-1 CIRCUMSTANCES
The circumstances under which an automatic suspension may be imposed and the scope of said suspension are defined in Section 9.4 of the Medical Staff Bylaws.

5.3-2 MEDICAL EXECUTIVE COMMITTEE DELIBERATION
As soon as practicable (a) after a practitioner's license is suspended, restricted or placed on inactive status or on probation, or (b) after his/her controlled substances number is revoked, restricted, suspended or made probationary, the MEC shall convene to review and consider the facts under which such action was taken. The MEC may then recommend such further corrective action as is appropriate to the facts disclosed in the investigation, including limitation of prerogatives. Thereafter, the procedure in Section 5.1-4 or 5.1-5, as applicable, is followed, but only with respect to any additional corrective action recommended by the MEC or by the Board.

5.3-3 MEDICAL RECORDS COMPLETION
All portions of the medical record of a hospitalized patient should be completed at the time of discharge, and must be completed within thirty (30) days of discharge.

Every month, the Health Information Management Department will send reminder letters to all practitioners with incomplete medical records. The practitioners will have at least fifteen (15) days from receipt of the reminder letter to complete those medical records. If the medical records have not been completed within twelve (12)
days after receipt of the reminder letter, the Health Information Management Department will send the practitioners a Special Notice. The Special Notice will advise the practitioners that they have three (3) business days from receipt of the Special Notice to complete the medical records, and that the sanctions set forth in the Medical Staff Bylaws will automatically be imposed if the records are not completed within that time.

The Health Information Management Department provides written notice to the practitioner, the Medical Staff President, the applicable Department Chairpersons/Service Chiefs, Medical Staff Services, the Admitting Office, the Emergency Department, the Operating Room, and each nursing station when a suspension is imposed.

A record is considered "complete" when the contents required by the Staff Rules and Regulations are assembled and authenticated.

5.3-4 MEDICAL RECORDS PREPARATION
All portions of a patient's medical record must be prepared within the time frames provided in the Staff Rules and Regulations. Unless a bona fide emergency as defined in Section 8.6 of the Medical Staff Bylaws exists, so certified in writing by the Staff member, that requires him/her to immediately treat the patient, the Department Chairperson/Service Chief, or his/her designee, when informed of the delinquency immediately gives the practitioner notice of it, advising him/her further that the sanctions provided in the Medical Staff Bylaws, will be imposed if the portion of the record involved is not prepared within the grace period defined in the Rules and Regulations. If this notice was oral in form, it will be followed up immediately by special notice. If he/she deems it necessary for the welfare of the patient, the Department Chairperson/Service Chief may require the record to be prepared within any shorter time span including immediately.

5.3-5 ADDITIONAL ACTION
The Health Information Management Department notifies, in writing, the practitioner, the Medical Staff President, the applicable Department Chairpersons/Service Chiefs, the applicable committee chairpersons, Medical Staff Services, Quality Management Resources, the Admitting Office, the Emergency Department, the Operating Room, and each nursing station when a suspension is imposed.

The Health Information Management Department is responsible for reporting justified delays to the Quality Council. That Council reviews, on a quarterly basis or more frequently if required, the cases in which the emergency exception is claimed to have been in effect and presents its findings to the MEC as to whether any patterns exist indicating that the emergency exception may be being claimed inappropriately.
PART SIX. LEAVE OF ABSENCE

6.1 LEAVE STATUS
A Staff member may obtain a voluntary leave of absence of up to two (2) years by submitting a request demonstrating good cause for a leave of absence to Medical Staff Services for review, recommendation and transmittal to the MEC. For the purposes of this section, "good cause" for such a request shall be limited to the following:

(a) Illness of the Staff member, or a member of their immediate family.
(b) Pursuit of additional training or education.
(c) The existence of a restrictive covenant or other contractual obligation precluding the Staff member from practicing in the Hospital’s service area.
(d) Military service.
(e) A bona fide sabbatical.
(f) Other special circumstances approved in advance by the MEC.

Such leave of absence shall be effective immediately upon review and a recommendation for approval by the MEC and approval by the Chief Executive Officer. The leave of absence shall remain in force for the specified term. The MEC shall report on any leave of absence to the Board of Directors.

A practitioner is not entitled to the procedural rights afforded by these Bylaws and the Fair Hearing Plan because his/her request for leave of absence is refused, terminated, restricted, or limited in any way.

6.2 RETURN FROM LEAVE
A physician desiring to return from leave of absence is required to submit the following information to Medical Staff Services:

(a) A copy of his/her current license to practice medicine in the State of Florida;
(b) A certificate of current insurance which must comply with the requirements for malpractice insurance policy of the Board of Directors;
(c) A copy of his/her current DEA registration;
(d) A statement of his/her activities during the leave of absence and appropriate supporting documentation; and
(e) Any other supporting documentation which may be requested.

The physician may be required to meet with his/her appropriate Department Chairperson/Service Chief. If Medical Staff Services recommends:
(1) Approving the reinstatement, this information shall be transmitted to the President of the Medical Staff and the Chief Executive Officer for review and consideration. Based upon the input, the Chief Executive Officer, in consultation with the President of the Staff, may immediately reinstate the practitioner’s membership and privileges.

If any refusal occurs to reinstate the privileges of the practitioner through this mechanism, the request will be referred to the MEC for review at their next regularly scheduled meeting.

(2) Disapproval of the reinstatement, this information shall be transmitted to the MEC for discussion at the next regularly scheduled meeting.

If the MEC recommends disapproval of the requested reinstatement or if the Chief Executive Officer disapproves the reinstatement of a practitioner, the practitioner will be provided the procedural rights afforded by the Fair Hearing Plan.

If the practitioner has not been actively practicing at another accredited healthcare facility (TJC/AAAHC) for a minimum of twelve (12) months during the term of the leave, implementation of a Focused Professional Practice Evaluation (FPPE) may be imposed for a time period defined by the MEC.

6.3 RESPONSIBILITY

It is the responsibility of the individual physician who desires a leave of absence to keep record of his/her current status. Therefore, a physician who does not submit a written request to reinstate or resign his/her membership and privileges will be considered as having voluntarily relinquished his/her privileges.
PART SEVEN. AMENDMENT

7.1 AMENDMENT
This Credentialing Procedures Manual may be amended or repealed, in whole or in part, in the same manner as provided in Article Thirteen of the Medical Staff Bylaws.