ANTELOPE VALLEY HOSPITAL MEDICAL STAFF

CREDENTIALS POLICY AND PROCEDURE MANUAL

2015 EDITION

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ARTICLE I: APPLICATION POLICY

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1.1 It is the policy of this Hospital to provide applications for appointment to the Medical Staff to licensed medical and osteopathic physicians, dentists, oral surgeons and podiatrists who are able to:

1.1-1 have a current, unrestricted license to practice in California and have never had a license to practice revoked or suspended by any state licensing agency;

1.1-2 have current, valid professional liability insurance coverage in a form and in amounts required by the Board of Directors;

1.1-3 where applicable to their practice, have a current, unrestricted DEA license;

1.1-4 have never been convicted or have entered a plea of guilty or no contest to Medicare, MediCal or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil monetary penalties for the same;

1.1-5 have never been and are not currently excluded or precluded from participation in Medicare, MediCal or other federal or state governmental health care program;

1.1-6 have never been convicted or have entered a plea of guilty or no contest to any felony or misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud, abuse or violence (federal or in any state);

1.1-7 agree to adhere to the Hospital's Code of Conduct;

1.1-8 agree to participate in and comply with the Hospital's computerized physician order entry (CPOE) system;

1.1-9 not be applying to a specialty which is subject to an exclusive contract(s) (unless the applicant is a member of the group holding the exclusive contract(s));

1.1-10 have successfully completed (or be in the last six (6) months of):

A. a residency program approved by the Accreditation Council for Graduate Medical Education ("ACGME") or the American Osteopathic Association ("AOA") in a specialty in which the applicant seeks clinical privileges; or
B. a dental or an oral and maxilla facial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association ("ADA"); or
C. a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association

1.1-11 be eligible/certified in their primary area of practice at the Hospital by the appropriate specialty/subspecialty board of the American Board of Medical Specialties ("ABMS") or the American Osteopathic Association "(AOA"), the American Association of Oral and Maxillofacial Surgery or other board as applicable to their specialty.

1.1-12 demonstrate recent active clinical practice in the individual's primary specialty during at least two (2) of the last four (4) years, at least a portion of which must have been in an acute hospital setting; and

1.1.13 explain in writing their plans for office location and their plans for utilizing this hospital.

ARTICLE II: APPLICATION REQUEST

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2.1 All requests for applications for appointment to the Medical Staff will be forwarded to the Medical Staff Services Office. Upon receipt of a request for an application, Medical Staff Services Office personnel will provide the potential applicant with an application request form. The potential applicant must meet the requirements set forth in Article I of the Credentials Policy Manual.

2.2 Upon receipt of a completed application request form, Medical Staff Services Office personnel will verify its contents and, if the requirements of Article 1 are met, will forward a copy of the current application to the applicant. In the event the requirements are not met, the potential applicant will be notified and given an opportunity for an informal discussion with the Chair of the Credentials Committee, the Director of Medical Staff & Credentialing or designee.

ARTICLE III: INITIAL APPOINTMENT

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3.1 Application for Staff Appointment is to be submitted by the applicant on the current approved application form in a legible manner. A copy of the Medical Staff Bylaws, Rules and Regulations, and pertinent Hospital and Medical Staff policies and procedures relating to clinical practice in the Hospital shall be made available.

3.2 By submitting a signed application form, the applicant:

3.2-1 Signifies the applicant's willingness to appear for interviews regarding the application, if requested;

3.2-2 Authorizes Hospital Representatives to consult with others who have been associated with the applicant and/or who have information bearing on the applicant's competence and qualifications;

3.2-3 Consents to Hospital Representatives' inspection of all records and documents that may be material to an evaluation of the applicant's professional qualifications and competence to carry out the requested clinical privileges, the applicant's physical and mental health status and of the applicant's professional and ethical qualifications;

3.2-4 Releases from any liability all Hospital Representatives for their acts performed in connection with evaluation of the applicant or the applicant's credentials;

3.2-5 Releases from any liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to Hospital Representatives concerning the applicant's competence, professional ethics, character, physical and mental health, emotional stability and other qualifications for Staff appointment and clinical privileges;

3.2-6 Authorizes and consents to Hospital Representatives providing other hospitals, medical associations, licensing boards and other organizations concerned with provider performance and the quality and efficiency of patient care with any information relevant to such matters that the Hospital may have concerning the applicant, and releases Hospital Representatives from liability for so doing upon the receipt of an appropriate signed release.

3.2-7 Signifies that the applicant has read the current Medical Staff Bylaws and associated manuals and agrees to abide by its provisions in regard to the individual's application for appointment to the Medical Staff (including the standards and procedures for evaluating applicants contained therein) and to release all persons and entities from any liability that might arise from their investigating and/or acting on the application; and

3.2-8 Agrees to provide and update the information requested on the original application and subsequent reapplications or privilege request forms when any information is inaccurate (specifically: hospital appointment; voluntary relinquishment of medical staff membership or clinical privileges or licensure status; voluntary or involuntary limitation, reduction or loss of clinical privileges at another hospital; involvement in liability including but not limited to, claims filed, reported to insurance carrier, letters of intent to sue, claims pending, judgments entered, claims in which the applicant or his professional liability insurance carrier had to or agreed to make a monetary payment; denials for professional liability insurance, policy cancellations or refusal of insurer to renew a policy or placed limitations on the scope of his coverage, or has any professional liability carrier expressed any intent to deny, cancel, not renew, or limit professional liability insurance of its coverage; license/DEA restrictions, or changes in health status that may affect his/her ability to practice his./her profession).

For purposes of this provision, the term, "Hospital Representative" includes the Governing Board, its directors and committees; the Chief Executive Officer or his/her designee, registered nurses and other employees of the Hospital; the Medical Staff organization and all Medical Staff members; clinical units and committees which have responsibility for collecting and evaluating the applicant's credentials or acting upon the application, and any authorized representative of any of the foregoing.

3.3 INITIAL REVIEW OF APPLICATION

3.3-1 A completed application form with copies of all required documents must be returned to the Medical Staff Office, accompanied by the application fee, if applicable.

The following documentation is necessary to complete an application. It is the applicant's responsibility to provide:

A. A legible, fully completed and signed application form and request for privileges;
B. A copy of current State license and, where applicable, DEA certificate;
C. A copy of current professional liability insurance coverage in the amount required by the Governing Board;
D. Copies of certificates or letters confirming completion of an approved residency/training program or other educational curriculum, if available;
E. Verification (copy of certificates or copy of letter from appropriate specialty board) of board status, i.e., board eligibility or board certification, if available;
F. Three (3) letters of recommendation from peers must be sent directly to the Medical Staff Services Office from individuals who have recently worked with the applicant and directly observed the applicant's professional performance over a reasonable period of time and who can and will provide reliable information regarding current clinical ability, ethical character and ability to work with others. References must be from individuals practicing in a field similar to the applicant;
G. Payment of the application fee;
H. Physical and Mental Capabilities:

1. Obtaining Information:

a. Information pertaining to the condition of the applicant's physical and mental health on a separate page of the form, which can be removed from the remaining application and processed separately. Upon receipt of the application, the page addressing physical and mental disabilities shall be removed and referred to the Chair of the Wellness Committee;
b. When Medical Staff Services verifies information and obtains references, it shall ask for any information concerning physical or mental disabilities to be reported on a confidential form which can be processed separately from the other information obtained regarding the applicant. This information will also be referred to the Chair of the Wellness Committee.
c. The Chair of the Wellness Committee, on behalf of the Committee, shall be responsible for investigating any practitioner who has or may have a physical or mental disability that might affect the practitioner's ability to exercise his/her requested privileges in a manner that meets the Hospital and Medical Staff's quality of care standards. This may include one or all of the following:

(1) Medical Examination: To ascertain whether the practitioner has a physical or mental disability that might interfere with his/her ability to provide care which meets the Hospital and Medical Staff's quality of care standards.
(2) Interview: To ascertain the condition of the practitioner and to assess how reasonable accommodations can be made, if any.

d. Any practitioner who feels limited or challenged in any way by a qualified mental or physical disability in exercising his/her clinical privileges and in meeting quality of care standards should make such limitation immediately known to the Chair of the Wellness Committee. Any such disclosure will be treated with the high degree of confidentiality that attaches to the Medical Staff's peer review activities.

2. Review and Reasonable Accommodations:

a. Any practitioner who discloses or manifests a qualified physical or mental disability will have his/her application processed in the usual manner without reference to the condition.

b. The Chair of the Wellness Committee shall not disclose any information regarding any practitioner's qualified physical or mental disability until the Credentials Committee (or, in the case of temporary privileges, the Medical Staff representatives who review temporary privilege requests and the Chief Executive Officer) has determined that the practitioner is otherwise qualified for membership and/or to exercise the privileges requested. Once the determination is made that the practitioner is otherwise qualified, the Chair of the Wellness Committee may disclose information he/she has regarding any physical or mental disabilities and the effect of those on the Practitioner's application for membership and privileges. The Wellness Committee and any other appropriate committees may meet with the practitioner to discuss if and how reasonable accommodations can be made.

c. As required by law, the Medical Staff and Hospital will attempt to provide reasonable accommodations to a practitioner with known physical or mental disabilities, if the practitioner is otherwise qualified and can perform the essential functions of the Staff appointment and privileges in a manner which meets the Hospital and Medical Staff quality of care standards. If reasonable accommodations are not possible under the standards set forth herein, it may be necessary to withdraw or modify a practitioner's privileges and the practitioner shall have the hearing and appellate review rights described in the Bylaws and Fair Hearing Plan.

3.3-2 If all information required above is not submitted within sixty (60) days of receipt of the application, it will be considered void and no further processing will take place (One reminder notice will be sent to the applicant thirty (30) days after receipt of the application).

3.3-3 Upon receipt of a completed application, Medical Staff Services Office personnel will verify its contents and collect additional information. Verification of information is acceptable in writing, via approved online primary sources, or via telephone provided the contact and information obtained is documented as a memorandum to file by the representative obtaining such information. Primary source verification is preferable whenever possible. Information to be verified is as follows:

A. Information from **ALL** prior and current insurance carriers concerning claims, suits and settlements (if any) during the past five (5) years;
B. Secure administrative and clinical reference questionnaires from all significant past practice settings;
C. Verified reports documenting the applicant's clinical work during the past six (6) to twelve (12) months;
D. Verification of licensure status from the Medical Board of California and in all current or past states or countries where licensure is or was held;
E. Information from the Federation of State Medical Boards;
F. The American Medical Association Physician Masterfile Profile (or its equivalent); and
G. Information from the National Practitioners' Data Bank established pursuant to the Healthcare Quality Improvement Act of 1986.

NOTE: In the event there is undue delay in obtaining required information, the Medical Staff Services Office will request assistance from the applicant. During this time period, the "time periods for processing" the application will be appropriately modified. After thirty (30) days, failure of an applicant to adequately respond to a request for assistance will result in termination of the application process.

3.4 DEPARTMENT CHAIR PROCEDURE

3.4-1 The Medical Staff Office shall transmit the complete application and all supporting materials to the Chair of each department in which the applicant seeks clinical privileges. Each Chair shall sign an attestation that the applicant has satisfied all of the qualifications for appointment and the clinical privileges requested

3.4-2 The Department Chair may recommend that an application raises no questions and should be considered for provisional appointment and privileges.

3.5 LEVEL I APPLICATION PROCEDURE

3.5-1 If recommended by the relevant Department Chair, applications for initial appointment may be processed as set forth in this Section so long as they meet the following conditions:

A. the applicant has successfully completed a residency in the specialty for which privileges are requested, with no disciplinary action or conditions during residency training;
B. all reference evaluations are completed and received within reasonable time of the initial request;
C. all references contain only favorable evaluations, including unqualified recommendations for appointment and clinical privileges;
D. the applicant's claims activity (including past malpractice claims, settlements or judgments) is reasonable in light of his or her specialty; and
E. there are no pending or past restrictions, investigations or disciplinary actions from any hospital or licensing agency.

3.5-2 Evaluation and Decision-Making Process:

A. The application shall be presented to the appropriate Department Chair or designee for review and recommendation. The Department Chair shall review the application to ensure that it fulfills the established standards for membership and clinical privileges.
B. Any member of the Credentials Committee, acting for the Committee as a whole, shall review all relevant information for presentation at the next Credentials Committee meeting. Level I applications may be processed on a consent agenda.
C. Following affirmative recommendation for appointment and privileges by the Credentials Committee, the information is presented for Medical Executive Committee review and recommendation. Level I applications may be processed on a consent agenda.
D. Following affirmative recommendation for appointment and/or privileges by the Medical Executive Committee, the application is forwarded to the Board of Directors for final approval. Expedited applications may be forwarded to the Board of Directors' designees who have been designated to approve appointments/reappointments and clinical privileges, acting on behalf of the Board. The Board of Directors has designated any two members of the Board as a Board Subcommittee who shall act as its designee as the Board in residence.
E. A report from the Medical Executive Committee shall be prepared for the Board of Directors identifying those practitioners who were appointed and granted clinical privileges via the Board Subcommittee process for ratification.

3.6 FULL CREDENTIALS COMMITTEE PROCEDURE

3.6-1 For all other applications, the Credentials Committee shall review and consider the report prepared by the relevant Department Chair and shall make a recommendation.

3.6-2 The Credentials Committee may use the expertise of the Department Chair, or any member of the department or an outside consultant, if additional information is required regarding the applicant's qualifications.

3.6-3 CANDIDATE INTERVIEW:

A. New applicants for appointment to the Medical Staff ineligible for Level I processing may be required to participate in a candidate interview. The interview may be clinical in nature and will be conducted by members of the Credentials Committee and/or Department Chair to which an applicant seeks assignment. A permanent record will be made of the interview including the general nature of questions asked, adequacy of answer and the conclusion of the committee (group) or interviewer relative to the qualifications of the applicant for privileges requested.

B. The interview may also be used to solicit information required to complete the credentials file or clarify information previously provided, e.g., past malpractice history, reasons for

leaving past hospitals, or other matters bearing on the applicant's ability to render care at the generally recognized level for the community.

C. It is the responsibility of the Medical Staff Services Office personnel to contact the applicant to arrange the interview, customarily conducted at the next regularly scheduled Credentials Committee meeting. The applicant should be notified of the date, time and place of such interview.

D. The findings and recommendations of the Credentials Committee will be documented in the confidential applicant file and forwarded to the Medical Executive Committee and Board of Directors for consideration at their next regularly scheduled meetings. (If any recommendation is adverse as defined in the Fair Hearing Plan, the provisions of the Fair Hearing Plan will become effective.)

3.6-4 After determining that an applicant is otherwise qualified for appointment and privileges, the Credentials Committee, at the recommendation of the Wellness Committee Chair, may require the applicant to undergo a physical and/or mental examination by a physician(s) satisfactory to the Credentials Committee if there is any question about the applicant's ability to perform the privileges requested and the responsibilities of appointment. The results of this examination shall be made available to the Committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall be considered a voluntary withdrawal of the application and all processing of the application shall cease.

3.6-5 The Credentials Committee may recommend the imposition of specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring). The Credentials Committee may also recommend that appointment be granted for a period of less than two (2) years in order to permit closer monitoring of an individual's compliance with any conditions.

3.7 MEDICAL EXECUTIVE COMMITTEE PROCEDURE

3.7-1 At its next regular meeting after receipt of the written findings and recommendation of the Credentials Committee, the Medical Executive Committee shall:

A. adopt the findings and recommendation of the Credentials Committee as its own; or

B. refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the Medical Executive Committee prior to its final recommendation; or

C. state its reasons in its report and recommendation, along with supporting information, for its disagreement with the Credentials Committee's recommendation.

3.7-2 If the recommendation of the Medical Executive Committee is to appoint, the recommendation shall be forwarded to the Board of Directors through the President of the Medical Staff.

3.7-3 If the recommendation of the Medical Executive Committee is to deny privileges, and entitle the applicant to request a hearing, the Medical Executive Committee shall forward its recommendation to the Chief Executive Officer, and special notice shall be provided to the applicant.

3.8 BOARD OF DIRECTORS' ACTION

3.8-1 Upon receipt of a recommendation that the applicant be granted appointment and clinical privileges, the Hospital Board or its designated Hospital Board Committee may:

A. adopt or reject, in whole or in part, a favorable recommendation of the Medical Executive Committee; or

B. refer the recommendation back to the Medical Executive Committee for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation must be made. Favorable action by the Governing Board is effective as its final decision.

C. If, after complying with the requirements, the Governing Board's action is adverse to the applicant, a special notice will be sent to the applicant who shall then be entitled to the procedural rights provided in the Fair Hearing Plan.

3.8-2 In the case of an adverse Medical Executive Committee recommendation, the Governing Board shall take final action in the matter as provided in the Fair Hearing Plan. "Adverse action" by the Governing Board means action to deny appointment or to deny or restrict requested clinical privileges.

3.8-3 The report of each individual or group, including the Governing Board, required to act on an application, must state the reasons for each recommendation or action taken, with specific reference to the completed application and all other documentation considered. Any dissenting views at any point in the process must also be documented, supported by reasons and references, and transmitted with the majority report.

3.9 NOTICE OF FINAL DECISION:

A decision and notice of appointment includes:

A. The Staff category to which the applicant is appointed;
B. The department to which the applicant is assigned;
C. The clinical privileges the applicant may exercise; and
D. Any special conditions attached to the appointment.

ARTICLE IV: PROVISIONAL STATUS

Revision Date 05/12 – Approval Dates: Credentials 05/22/12 – MEC 06/05/12 – Board 06/27/12

4.1 **NATURE OF PROVISIONAL PERIOD**: Initial appointments to the Medical Staff (regardless of the staff category) and all initial grants of clinical privileges, whether at the time of appointment, reappointment, or during the term of an appointment, will be provisional. During the provisional period, the individual may not vote on Medical Staff matters.

4.2 **FOCUSED PROFESSIONAL PRACTICE EVALUATION**: During the provisional period, the individual's exercise of the relevant clinical privileges will be evaluated by the respective Department Chair or designee. The evaluation may include chart review, monitoring of the individual's practice patterns, and proctoring. The numbers and types of cases to be reviewed are outlined in the specific privilege request form, and approved by the Department Chair and Credentials Committee.

4.3 **DURATION OF PROVISIONAL PERIOD**:

A. The usual and customary duration of the provisional period for initial appointments and privileges will be twelve (12) months.

B. The duration of the provisional period for all other initial grants of privileges will be a number of cases or period of time as recommended by the Department Chair to the Credentials Committee and approved by the Medical Executive Committee.

1. Should the member be unable to fulfill the provisional period for other initial grants of privileges within twelve (12) months, he/she may request an extension in writing to the respective Department Chair, Credentials Committee and Medical Executive Committee. The request must include the reason why he/she was e unable to fulfill the required provisions and the length of extension requested.
2. Should the member be unable to fulfill the provisional period, including any extensions granted, within twenty-four (24) months or upon reappointment (whichever is longer), the member must sign the request, signifying intent to continue the request and reasons she/she was unable to fulfill the required provisions, for consideration by the respective Department Chair, Credentials Committee and Medical Executive Committee. If the request is granted, the provisional period duration will begin as stated in 4.3 (b).

4.4 **DUTIES DURING THE PROVISIONAL PERIOD**:

A. During the provisional period, a member must arrange for, or cooperate in the arrangement of, the required numbers and types of cases to be reviewed by the Department Chair and/or by other designated physicians.

B. A new member of the Medical Staff shall automatically relinquish his or her appointment and privileges at the end of the provisional period if that new member fails, during the provisional period, to:

1. participate in the required number of cases
2. cooperate with the monitoring and review conditions including ensuring all required proctoring reports are returned to the Medical Staff Office; or
3. fulfill all conditions of appointment as outlined in the Medical Staff Bylaws

C. During the provisional period, if a member of the Medical Staff who has been granted additional clinical privileges fails to participate in the required number of cases or cooperate with the monitoring and review conditions, the additional clinical privileges shall be automatically relinquished at the end of the provisional period, including any extension granted by the Medical Executive Committee.

D. When, based on the evaluation performed during the provisional period, clinical privileges are terminated, revoked or restricted for reasons related to clinical competence or professional conduct, the individual shall be entitled to a hearing and appeal.

ARTICLE V: REAPPOINTMENT

ALL APPOINTMENTS (EXCEPT PROVISIONAL) ARE FOR A PERIOD NOT TO EXCEED TWO YEARS.

5.1 INFORMATION COLLECTION AND VERIFICATION:

5.1-1 **FROM STAFF MEMBERS**: On or before three (3) months prior to the date of expiration of a Medical Staff appointment, the Medical Staff Services Office notifies the member of the date of expiration. At least sixty (60) days prior to this date, the member furnishes, in writing:

A. Complete information to update the member's file on items listed in the original application (refer to section 3.2-8);
B. Continuing medical education during the preceding period;
C. Specific request for the clinical privileges sought on reappointment, with any basis for changes; and
D. Requests for changes in Staff category or department/section assignments.

Failure, without good cause, to provide this information is deemed a voluntary resignation from the Staff and automatically results in expiration of appointment unless explicitly extended for not more than two (2) thirty (30) day periods by action of the Credentials Committee. The Medical Staff Services Office verifies this additional information, and notifies the Staff member of any information inadequacies or verification problems. The Staff member then has the burden of producing adequate information.

5.1-2 **FROM INTERNAL AND/OR EXTERNAL SOURCES**: The Medical Staff Services Office collects information from each Staff members' credentials file and other relevant sources regarding the individual's professional and collegial activities, performance and conduct in this Hospital and/or other hospitals. Such information includes, without limitation: Patterns of care as demonstrated in findings of quality improvement activities; medical records/hospital reports; continuing education activities; attendance at required Medical Staff and department/section meetings; service on Medical Staff, department and hospital committees; timely and accurate completion of medical records; compliance with all applicable bylaws, policies, rules, regulations and procedures of the Hospital and Staff.

5.1-3 All returned documents shall be reviewed and verified as described in the INITIAL APPOINTMENT AND PROCEDURE.

5.1-4 The Director of Medical Staff Services, or appropriate designee, will compile a summary of clinical activity for each member due to reappoint.

5.2 PROCEDURE FOR PROCESSING APPLICATIONS FOR STAFF REAPPOINTMENT:

5.2-1 The Director of Medical Staff Services or designee shall review all pertinent Medical Staff committee reports and studies and prepares a summary of findings for each member due for reappointment.

5.2-2 The completed file, including all documentation mentioned above, shall be sent to the Chair of the clinical department(s)/section(s) for review.

5.2-3 **DEPARTMENT ACTION:** Each Chair of a department/section, in which the Staff member requests or has exercised privileges, reviews the member's file as described above, including ongoing professional practice evaluation, and forwards a written report of the Staff member's performance to the Credentials Committee, including a statement as to whether or not he/she knows of, or has observed or been informed of any conduct which indicates significant present or potential physical or behavioral problems affecting the practitioner's ability to perform professional and Medical Staff duties appropriately and with recommendations for reappointment, non-reappointment and for Staff category, department/section assignment and clinical privileges.

5.2-4 **CREDENTIALS COMMITTEE ACTION**: The Credentials Committee reviews the member's file, the department/section reports and all relevant information available to it and forwards a written report with recommendations for reappointment, or non-reappointment and for Staff category, department assignment and clinical privileges to the Medical Executive Committee.

5.2-5 **MEDICAL EXECUTIVE COMMITTEE ACTION**: The Medical Executive Committee reviews the member's file, the department/section reports, Credentials Committee report and all relevant information available to it and forwards a written report with recommendations for reappointment or non-reappointment and for Staff category, department/section assignment and clinical privileges to the Governing Body.

If the Medical Executive Committees recommendation is deemed adverse under the terms of the ***Fair Hearing Plan***, the provisions of the ***Fair Hearing Plan*** will become effective.

5.2-6 **FINAL PROCESSING AND GOVERNING BOARD ACTION:** Final processing of requests for reappointment follows the procedure set forth earlier for initial appointment. For the purposes of reappointment, an "adverse recommendation" by the Governing Board as used in these provisions means a recommendation or action to deny reappointment, to deny a requested change in or to change without the Staff member's consent, his/her Staff category or department/section assignment, or to deny or restrict requested clinical privileges. The terms "applicant" and "appointment" as used in these sections shall be read respectively as "Staff member" and "reappointment."

5.2-7 **REQUEST FOR MODIFICATION OF APPOINTMENT STATUS OR PRIVILEGES**: A Staff member, either in connection with reappointment or at any other time, may request modification of his/her Staff category, department/section assignment or clinical privileges by submitting a written application to the Credentials Committee on the prescribed form. A modified application is processed in the same manner as a reappointment. All requests for increased privileges must be accompanied by information demonstrating current clinical competence in the specific privilege requested.

ARTICLE VI: DELINEATION OF CLINICAL PRIVILEGES

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6.1 **EXERCISE OF PRIVILEGES**: A practitioner providing clinical services at the Hospital may exercise only those privileges granted to the practitioner by the Governing Board or emergency privileges as described herein.

6.2 **DELINEATION OF PRIVILEGES IN GENERAL**:

6.2-1 **REQUESTS**: Each application for appointment or reappointment to the Medical Staff must contain a request for specific clinical privileges desired by the applicant. Specific requests must also be submitted for temporary privileges and for modification of privileges in the interim between reappraisals.

6.2-2 **BASIS FOR PRIVILEGES DETERMINATION**: Requests for clinical privileges will be considered only when accompanied by evidence of education, training, experience and demonstrated competence as specified by the Medical Staff. In the event a request is submitted for which no criteria have been created, the request will be tabled for a reasonable period of time during which the Board will, after consultation with the Credentials and Medical Executive Committees, formulate the necessary criteria. Once objective criteria have been established, the original request will be processed as described herein.

Valid requests for clinical privileges will be evaluated on the basis of education, training, experience, demonstrated competence, ability and judgment. The basis for privileges determination to be made in connection with periodic reappointment or a requested change in privileges must include observed clinical performance and documented results of the Staff's quality improvement program activities. Privileges determinations may also be based on pertinent information from other sources, especially other institutions and health care settings where a professional exercises clinical privileges including the information specified in Section 3.2-8. The information will be added to and maintained in the Medical Staff file established for the Staff member.

6.2-3 The procedure by which requests for clinical privileges are processed and the specific qualifications for the exercise of privileges are found elsewhere in this Manual.

6.2-4 If an applicant does not have evidence of a current professional performance record for presentation at the time of consideration of his/her appointment, data should be collected during a time-limited period of privilege-specific professional performance monitoring conducted at this Hospital. This process will be considered as a focused professional practice evaluation and is not considered a punitive process.

6.2-5 The Chair of the respective department and/or Credentials Committee, in consultation with Hospital Administration, will determine whether sufficient space, equipment, staffing and financial reserves are in place or available within a specified time period to support each request for clinical privileges.

6.3 TELEMEDICINE PRIVILEGES: Requests for telemedicine privilege applications must be approved by the Chief Executive Officer/designee and the Medical Executive Committee. Telemedicine privileges are granted based upon clinical need as determined by the Hospital and Medical Executive Committee, and approved by the Board. Practitioners who are responsible for the patient's care, treatment, and services via a telemedicine link shall be credentialed and privileged to do so by the Hospital in accordance with the Bylaws and this Policy, accreditation requirements, and applicable law. If the Hospital has a pressing clinical need and the Practitioner can supply that service through a telemedicine link, the Practitioner may be evaluated for Temporary Privileges in accordance with the procedures set forth in article 5.4 of the Medical Staff Bylaws.

Practitioners providing telemedicine services to Hospital patients shall be credentialed and privileged to do so through one of the following mechanisms:

A. The Practitioner is credentialed and privileged by the Hospital in accordance with the applicable procedure set forth in the Bylaws and this Policy.

B. The Practitioner is credentialed and privileged by the Hospital in accordance with the applicable procedure set forth in the Bylaws and this Policy with the exception that the credentialing information and/or privileging decision from the distant site may be relied upon by the Medical Staff and Board in making its recommendations/decision provided that the Hospital has entered into a written agreement with the distant site and all of the following requirements are met:

1. The distant site is a Joint Commission accredited hospital or a facility that qualifies as a "distant site telemedicine entity." A "*distant site telemedicine entity*" is defined as an entity that (1) provides telemedicine services; (2) is not a Joint Commission accredited hospital; and (3) provides contracted services in a manner that enables hospitals to meet all of the credentialing requirements of 42 C.F.R. 482.12 (a) (1)-(a) (7), as that provision may be amended from time to time, for the individual Practitioners providing telemedicine services.
2. When the distant site is a Joint Commission accredited hospital, the written agreement shall specify that it is the responsibility of the distant site hospital to meet the credentialing requirements of 42 C.F.R. 482.12 (a)(1)-(a)(7), as that provision may be amended from time to time.
3. When the distant site is a "distant site telemedicine entity", the written agreement shall specify that it is the responsibility of the distant site telemedicine entity to provide services in a manner that allows the Hospital to meet the credentialing requirements of 42 C.F.R. 482.12 (a)(1)-(a)(7), as that provision may be amended from time to time.
4. The individual distant site Practitioner is privileged at the distant site for those services to be provided to Hospital patients via telemedicine link and provides the Hospital with a current list of his/her privileges at the distant site.
5. The individual distant site Practitioner holds an appropriate license issued by the Medical Board of California or other appropriate licensing entity.
6. The Hospital maintains documentation of its internal review of the performance of each distant site Practitioner and sends the distant site such performance information for use in the distant site's periodic appraisal of the distant site Practitioner. At a minimum, this information must include:
    i. All adverse events that result from the telemedicine services provided by the distant site Practitioner to Hospital patients; and
    ii. All complaints the Hospital receives about the distant site Practitioner.

ARTICLE VII: TEMPORARY PRIVILEGES POLICY

7.1 Temporary clinical privileges are not automatically granted and must be specifically requested. Temporary privileges will be processed and approved in accordance with the Medical Staff Bylaws and the procedure outlined below. Temporary privileges may be granted to fulfill an important patient care need or when an applicant has a complete application and is awaiting final approval by the Board.

At all times, practitioners who have been granted temporary privileges shall agree to and be responsible for adhering to the policies of the Hospital and the Bylaws, Rules and Regulations of the Medical Staff.

If the practitioner's license is not renewed, becomes revoked and/or restricted or if there is cessation of appropriate liability insurance coverage, temporary privileges shall cease immediately. A practitioner's Disaster Volunteer Staff privileges are addressed in the Disaster policy.

7.2 CIRCUMSTANCES

7.2-1 **Pendency of Application:** In extraordinary circumstances, after completion of an application for Staff appointment, including a written request for specific temporary privileges and recommendation for approval by the Department Chair, Credentials Committee and Medical Executive Committee, temporary privileges may be granted for an initial period of not more than one hundred twenty (120) days. Temporary privileges not renewed will automatically expire.

7.2-2 **Care of Specific Patients:** Upon receipt of a written request for specific temporary privileges for the care of one or more specific patients from a practitioner who is not an active or affiliate member of the Medical Staff. Such privileges shall be restricted to the treatment of no more than six (6) patients in any twelve (12) month period.

7.2-7 **Locum Tenens:** Upon receipt of a written request for specific temporary privileges, an appropriately licensed practitioner of documented competence who is serving as a locum tenens for a member of the Medical Staff may be granted temporary privileges for an initial period of sixty (60) days of coverage to be completed within a ninety (90) day calendar time frame. Locum tenens privileges may be renewed for an additional sixty (60) days of coverage within an additional ninety (90) day calendar time frame provided the request is accompanied by a completed application for full privileges and membership. They are limited to treatment of the patients of the Staff member for whom this practitioner is serving as locum tenens and do not entitle him to admit his/her own patients to the Hospital.

7.3 PROCEDURE

7.3-1 **Temporary Privilege Request:** Requests for temporary privileges must be made a minimum of three (3) working days (Monday – Friday) in advance of the date temporary privileges will be needed in order to allow for the required verifications to take place. Requests are made by submitting a written request to the Medical Staff Office, Monday through Friday, 8:00 a.m. to 4:30 p.m.

7.3-2 **Required Information/Documents:** Prior to temporary privileges being granted, the following must be provided to the Medical Staff Office:

A. Temporary Privilege Request;
B. Temporary Privilege application or fully completed Application for Medical Staff Privileges;
C. Application Fee ($1,000 Full Privileges, $500 Initial Temporary/Locum, $100 Locum Reappointment);
D. Current Government Issued Photo ID;
E. Current California Licensure with no current or previously successful challenge to licensure or registration exists;
F. Current DEA certificate, if applicable;
G. Current professional liability insurance coverage in at least minimum amounts determined by board;
H. Date of Birth;
I. Name of Medical School and graduation date;
J. Name of at least one hospital where practitioner currently has privileges and copy of current privilege delineation form.

7.3-3 **Verification:** Prior to temporary privileges being granted, the following information must be verified by the Medical Staff Office:

A. The results of the National Practitioner Data Bank query, the Medical Board of California query and Office of the Inspector General query have been obtained and evaluated.
B. Verification from at least one hospital where the practitioner is currently practicing and the practitioner has the following:

1. Requested privileges;
2. Relevant training or experience;
3. Current competence; and
4. Ability to perform the privileges requested.

C. The applicant has:

1. Not been subject to involuntary termination of medical staff membership at another organization; and
2. Not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges.

7.3-4 **Additional Information Required:** The Department Chair has the discretion to determine if additional information is necessary prior to granting temporary privileges. Such information may include, but not be limited to: case summaries or other documentation regarding performance of specific procedures, reference(s) from physician(s) currently on Staff, x-ray supervisor and operator certificate, etc.

7.3-5 **Proctoring:** Every practitioner granted temporary privileges shall have imposed the requirements for focused professional practice evaluation (proctoring and monitoring), as outlined in the Bylaws, Rules & Regulations, Medical Staff Policies, and Clinical Privilege Forms. The Department Chair will specify the required proctoring for the applicant.

7.3-6 **Approval:**

A. Temporary privileges may be granted after the applicant completes the application procedure and the Medical Staff Office completes the application review process.
B. Upon concurrence of the chair of the department where the privileges will be exercised and the President of the Medical Staff, the Chief Executive Officer may grant temporary privileges.

7.3-7 **Notification:**

A. Approval – The Medical Staff Office will notify the physician by either electronic mail or phone.
B. Credentialing database will be updated.

7.4 EMERGENCY

In an emergency, any Medical Staff member with clinical privileges is permitted to provide any type of patient care, treatment and services necessary as a life-saving measure or to prevent serious harm regardless of his or her Medical Staff status or clinical privileges provided that the care, treatment, and services provided are within the scope of the individual's license.

7.5 DENIAL OR TERMINATION OF TEMPORARY PRIVILEGES

There is no right to temporary privileges. Accordingly, temporary privileges should not be granted unless the available information supports, with reasonable certainty, a favorable determination regarding the requesting applicant's qualifications, ability and judgment to exercise the privileges requested. If available information is inconsistent or casts any reasonable doubts on the applicant's qualifications, action on the request for temporary privileges may be deferred until the doubts have been satisfactorily resolved.

A person shall be entitled to the procedural rights afforded by Bylaws Article 10, Procedural Rights, only if a request for temporary privileges is refused based upon, or if all or any portion of temporary privileges are terminated or suspended for a medical disciplinary cause or reason. In all other cases (including a deferral in acting on a request for temporary privileges), the affected practitioner shall not be entitled to any procedural rights based upon any adverse action involving temporary privileges. A determination to grant temporary privileges shall not be binding or conclusive with respect to an applicant's pending request for appointment to the Medical Staff.

Temporary privileges shall automatically terminate at the end of the designated period unless affirmatively renewed or earlier terminated. Temporary privileges may be terminated with or without cause at any time by the Chief of Staff, the responsible Department Chair, the Chief Medical Officer or the Chief Executive Officer after conferring with the Chief of Staff or the responsible Department Chair.

ARTICLE VIII: INVESTIGATION AND CORRECTIVE ACTION POLICY

8.1 BEHAVIOR LEADING TO INITIATION OF INVESTIGATION:

8.1-1 **ROUTINE INVESTIGATION**: Investigation may be initiated whenever a practitioner with clinical privileges engages in, makes or exhibits acts, statements, demeanor or professional conduct which may be a violation of the Medical Staff and Hospital Bylaws and Rules and Regulations, or otherwise unethical or below applicable professional standards either within or outside the Hospital, and the same may be or is reasonably likely to be detrimental to the quality of patient care or safety, disruptive to the Hospital's operations.

8.2 ROUTINE INVESTIGATION: Routine investigation may be initiated by any officer of the Medical Staff, by the Chair of the department in which the practitioner holds appointment or exercises clinical privileges, by the Chief Executive Officer, by the Medical Executive Committee or by the Board of Directors.

8.3 AUTOMATIC SUSPENSION:

8.3-1 **AUTOMATIC SUSPENSION**: Automatic suspension shall be initiated whenever there is revocation, suspension, restriction or probation of the practitioner's State license or DEA number; whenever there is failure to satisfy a special appearance requirement; whenever the practitioner fails to maintain required malpractice insurance coverage and whenever a practitioner's medical records are not completed in a timely manner.

8.3-2 **STATE LICENSE:**

A. REVOCATION: Whenever a practitioner's license to practice in this State is revoked, there is immediate and automatic revocation of Staff appointment and all clinical privileges.
B. RESTRICTION: Whenever a practitioner's license is partially limited or restricted in any way, those clinical privileges which he/she has been granted that are within the scope of the limitation or restriction are similarly limited or restricted automatically.
C. SUSPENSION: If a license is suspended, the practitioner's Staff appointment and clinical privileges are automatically suspended effective upon and for at least the term of the suspension.
D. PROBATION: If a practitioner is placed on probation by his/her licensing authority, the practitioner's voting and office holding prerogatives are automatically suspended effective upon and for at least the term of the probation.

8.3-3 **DRUG ENFORCEMENT (DEA)**: If a practitioner's right to prescribe controlled substances is revoked, restricted, suspended, or placed on probation by a proper licensing authority, the practitioner's privileges to prescribe such substances in the Hospital will also be revoked, restricted, suspended, or placed on probation automatically and to the same degree. This will be effective upon and for at least the term of the imposed restriction.

8.3-4 **FURTHER ACTION**: The procedures for further action on these matters are contained in the ***Fair Hearing Plan***.

8.3-5 **MEDICAL RECORDS**: TIMELY COMPLETION: The failure to prepare and/or to complete medical records in a timely fashion will result in limitation or automatic suspension of some or all of a practitioner's prerogative and clinical privileges. This will not occur without written warning and he/she will be given sufficient warning and time so that this will not constitute a hardship.

8.3-6 **PROFESSIONAL LIABILITY INSURANCE**: For failure to maintain the minimum amount of professional liability insurance required by the Governing Board, a practitioner's Medical Staff appointment and clinical privileges are immediately suspended.

8.4 SUMMARY RESTRICTION OR SUSPENSION:

8.4-1 **CRITERIA FOR INITIATION**:

A. Whenever a member's conduct is such that a failure to take action may result in an imminent danger to the health of any individual, the President of the Medical Staff, the

Medical Executive Committee or the chair of the department in which the member holds privileges may summarily restrict or suspend the Medical Staff membership or privileges of such member.

B. Unless otherwise stated, such summary restriction or suspension ("summary action") shall become effective immediately upon imposition and the person or body responsible shall promptly give special notice to the member and written notice to the Governing Body, the Medical Executive Committee, and the Chief Executive Officer. The notice shall generally describe the reasons for the action.

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

D. The notice of the summary action given to the Medical Executive Committee shall constitute a request to initiate corrective action.

8.4-2 **MEDICAL EXECUTIVE ACTION**: The affected member may request an interview with the Medical Executive Committee. The interview shall be convened as soon as reasonably possible under all circumstances and shall be informal and not constitute a hearing, as that term is used in the Bylaws. The Medical Executive Committee may thereafter continue, modify, or terminate the terms of the summary action. It shall give the member special notice of its decision.

8.4-3 **PROCEDURAL RIGHTS**: Unless the Medical Executive Committee terminates the summary action, it shall remain in effect during the pendency and completion of the corrective action process and of the hearing and appellate review process. When a summary action is continued for more that a total of fourteen (14) days, the affected member shall be entitled to the procedural rights afforded by the fair hearing plan, but the hearing may be consolidated with the hearing on any corrective action that is recommended so long as the hearing commences within sixty (60) days after the hearing on the summary action was requested.

8.4-4 **INITIATION BY GOVERNING BODY**:

A. If, under Section 7.4-1.A, no one authorized to take a summary action is available to restrict or suspend summarily a member's membership or privileges, the Governing Body or the President/Chief Executive Officer may immediately suspend or restrict a member's privileges if a failure to act immediately is likely to result in imminent danger to the health of any individual, provided that the Governing Body or President and Chief Executive Officer made reasonable attempts to contact the Chief of Staff, Medical Executive Committee, and the Chair of the department to which the member is assigned before acting.

B. Such summary action is subject to ratification by the Medical Executive Committee. If the Medical Executive Committee does not ratify such summary action within two (2) working days, excluding weekends and holidays, the summary action shall terminate automatically.

ARTICLE IX: LEAVE OF ABSENCE (effective 08/01/13)

Revision Date 06/13 – Approval Dates: Credentials 06/25/13 – MEC 07/02/13 – GMS 07/09/13 – Board 08/01/13

9.1 **LEAVE STATUS**: A Staff member may obtain a voluntary leave of absence by giving written notice to Medical Staff Services for transmittal to the appropriate Department Chair. The notice must state the reason for and approximate period of time of the leave, which may not exceed two (2) years, except for military service. During the period of time of the leave, the Staff member's clinical privileges, prerogatives and responsibilities are suspended. If approved by the Department Chair, the Credentials Committee, Medical Executive Committee and Board of Directors will be informed.

9.2 **TERMINATION OF LEAVE**: The Staff member must, at least thirty (30) days prior to the termination of the leave, or may at any earlier time, request reinstatement by sending a written notice to Medical Staff Services for transmittal to the appropriate Department Chair. The Staff member must submit a written summary of relevant activities during the leave if so requested. If approved, the Chair shall forward the request for reinstatement to the Credentials Committee, Medical Executive Committee and Governing Board concerning reinstatement, and the applicable procedures are followed. Failure to request reinstatement within the specified time period will result in a voluntary resignation from the Staff.

9.3 **REAPPOINTMENT DURING LEAVE**: If the Staff member’s appointment will expire during the leave period, the Medical Staff office will:

A. Process the practitioner's reappointment before the leave is in effect, even if this date occurs before his or her reappointment date
B. Process the practitioners' reappointment during his or her leave, if the practitioner is available to complete the reappointment application packet; or
C. Allow the reappointment to lapse and fully re-credential the practitioner upon his or her return.

ARTICLE X: PRACTITIONER PROVIDING CONTRACTUAL SERVICES

10.1 **EXCLUSIVITY POLICY**: Whenever hospital policy specifies that certain hospital facilities or services may be used on an exclusive basis in accordance with contracts or letters of agreement between the Hospital and qualified practitioners, then other Staff members must, except in an emergency or life-threatening situation, adhere to this exclusivity policy in arranging care for their patients. Application for initial appointment or for clinical privileges related to hospital facilities or services covered by exclusivity agreements will not be accepted or processed unless submitted in accordance with the existing contract or agreement with the Hospital.

10.2 **QUALIFICATIONS**: A practitioner who is or will be providing specified professional services pursuant to a contract or a letter of agreement with the Hospital must meet the same qualifications, must be processed in the same manner, and must fulfill all the obligations of his/her appointment category as any other applicant or Staff member.

10.3 **EFFECT OF STAFF APPOINTMENT TERMINATION**: Because practice at the Hospital is always contingent upon continued Staff membership and is also constrained by the extent of clinical privileges enjoyed, a practitioner's right to use Hospital facilities is automatically terminated when his/her Staff membership expires or is terminated. Similarly, the extent of his/her clinical privileges is automatically limited to the extent the pertinent clinical privileges are diminished.

10.4 **EFFECT OF CONTRACT EXPIRATION OR TERMINATION**: The effect of expiration or other termination of a contract upon a practitioner's Staff membership and clinical privileges will be governed solely by the terms of the practitioner's contract with the Hospital, provided, however, that if the contract is terminated for medical disciplinary cause or reason pertaining to a practitioner, such practitioner shall be afforded the rights of hearing and appeal identified in the Fair Hearing Plan.

10.4-1. In the case of subcontractors, or individuals providing services for the party holding the contract with the Hospital, the effect of expiration or other termination of their subcontract or agreement, shall result in a voluntary relinquishment of medical staff membership and clinical privileges without access to due process, provided, however, that if the contract or agreement is terminated for medical disciplinary cause or reason pertaining to a practitioner, such practitioner shall be afforded the rights of hearing and appeal identified in the Fair Hearing Plan.

ARTICLE XI: ALLIED HEALTH PROFESSIONALS

11.1 **INDEPENDENT ALLIED HEALTH PROFESSIONALS**:

11.1-1 This category of practitioners will consist of the following persons:

A. Individuals with a doctorate in psychology or its equivalent from an accredited college or university, and licensed in this State;
B. Individuals with a master's degree in psychiatric social work from an accredited college or university with appropriate academic and field placement experience; and
C. Individuals who are employees of the Hospital who possess an advanced practice registered nurse designation;
D. others as designated by the Governing Board.

11.1-2 Independent allied health professionals may provide patient care services within the limits of their professional skills and abilities. The degree of participation of Independent Allied Health Professionals in patient care shall be determined according to protocol or permission to practice recommended and approved by the Governing Board. Descriptions of the approved categories of Allied Health Professionals will be maintained in Medical Staff Services.

11.1-3 Independent allied health professionals shall:

A. Exercise independent judgment in their areas of competence, provided that an Active Staff member of the Medical Staff shall have the ultimate responsibility for patient care with the exception of psychologists who may perform services within the scope of their license without discrimination or supervision by a member of the Medical Staff.
B. Participate directly in the management and care of patients as described in the specific outline of categories on file in Medical Staff Services as approved by the Medical Staff and Governing Board.
C. Record reports and progress notes on the patients' records and write orders for treatment to the extent established in the rules and regulations of the Medical Staff, provided that such orders are within the scope of his/her license, certificate or other legal credentials; and
D. Not admit or discharge patients at the Hospital with the exception of psychologists who are permitted, within the scope of their license to admit and manage the care of their patients.

11.1-4 Applications for clinical privileges as an Independent Allied Health Professional shall be generally processed in accordance with the procedure set forth for appointment to the Medical Staff. An individual applying for permission to practice as an Allied Health Professional must be recommended to the Credentials Committee by a physician member of the Active Medical Staff if the individual is not an employee of the Hospital. If the individual is an employee of the Hospital, the respective Medical Staff Department Chair shall act in that capacity. Psychologists are exempt from the requirement of a physician sponsor and may apply at their own discretion.

11.1-4 Independent Allied Health Professionals may serve on appropriate committees of the Medical Staff, as appointed by the Chief of Staff. Such individuals may be invited to attend Medical Staff meetings, and may, as a condition of continued privileges, be required to attend meetings involving the clinical review of patient care in which they participated.

11.2 REAPPRAISAL AND REDELINEATION OF CLINICAL PRIVILEGES:

11.2-1 All Allied Health Professional personnel will be subject to a formal biannual reappraisal of their clinical activities by the appropriate Department Chair(s).

11.2-2 Procedures to be used for purposes of reappraisal and redelineation of clinical privileges will be of the same general nature as those for appointees to the Medical Staff. All procedures used will be contained in these Bylaws or the Credentials Policy and Procedure Manual.

11.3 REMOVAL PROCEDURES AND STATUS:

11.3-2 Persons maintaining any of the foregoing positions are not members of the Medical Staff and accordingly, have none of the duties and prerogatives of Staff members.

11.3-3 The Hospital retains the right through the Chief Executive Officer, with or without the recommendation of the Medical Executive Committee or Credentials Committee, to suspend or terminate any or all of the privileges or functions of any allied health professional without recourse on the part of such person(s) or others to the review and appeal procedures of the Fair Hearing Plan.

A. Independent allied health professional personnel who are terminated or curtailed shall be told the reasons for such action and, if they so request, shall be entitled to have such action reviewed by the Medical Executive Committee or Credentials Committee. At any review meeting, the individual shall be present and allowed to fully participate.

ARTICLE XII: ANNUAL REVIEW, ADOPTION AND AMENDMENT

12.1 **ANNUAL REVIEW**: This policy manual will be reviewed on an annual basis by the Credentials Committee.

ARTICLE XIII: USE OF TERMS

When used herein, the terms "department," "chair," "Credentials Committee Chair," "Chief Executive Officer," "President," "Director of Medical Staff and Credentialing" and "Governing Board" are construed to include "designee."

13.1 **AMENDMENT**: This Credentials Policy and Procedure Manual may be adopted, amended or repealed, in whole or in part, by the following mechanism: A resolution of the Medical Executive Committee recommended to and adopted by the Governing Board.

13.2 **CORRECTIONS**: The Credentials Committee may correct typographical, spellings or other obvious errors in this Manual. The Credentials Committee may also make any changes specifically required by law, State regulation or Joint Commission on Accreditation of Healthcare Organization standards.

13.3 **RESPONSIBILITIES AND AUTHORITY**: The procedures outlined in the Medical Staff and Hospital Corporate Bylaws regarding Medical Staff responsibility and authority to formulate, adopt and recommend Medical Staff Bylaws and amendments thereto, apply as well to the formulation, adoption and amendment of this Credentials Policy and Procedure Manual.

EFFECTIVE DATE: 06/24/04
REVISED DATES: 08/04; 01/07; 08/13; as *noted on individual articles*; 09/15
REVIEW DATES: 08/04; 08/05; 06/06; 01/07; 01/08; 01/09; 01/10; 01/11; 05/12; 07/14; 08/15

CROSS REFERENCES: Bylaws of the Medical Staff
General Rules and Regulations of the Medical Staff
Fair Hearing Plan