BYLAWS

OF THE

MEDICAL STAFF

OF

Community Medical Center | RWJBarnabas HEALTH

Amended by Medical Staff: November 12, 2020
Approved by Board of Trustees: December 4, 2020

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DEFINITIONS

1. Active Staff are Attending, Associate Attending and Assistant Attending members of the Medical Staff.

2. Applicant means a Physician or Independent Limited Health Professional who is in the process of applying for Staff status but has not yet attained Membership.

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

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

5. Days mean calendar Days.

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

7. Executive Committee means the Executive Committee of the Medical Staff.

8. Hospital President/CEO means the individual appointed by the Board of Trustees to act on its behalf in the overall administrative management of the Hospital, or his designee.

9. Hospital means the Community Medical Center.

10. Independent Limited Health Professional means a licensed health professional other than a Physician who exercises independent judgment within his areas of professional competence, and who is granted Clinical Privileges as provided in these Bylaws.

11. Medical Staff or Staff means the formal organization of all Physicians and other licensed individuals permitted by law and the Hospital to provide patient care services in the Hospital who are privileged through the Medical Staff process and who are subject to the Medical Staff Bylaws, to attend or provide care to patients at the Hospital.

12. Membership means that status with the Medical Staff as determined by the Medical Staff, with the approval of the Board, which defines a Medical Staff member's rights, prerogatives and responsibilities to participate in the Medical Staff organization.

13. Office means the physical space located within the Hospital service area wherein the Practitioner can examine the patient in privacy and wherein the Practitioner will provide non-hospital patient care on a continuing basis for patients treated by the Practitioner in the Hospital.

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

15. Practitioner means, unless otherwise expressly limited, any Physician or Independent Limited Health Professional applying for or exercising Clinical Privileges in the Hospital.

16. President means the President of the Medical Staff.

17. Service Patients refers to those patients who shall be treated as outpatients or admitted to one of the departments or sections of the Hospital (including the Emergency Department) and who do not have a private physician or dentist on the Staff, or whose private physician or dentist on Staff, or designee, may not be immediately available. Service Patients may include indigent or "charity care" patients.

18. Supplemental Medical Staff Governance Documents means those other documents including the General Rules and Regulations and policies that are referred to in these Bylaws which set forth with more specificity administrative procedures related to Appointment and Reappointment, Corrective Action and Hearing and Review Procedures and Committee Structure.

19. Chief Medical Officer means the medical officer appointed by the Board who has primary responsibility for liaison between the Medical Staff and the Hospital administration.

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

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

ARTICLE I

NAME

The name of the organization shall be the Medical Staff of Community Medical Center.

ARTICLE II

PURPOSES

The purposes of this organization are as follows:

1. To serve as the primary means for accountability to the governing body for the appropriateness of the professional performance and ethical conduct of its members and affiliates and, in such capacity, to provide professional oversight of care, treatment and services provided by Practitioners with privileges;

2. To strive toward assuring that the pattern of patient care in the hospital is consistently maintained at the level of quality and efficiency achievable by the state of the healing arts and the resources locally available;

3. To seek to provide a high level of professional performance of all practitioners authorized to practice in the hospital through the appropriate delineation of the clinical privileges that each practitioner may exercise in the hospital and through an ongoing review and evaluation of each practitioner's performance in the hospital;

4. To provide an appropriate educational setting that will maintain scientific standards and that will lead to continuous advancement in professional knowledge and skill;

5. To initiate and maintain rules and regulations for self-governance of the Medical Staff and Medical Staff activities and to create a framework within which Medical Staff members can act with a reasonable degree of freedom and confidence;

6. To provide a means whereby issues concerning the Medical Staff and the hospital may be discussed by the Medical Staff with the governing body and the administration;

7. To implement a process to identify and manage matters of individual physician health that is separate from the Medical Staff disciplinary function;

8. To educate the public, the community and the profession on issues of health, clinical and other accountability and applicable regulations so as to improve access, the provision of care and the profession of medicine;

9. To provide a leadership role in hospital performance improvement activities to improve quality of care, treatment, and services and patient safety; and

10. To participate in the measurement, assessment, and improvement of other processes including organization wide performance improvement activities.

11. To establish and maintain patient care standards and oversee the quality of care, treatment and services rendered by Practitioners privileged through the Medical Staff process.

ARTICLE III

MEDICAL STAFF MEMBERSHIP

Section 1. Nature of Medical Staff Membership

Membership in the Medical Staff of Community Medical Center is a privilege extended only to practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws.

The Medical Staff Credentialing/Re-credentialing and Appointment/Reappointment process is delineated within the General Rules and Regulations of the Medical Staff.

Section 2. Qualifications for Membership

(a) Only practitioners licensed to practice in the State of New Jersey, who can document their current license status, ability, experience, training, demonstrated competence, their adherence to the ethics of their profession, their good reputation, and their ability to work with others, with sufficient adequacy to assure the Medical Staff and the governing body that any patient treated by them in the hospital will be given a high quality of medical care, shall be qualified for membership on the Medical Staff. No practitioner shall be entitled to membership by virtue of being licensed to practice medicine or dentistry in this or in any other state, that he/she is a member of any professional organization, or that he/she had in the past, or presently has, such privileges in another hospital.

(b) The applicant shall maintain in force professional liability insurance in amounts no less than the minimum allowable by the State of New Jersey. A current certificate of insurance shall be kept on file with the Administration.

(c) Acceptance of membership on the Medical Staff shall constitute the staff member's agreement that he/she will strictly abide by the Principles of Medical Ethics of the American Medical Association or by the Code of Ethics of the American Osteopathic Association, whichever is applicable. All of the foregoing current Code of Ethics shall be maintained and kept on file by the Chief Medical Officer.

(d) The applicant shall maintain an office within the service area as defined in the Rules and Regulations of the clinical departments of the Medical Staff of Community Medical Center. Each applicant shall have the ability to be physically present in response to emergent issues within 60 minutes, unless otherwise defined in a Department's Rules and Regulations. For regional and consulting privileges, the 60 minute response time shall not apply.

(e) All employed or contract practitioners, or employees of contract practitioners are required to become members of the Medical Staff without admitting privileges. Admitting privileges may be granted only if specifically set forth in the contract of employment or contract with such practitioner and if approved by the Executive Committee of the Medical Staff. The President of the Medical Staff shall participate in search committee activities for practitioner employees or independent contractors of the hospital.

(f) Each member of the Medical Staff must attest to or provide documentation that he/she has no physical or mental limitations which could impair his/her ability to render quality patient care at the time of appointment and upon each biannual reapplication for Medical Staff membership and clinical privileges.

The Medical Staff will follow the State guidelines for impaired practitioners as delineated by the New Jersey Board of Medical Examiners and as otherwise set forth in the General Rules and Regulations of the Medical Staff.

(g) Each member of the Medical Staff shall agree to treat Service Patients (including assignment to Emergency Department call as set forth in the Bylaws and/or the rules and regulations of his assigned Department or Section and may be considered for an opportunity for reimbursement for care rendered to indigent and self-pay patients in certain settings

(h) All applicants will be provided with these Bylaws and the general Rules and Regulation/Supplemental Medical Staff Governance Documents for review and signature at the time of their appointment. Notwithstanding any applicant's failure to review and/or sign the Bylaws, all applicants and members of the Medical Staff shall be bound by the Bylaws, the General Rules and Regulations/Supplemental Medical Staff Governance Documents and such other Policies and Rules as may be promulgated from time to time.

(i) Each member of the Medical Staff agree to comply by the requirements for the completion of a History and Physical examination for each patient as further defined within the Medical Staff General Rules and Regulations, Article VIII.

(j) Each member of the Medical Staff agrees to serve on any Ad Hoc Committee in which the member is appointed except for good cause shown. Physicians who show good cause will be first on the list for the next Ad Hoc Committee. (added March 2011)

(k) Each new applicant to the Medical Staff who was not a member of the Medical Staff on January 1, 2012 shall be Board certified or Board qualified (in the tracking process) in their specialty by the American Board of Medical Specialties (ABMS), the American Dental Association (ADA), the American Osteopathic Association (AOA) or the American Podiatric Medical Association (APA). If an applicant is Board eligible, qualified or in the tracking process and not Board certified at the time of application, the applicant will have five (5) years from the completion of post graduate training to achieve Board certification. In unusual circumstances such as illness, an extension may be granted by the Medial Executive Committee for up to eighteen (18) months. The Board may waive the initial and/or continuing requirement for Board certification or Board qualification if recommended by the Medical Executive Committee, based upon clinical need if current clinical competence, experience, training, behavior and ethics are demonstrated. Unless the Board has granted such waiver, failure to achieve Board certification within the five (5) year time limit will result in automatic termination of Medical Staff appointment and privileges without right of appeal with any review limited to the issue of whether the individual meets the Board certification requirements.

(l) New applications that have been previously Board Certified and have not maintained their recertification, shall not be considered Board Certified for the purpose of this application.

Section 3. Conditions and Duration of Appointment

(a) Initial appointments and reappointments to the Medical Staff shall be made by the governing body only after there has been a recommendation from the Medical Staff as provided in these Bylaws except as hereinafter provided under the Supplemental Medical Staff Governance Documents. Should the Medical Staff fail to affirmatively recommend the appointment or reappointment within one hundred and twenty (120) days of having received a completed application, then the application shall be deemed denied and the applicant shall be entitled to a hearing pursuant to the Supplemental Medical Staff Governance Documents.

(b) Initial appointments shall be for a period not to exceed two (2) Medical Staff years. Reappointments shall be for a period of not more than two (2)

Medical Staff years. For the purposes of these Bylaws, the Medical Staff year commences on the 1st day of January and ends on the 31st day of December of each year.

(c) Appointments to the Medical Staff shall confer upon the appointee only such privileges as have been granted by the governing body in accordance with these Bylaws.

(d) Every application for staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgment of every Medical Staff member's obligations to provide continual care and supervision of his/her patients, to abide by the Medical Staff Bylaws, all rules and regulations, to accept committee assignments, to accept all service calls and consultation assignments, emergency call service, and supervisory and hospital financed clinic assignments.

(e) The application shall include information as to whether the Bureau of Narcotics and Dangerous Drugs or Drug Enforcement agency (or successor agencies) have taken any adverse action against the applicant; a statement that all information contained in the application is valid and current; and to provide said information and accept the provisions of Article X of these Bylaws.

(f) The application and reappointment application shall include information concerning whether the Applicant has ever been or is presently the subject to of sanctions under the Medicare or Medicaid Programs or has ever been or is presently under investigation related to violations of the laws or regulations governing the Medicare or Medicaid Programs, any program under the federal Social Security laws or any program under the jurisdiction of the Federal Department of Health and Human Services.

(g) The applicant shall have the burden of producing adequate information for a proper evaluation of qualifications, competence, character, health status, and ethical standing. The applicant authorizes this Medical Staff and hospital administration to submit similar data to any other institution, governing body, governmental agency or third party inquiry.

(h) Each applicant, except those requesting consulting privileges at the invitation of the Medical Staff, shall submit a non-refundable fee with each new application to the hospital. This fee is considered reimbursement to the hospital for the costs in reviewing the application. Expenses incurred by the Medical Staff or any of its committees in reviewing the application or reapplication shall be borne by the Administration.

(i) A checklist approved by the hospital shall be given to the applicant setting forth all the items required before an application shall be considered a completed application.

(j) An applicant shall report involvement in any liability action during re-credentialing as well as during initial appointment.

(k) Within ninety (90) days after obtaining privileges, each applicant shall present documentation showing that he/she has the ability to respond to emergencies within thirty (30) minutes. For Regional and Consulting privileges, the thirty (30) minute response time shall not apply. If the decision to admit the patient is made between noon and midnight the patient must be seen before noon the following day. If the decision to admit the patient is made after midnight, the patient must be seen within twelve (12) hours. Longer telephone response time shall be subject to the peer review and quality assurance processes of the Medical Staff and the Departments, and may be the subject of subsequent recommendation and/or corrective action if so indicated.

(l) Newly-appointed members of the Medical Staff shall attend "New Physician Orientation" within ninety (90) days of date of appointment or at the first available orientation date after appointment with the exception of Tele-Radiologists. Failure to attend such New Physician Orientation, except for good cause shown, will result in automatic suspension of clinical privileges until such time as the member has attended New Physician Orientation, without the right to a fair hearing or appellate review.

Section 4. Dues

(a) Active, Interim, Regional, Affiliate and Adjunct members of the Medical Staff along with First Assistants shall pay dues each year as prescribed in these Bylaws. Consultants, Emeritus and Tele-Medicine are exempt from paying dues.

(b) Failure to pay dues by the end of the calendar year may constitute delinquency. If the dues are delinquent, voting privileges will be suspended thirty (30) days after receipt of notice from the Medical Staff Office and admitting privileges may be withdrawn.

(c) Periodic assessments, if necessary, must be approved and paid only by an act passed by a quorum of the Active Medical Staff at a Quarterly Medical Staff meeting upon recommendation of the Executive Committee of the Medical Staff.

Section 5. Continuing Medical Education Credit Requirements

One hundred fifty (150) hours of continuing medical education credits over three (3) years will be required for re-credentialing. This requirement will be satisfied by the American Medical Association Physician's Recognition Award, individual specialty board credit, or equivalent, totaling one hundred fifty (150) credits.

During the re-credentialing period, a total of one hundred (100) continuing medical education credits for two years, of which forty (40) hours must be Category 1 or a valid American Medical Association Physician Recognition Award are required.

Specialties such as Oral Surgery and Podiatry, as well as Adjunct Staff members, such as Nurse Midwife, must fulfill their State/Specialty continuing medical education requirements for re-credentialing.

Section 6. Resignation

A member of the Medical Staff may resign his or her Medical Staff membership effective no less than thirty (30) days after the provision of written notice of such resignation to the Chair of such resigning member's department, the President and to the Chief Medical Officer. Such resignation of Medical Staff membership shall be deemed a resignation of all Clinical Privileges, Committee assignments and Officer Position without right of appeal. A resigning member of the Medical Staff shall be required to fulfill his or her Medical Staff responsibilities prior to the effective date of resignation and to complete all medical records. Any desired resumption of membership after the effective date of the resignation shall be treated as a new application.

Section 7. Summary Precautionary Suspension

The Medical Staff defined process for the Summary Suspension of membership and privileges are defined within Article IX, Section 3 of the General Rules and Regulations of the Medical Staff. (added March 2011)

Section 8. Automatic Suspension

The Medical Staff defined process for Automatic Suspension of membership or privileges is defined within Article IX, Section 4 of the General Rules and Regulations of the Medical Staff. (added March 2011)

Section 9. Fair Hearing and Appeal Process

The Medical Staff defined process for the Fair Hearing and Appeal Process is defined within Article X of the General Rules and Regulations of the Medical Staff. The article also addresses the composition of the Fair Hearing Committee. (added March 2011)

ARTICLE IV

CATEGORIES OF THE MEDICAL STAFF

The Medical Staff shall be divided into Active, Emeritus, Consulting, Regional, Adjunct, and Affiliate categories.

Section 1. Interim Medical Staff Status

(a) All initial appointments to any category of the Medical Staff shall be Interim for at least a two and one-half (2½) year period effective January 1, 1999.

(b) Members with interim status shall perform the functions and duties as delegated by the Chairperson of their assigned department. Their performance shall be observed by the Chairperson of the department, or designee, to determine the eligibility of the Interim member for regular staff membership as Assistant Attending staff and for extending privileges probationally granted to such members.

(c) If the Interim appointment is unsatisfactory, the appointee may be required to repeat the interim status for the original term under new supervision or be dropped from the Medical Staff, subject to the rights accorded by the Bylaws to a member of the Medical Staff who has failed to be approved. Such repetition may occur for only one (1) year following the initial interim term.

(d) Interim periods may be extended at the recommendation of the department, Credentials Committee, Executive Committee, and Board of Trustees. An extension of the Interim period may be made for any of the following reasons:

(i) Failure to do an adequate number of procedures upon which a recommendation for advancement can be made;

(ii) Failure of the practitioner to affirmatively demonstrate ability to effectively work with other members of the Medical Staff and hospital employees in the delivery of health;

(iii) The occurrence of disciplinary action against the practitioner during the Interim period under these Bylaws; and

(iv) Active investigation of the practitioner based upon the failure to have provided information either in the initial application or based upon the practitioner's conduct as an Interim member.

The failure to advance from Interim to Active Staff status or to extend the Interim period shall be deemed a termination of a staff appointment. An

Interim appointee whose membership is so terminated shall have the rights accorded by these Bylaws to a member of the Medical Staff who has failed to be reappointed.

Section 2. The Active Medical Staff

(a) The Active Medical Staff shall consist of those persons licensed to practice medicine, osteopathic medicine, podiatric medicine or dentistry who regularly admit patients to the hospital, and who assume all the functions and responsibilities of membership on the Active Medical Staff. Members of the Active Medical Staff shall be appointed to a specific department, shall be eligible to vote, to hold office and to serve on Medical Staff committees. Active staff shall pay annual dues and assessments, except those members who are employed on a limited or part-time basis and accept committee appointments, shall appear before the committees of the Medical Staff and the Joint Conference Committee when requested by the committees, attend committee hearings, departmental meetings and Medical Staff meetings.

(b) Active members shall be further designated as Attending, Associate Attending, or Assistant Attending. The privileges, functions and obligations of each designated category of Active members shall be defined by the individual departments of the Medical Staff, according to their department rules and regulations as approved by the Executive Committee and governing body and subject to the following guidelines:

A. Attending Staff

(1) To the Attending rank insofar as is possible, promotion shall be made from members of the Associate Attending Medical Staff. Before promotion to Attending, the staff member should be in the rank of Associate Attending for a minimum of two (2) years. Promotion of advancement is not necessarily based on seniority and will follow the Department table of organization.

(2) In order to be eligible for advancement to Attending status, the staff member must be initially board certified or board qualified (in the tracking process) pursuant to the standards of the applicable certifying board.

(3) The duties of the Attending Medical Staff members shall be to attend all patients admitted to their service. Members of the Attending Medical Staff shall be in charge of a service or section in one of the departments of the hospital. No practitioner shall hold the rank of an Attending concurrently in more than one (1) department. A Chairperson of a department or section may or may not be in charge of a service at his or her discretion.

(4) Insofar as private patients are concerned, members of the Attending staff shall have unrestricted privilege wherein they are appointed or as will be determined by the Credentials Committee in conformity with these Bylaws and the Rules and Regulations of the department assigned.

B. Associate Attending Staff

(1) Members of the Active Medical Staff holding the rank of Associate Attending shall be practitioners whose qualifications are essentially the same as those of Attending rank with the exception that they shall not be in charge of a service or a section. Their duties and privileges shall be the same otherwise as an Attending.

(2) Insofar as possible, promotion to the Associate Attending staff shall be made only after being in the rank of Assistant Attending for at least three (3) years and must follow the Department table of organization.

C. Assistant Attending Medical Staff

(1) The Assistant Attending Medical Staff shall consist of more recent appointees and/or less experienced practitioners who have not been heretofore active in the work of the hospital but has expressed a wish to become active in a specific department or section.

(2) Duties of the members of the Assistant Attending Staff shall be to attend service patients in accordance with assignments by the Chairpersons of the respective departments to whom they are assigned. Insofar as service cases are concerned, members of the Assistant Attending Medical Staff shall treat patients in both the in-patient and outpatient departments as assigned by the department head or designee.

(3) Insofar as private patients are concerned, members of the Assistant Attending rank shall have privileges in the treatment of patients with their training and experience as may be determined by the Credentials Committee in conformity with these Bylaws and Rules and Regulations of the department assigned.

(4) In so far as possible, promotion to the Assistant Attending staff shall be after a period of at least two and one-half (2½) years as a member of the Interim staff not necessarily on the basis of rank or seniority according to the Department table of organization.

Section 3. The Emeritus Medical Staff

(a) Emeritus members assigned such status after January 1, 2002 shall be those practitioners who have served Community Medical Center for at least twenty-five (25) years, including any military service, who have retired from active practice and who have applied for emeritus status. Emeritus members assigned such status prior to December 31, 2001, need not have retired from active practice and may have clinical privileges, if requested and qualified.

(b) Emeritus members shall not have a vote. They shall not hold office nor serve on any committee of the Medical Staff except upon special appointment by the President.

(c) To be eligible for emeritus status, a Practitioner must have the approval of his/her department, the Executive Committee and the governing body. The change to Emeritus status shall occur at the time the Practitioner is eligible for emeritus status and not as otherwise provided in Article V, "Reappointment Process."

(d) A Practitioner who has completed 25 years of service at the Hospital, who has not requested Emeritus status and who continues to practice medicine may, if she/he so desires, be relieved from the responsibility of taking service call following a request to their respective Department Chair, per the Rules of the Department to which such Practitioner has been assigned and being granted such approval from the Executive Committee after consideration of the requirements of EMTALA and the needs of the Hospital.

Section 4. Consulting Medical Staff

Consulting members shall be those practitioners who have attained such prominence in their field of specialty as to enable them to render advisory assistance to the Medical Staff. They shall be recommended for appointment by the Chief Medical Officer, Department Chair and President of the Medical Staff and shall be able to perform procedures as provided in their privileges upon approval of the Credentials Committee, Executive Committee and governing body.

Section 5. The Affiliate Medical Staff

Affiliate Staff shall consist of Physicians who meet the basic qualifications for membership contained in Article III, Section 2 of these Bylaws and those other requirements of Affiliate Staff status, if any, contained in the Rules and Regulations of such departments where the Physicians will request appointment. Those Physicians assigned to the Courtesy Staff prior to December 31, 2001 and who maintain membership on the Courtesy Staff shall automatically be converted to membership in the Affiliate Staff. Notwithstanding the foregoing, each department, if set forth in such department's Rules and Regulations, may decline to permit the appointment of Affiliate Staff in such department.

Affiliate shall have privileges limited to review of the patient's chart or computerized medical records. They may not make entries into the patient's chart or computerized medical record. Affiliate Staff members shall be appointed to a specific department but shall not be eligible to vote or hold office in the Medical Staff

organization. Additional duties of Affiliate Staff members shall be assigned by the specific department.

Section 6. Regional Medical Staff

The category of Regional Medical Staff shall include those physicians who do not practice in the immediate vicinity of the Medical Center but who wish to be able to use a service of Community Medical Center, or for those physicians who practice in the area but do not wish to regularly care for patients in the hospital. They may defer their care to other members of the Medical Staff. In addition, there shall be a limited number of admissions not to exceed 20 per year.

Section 7. Chief Medical Officer

The Chief Medical Officer, CMO, shall be appointed as a member of the Medical Staff without vote. The Chief Medical Officer shall be subject to the same procedures as all other applicants for Clinical Privileges, if Clinical Privileges are requested. The terms of the Chief Medical Officer employment agreement shall govern all other aspects of the relationship between the Chief Medical Officer and the Hospital. The CMO appointment to the Medical Staff shall be coterminous with his employment and shall terminate, without right of appeal, upon termination of his employment as Chief Medical Officer.

Section 8. Adjunct Medical Staff

Members of the Adjunct Medical Staff shall be assigned, pursuant to their specialty, to departments of the Medical Staff. Adjunct Medical Staff members include dentists, (see Section 9 A below), Advanced Practice Nurses/Anesthesia, Physician Assistants, and Certified Nurse Midwives.

Members of the Adjunct Medical Staff shall have the same obligations, including the requirements for meeting attendance, as regular members of the Medical Staff.

Members of the Adjunct Medical Staff shall not have the privilege of admitting patients to the Hospital. They shall provide services to patients of the Hospital as requested by the treating medical or osteopathic physician within the scope of privileges/duties of their assigned departments. The treating medical or osteopathic physician shall be responsible for collaborating with or supervising the conduct and delivery of services by the Adjunct Member.

Members of the Adjunct Medical Staff shall arrange directly with the patient for compensation for their services.

A. Dentists

(1) The Dentistry Adjunct Medical Staff shall consist of individuals who currently have a valid license under the laws of the state of New Jersey to practice dentistry.

(2) Licensed Dentists shall apply, pursuant to the regular application sections of these Bylaws, for Adjunct Staff membership and the delineation of Clinical Privileges including histories and physicals.

(3) Based upon the needs of the institution as well as the training and experience of the individual applicant, privileges shall be delineated pursuant to these Bylaws.

(4) Dentists will have a vote within their own Section of Dentistry, have no vote within the Department of General Surgery, but will be voting members of the Medical Staff.

(5) Oral surgeons shall have admitting privileges. Dentists shall have co-admitting privileges as stated in the Rules and Regulations of the Department of General Surgery.

(6) A Section of Dentistry will be maintained under the direction of the Department of General Surgery.

(7) The Section of Dentistry will have its own Rules and Regulations and be obligated to follow the General Rules and Regulations and Bylaws of the Medical Staff.

(8) Dentists will be responsible for supervision of Interim Dentistry Adjunct Staff newly admitted dentists.

(9) The Chairperson of the Department of General Surgery and the chairperson of the Section of Dentistry will approve the delineation of privileges forms of the dentists.

(10) Privileges will be delineated by the Chairperson of the Department of General Surgery and the Chairperson of the Section of Dentistry and fall within state guidelines.

Section 9. The Specified Staff

Appointments to the Specified Staff shall be made to those Members who meet the requirements contained in these Medical Staff Bylaws and Rules and Regulations who

are assigned to the Department of Medicine: Section of Hospitalists and the Department of Medicine: Section of Pulmonary/Critical Care, Subsection of Intensivists.

A. Department of Medicine Section of Hospitalists

Hospitalists shall be Board qualified or Board certified in Internal Medicine in the time frame and manner described in Article III, Section 2(k) of the Medical Staff Bylaws and need not maintain an outpatient office but must maintain a business office.

Section members may not refuse the treatment of admitted patients for Physicians they cover, and may not provide follow-up care for patients after discharge. Section members shall refer all follow-up care to the patient's medical attending or to a medical attending in good standing on the Hospital Medical Staff. Hospitalist consults shall be distributed pursuant to a list of specialists as per patients' preference, covering physician's preference or referring physician. In default, the specialist on call shall be assigned to the patient.

The Chair of the Department of Medicine or his/her designee shall evaluate all Hospitalists no less than quarterly, shall review and provide Crimson and other related data including follow-ups arranged and flow of consults.

Hospitalists may serve on Committees if appointed. Hospitalists shall be required to pay dues. Hospitalists will have a vote in the Section of Hospitalists

B. Department of Medicine, Section of Pulmonary/Critical Care, Subsection of Intensivists

Membership in the Section subject to waiver for those members of the Medical Staff prior to January 1, 2012 who are currently granted and exercising critical care clinical privileges, Intensivists shall be Board qualified or Board certified in Critical Care in the time frame and manner described in Article III, Section 2(k) of the Medical Staff Bylaws and need not maintain an outpatient office but must maintain a business office.

Section members may not refuse the treatment of admitted patients to Intensive Care for Physician's they cover, and may not provide follow-up care for patients after discharge. Section members shall refer all follow-up care to the patient's medical attending or to a medical attending in good standing on the Hospital Medical Staff. ICU Intensivists consults shall be distributed pursuant to a list of specialists as per patients, covering physician preference or referring physician who they are in direct contact with. In default, the specialist on call shall be assigned to the patient.

The Chair of the Section of Pulmonary/Critical Care or his/her designee shall evaluate all Intensivists no less than quarterly, shall review and provide Crimson and other related data including follow-ups arranged and flow of consults as per above regulation.

Intensivists may serve on Committees if appointed. Intensivists shall be required to pay dues. Intensivists will have a vote in the Subsection of Intensivists under the Section of Pulmonary/Critical Care.

a. The Primary Care Physician (PCP) will service as the Attending Physician (physician of record) for his or her patients admitted to the Intensive Care Unit (ICU) subject to the authority of the RWJBH Intensivist;
b. The RWJBH providers will work in collaboration with the PCP;
c. When specialty consultation is required, the Intensivist will confer with the PCP regarding the available options for specific consultants in that specialty (or specialties);
d. If a patient is routinely followed by a specialist, then that specialist will be promptly notified of the patient's admission to the ICU and consulted as appropriate regarding care for the patient;
e. The RWJBH Intensivists will be the "Captains of the ship" and will have the ultimate authority and responsibility for the care of each patient while that patient is in the ICU, subject to the conditions set forth in subparagraphs (a) through (d) hereof;
f. In instances where the PCP's or specialty physicians believe certain orders are needed, the Intensivist will collaborate with and discuss such orders with the PCP's or specialists who may, upon receiving the approval of the Intensivist, enter patient orders;
g. It is understood that, should any of these provisions prove unworkable, CMC and/or its Board of Trustees will confer and collaborate with the leadership of the Medical Staff before implementing any changes in the ICU; and
h. The parties further understand that the terms of the contract between CMC and RWJBH Intensivists, which shall not conflict with this Order, are applicable to the RWJBH Intensivists (added Court Order 16, 2018)

Section 10. Telemedicine

Telemedicine physicians shall be contracted with the hospital to provide diagnosis and treatment to patients in the hospital remotely soley through telecommunications links. Physicians must apply for and be granted specialty and procedure-specific telemedicine privileges. The credentialing process shall involve sufficient inquiry to assure the physicians identity, education and training, but the physician is not required to attend the Credentials Committee Meeting. Physicians will not be granted active membership to the medical staff, therefore they may not vote, hold office, or serve as department or committee chairperson. Physicians may be required, by contract, to assume responsibilities and functions such as emergency care and consultation and will abide by the response time bylaw of 20 minutes. They are bound by all quality measures and are to participate in peer review activities.

ARTICLE V

PRIVILEGES

Section 1. Privileges Restricted

(a) Every practitioner practicing at Community Medical Center by virtue of Medical Staff membership or otherwise, shall, in connection with such practice, be entitled to exercise only those privileges specifically granted by the governing body, except as provided in Sections 2, 3 and 4 of this Article V.

(b) Every initial application for staff appointment must contain a request for the specific privileges desired by the applicant. The Executive Committee, in consultation with the Chief Medical Officer, shall determine whether sufficient space, equipment, staffing and financial resources are in place or available within a specified time frame to support each requesting privilege. The resources needed for privileges shall be determined on a consistent basis.

(c) Periodic re-determination of privileges and the increase or curtailment of same shall be based upon the direct observation of care provided, review of the records of patients treated at this or other hospitals and review of the records of the practitioner, which document the evaluation of the practitioner's participation in the delivery of the medical care.

(d) The scope and extent of surgical procedures that each dentist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by dentists shall be under the overall supervision of the Chairperson of the Department of Surgery, or designee. All dental patients shall receive the same basic medical appraisal as patients admitted to other surgical services. An active practitioner member of the Medical Staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization.

(e) Locum Tenens shall not be recognized at this hospital.

Section 2. Temporary Privileges

(a) Upon receipt of an application for Medical Staff membership from an appropriately licensed practitioner, the Hospital CEO in conjunction with the Credentials Committee may, upon the basis of information then available which may reasonably be relied upon as to the competence and ethical standing of the Applicant, and with the written concurrence of the departmental Chairperson concerned and the President or Chairperson of the Executive Committee, for the good of the Hospital to fulfill an important patient care, treatment and service need, grant temporary clinical privileges to the applicant. In exercising such privileges, the applicant shall act under the

supervision of the Chairperson of the department, or designee, to which he/she is assigned.

In the event the practitioner is to practice with another practitioner or group of practitioners presently on the Medical Staff of the Community Medical Center then, and in such event, such practitioner or group of practitioners shall supervise the applicant and countersign all applicant's charts until appointed but ultimate responsibility remains with the Chairperson of the department, or designee. Such temporary privileges shall be restricted to a period of not more than ninety (90) days to the practitioner, after which such practitioner shall be required to secure membership on the Medical Staff before being allowed to attend additional patients.

(b) Temporary privileges may be granted by the Hospital CEO, on the recommendation of the President of the Medical Staff, or designee, for the care of a specific patient to a practitioner who is not an applicant for membership in the same manner and upon the same conditions as set forth in subparagraph (a) of this Section 2. There shall first be obtained such practitioner's signed acknowledgement that he/she has received and read and will abide by the Bylaws and General Rules and Regulations of the Medical Staff and the Rules and Regulations of the appropriate department and that he/she agrees to be bound by the terms thereof in all matters relating to his/her temporary privileges. In the event of emergency, the practitioner's acceptance of temporary privileges will be taken to mean his/her agreement to abide by the Medical Staff Bylaws, Departmental Rules & Regulations, and the terms of temporary privileges. Patient specific temporary privileges will be granted only to fulfill an important patient care, treatment or service need, and shall not exceed sixty (60) days in any one year.
(Added 4/2008)

(c) Special requirements of supervision and reporting may be imposed by the department Chairperson, or designee, concerned on any practitioner granted temporary privileges and the Hospital shall be informed of said requirements; provided, however, that such requirements shall not exceed similar requirements granted to Practitioners with full privileges in the Department. Temporary privileges shall be immediately terminated by the President of the Medical Staff, or designee, or the Hospital CEO upon recommendation of the President's notice of any failure by the practitioner to comply with such special conditions or failure to comply with terms in this Section 2.

(d) The President of the Medical Staff may at any time, upon the recommendation of the Chairperson of either the Executive Committee or of the department concerned, or his/her designee, terminate a practitioner's temporary privileges effective as of the discharge from the Hospital of the practitioner's patient(s) then under his/her care in the hospital and the administration shall so be informed. However, where it is determined that the life or health of such patient(s) would be endangered by continued treatment by the practitioner, the termination may be imposed by a person entitled to impose a precautionary suspension pursuant these Bylaws or the Rules and Regulations of the Medical Staff, and the same shall be immediately effective. The appropriate department Chairperson, or President of the Medical Staff, or designee in

his/her absence, the Chairperson of the Executive Committee, or designee, shall assign a member of the Medical Staff to assure responsibility for the care of such terminated practitioner's patient(s) whose wishes shall be considered where feasible in selection of such substitute practitioner having appropriate privileges.

(e) Practitioners temporarily approved shall not be considered members of the Medical Staff and therefore shall not be entitled to the same privileges as those accorded to the Medical Staff who are terminated or not re-appointed under these Bylaws.

(f) Temporary privileges may only be granted pursuant to (a) or (b), above, upon verification of the following:

(i) current licensure;
(ii) relevant training or experience;
(iii) current competence;
(iv) ability to perform the privileges requested;
(v) a query and evaluation of the NPDB information;
(vi) a complete application;
(vii) no current or previously successful challenge to licensure or registration;
(viii) no subjection to involuntary termination of medical staff membership at another organization; and
(ix) no subjection to involuntary limitation, reduction, denial or loss of clinical privileges.

Section 3. Emergency Privileges

In the case of emergency, any physician or dentist member of the Medical Staff, to the degree permitted by his/her license and regardless of service or staff status or lack of it, shall be permitted and assisted to do everything possible to save the life of a patient, using every facility of the hospital necessary, including the calling for any consultation necessary or desirable. When an emergency situation no longer exists, such physician or dentist must request from appropriate department Chairperson or designee the privileges necessary to continue to treat the patient. In the event such privileges are not granted, the patient shall be assigned to an appropriate member of the Medical Staff having such appropriate privileges. For the purpose of this section, an "emergency" is defined as a condition in which serious permanent harm would result to a patient or in which the life of a patient is in immediate danger in any delay in administering treatment wherein delay would add to that danger.

Section 4. Disaster Privileges

Disaster privileges may be granted to eligible volunteer practitioners when the following two conditions are present:

- Community Medical Center has activated the Emergency Management/Disaster Plan, and
- Community Medical Center is unable to meet immediate patient needs.

The Hospital CEO of Community Medical Center is responsible to determine the need for, and to activate the process for granting, disaster privileges.

The Hospital CEO or the Chief Medical Officer, in consultation with the President of the Medical Staff or the relevant Department Chairperson, is responsible for granting disaster privileges to individual volunteers, based on Community Medical Center's needs, patient needs, and the qualifications of the volunteer. The Hospital CEO and Chief Medical Officer are not required to grant privileges to any volunteer and will handle each case on a case-by-case basis at their discretion. Disaster privileges may be granted to physicians and to other classes of independent practitioners eligible to apply for privileges under these Bylaws.

Volunteers desiring to obtain disaster privileges shall provide, at a minimum, the following documentation:

(a) A valid government issued photo identification issued by a state or federal agency such as a driver's license or passport, and

(b) At least one of the following:

(i) A current picture hospital identification card from another hospital that clearly identifies the volunteer's professional designation,

(ii) A current license to practice the volunteer's profession,

(iii) Primary source verification of the volunteer's license,

(iv) Identification indicating that the volunteer is a member of a Disaster Medical Assistance Team (DMAT), or a Medical Reserve Corps (MRC) unit, the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or another recognized state or federal organization or group which credentials health care practitioners for emergencies,

(v) Identification indicating that the volunteer has been granted authority to render patient care in emergency circumstances by a state, federal or municipal authority, or

(vi) Identification by a current member of the [Hospital] staff or of the Medical Staff who has personal knowledge of the volunteer's identity and can confirm the volunteer's ability to act as a licensed independent practitioner during a disaster. Copies shall be made of all documentation provided if possible, and if not possible due to the nature of the emergency situation, all identifying information will be hand copied from the identifying documents.

The Primary source verification of licensure process shall begin as soon as the immediate situation is under control, and, except in extraordinary circumstances, shall be completed within 72 hours from the time the volunteer presents to Community Medical Center. In the extraordinary circumstances that primary source verification cannot be completed in 72 hours (such as an instance in which no means of communication exists or there is a lack of government resources to provide the verification), it should be done as soon as possible. In such an extraordinary circumstance, there must be documentation of the following:

(a) Why primary source verification could not be performed in the required time frame,

(b) Evidence of the volunteer's demonstrated ability to continue to provide adequate care, treatment and services, and

(c) An attempt to rectify the situation as soon as possible.

Primary source verification of licensure is not required if a volunteer has not provided care, treatment and services under his or her disaster privileges.

Volunteers with disaster privileges shall be under the overall direction of the Hospital CEO of Community Medical Center. Each volunteer having disaster privileges shall be assigned to a current member of the Medical Staff who will act as a mentor and be responsible for providing oversight and monitoring of the activities of the volunteer and for providing the volunteer such information and assistance as the volunteer may require. Additional oversight of volunteers with disaster privileges will be completed through clinical record review and/or direct observation of the volunteer. A record shall be kept for each volunteer having disaster privileges which includes the privileges granted, the mentor assigned to monitor the volunteer, and any relevant documentation related to the oversight of the volunteer's professional performance.

Each volunteer granted disaster privileges shall be issued and shall wear a clearly visible badge containing photo ID, his or her name, license status (i.e., physician or other), volunteer status, and the name of the mentor assigned to the volunteer.

Initial disaster privileges shall be granted for a period of time not to exceed seventy-two (72) hours. A continuation of disaster privileges may be granted within this 72 hour period by the Hospital CEO or the Chief Medical Officer. A decision to continue disaster privileges shall be based on a recommendation by the relevant department chairperson and/or the President of the Medical Staff to continue, modify, limit or terminate the disaster privileges. A continuation of disaster privileges may only be granted after primary source verification of the volunteer's license (unless extraordinary circumstances exist and verification is not possible as set forth above), and a review of the professional practice of the volunteer by the volunteer's mentor.

Notwithstanding any other provision, the Hospital CEO or Chief Medical Officer may terminate all or part of the disaster privileges granted to a volunteer at any time without cause or reason. Termination of disaster privileges shall not entitle the volunteer to a fair hearing or other review.

If the disaster situation ceases to exist, all disaster privileges shall immediately terminate. If desired, a volunteer holding disaster privileges must follow the procedures outlined elsewhere in these Bylaws to request temporary privileges necessary to continue

to treat specific patients. In the event such privileges are denied or are not requested, patients shall be assigned by the relevant department chairperson to another current member of the Medical Staff.

All references in this section to particular offices, such as the Hospital CEO, Chief Medical Officer, President of the Medical Staff, and Department Chairpersons, shall mean the individual in the office indicated or his or her designee or other individual authorized to act in his or her stead pursuant to the Emergency Management/Disaster Plan. (added March 2011)

Section 5. Telemedicine Privileges

(a) Delineation of Clinical Services: The Executive Committee, in conjunction with the medical staff of the distant site (i.e., the site where the Practitioner providing the telemedicine service is located), will recommend the clinical services to be provided by telemedicine. The clinical services to be provided by telemedicine shall be consistent with commonly accepted quality standards.

(b) Privileging Process:

(1) Practitioners requesting privileges to provide telemedicine services for the treatment and diagnosis of patients will be subject to the credentialing and privileging processes set forth in these Bylaws, and will be assigned to a specific department/section.

(2) The verification process may utilize credentialing information from the distant site if the distant site is a Joint Commission-accredited institution so long as the Physician is privileged at the distant site for those Clinical Services to be provided at the Hospital and the distant site provides the Hospital with a current list of the Physician's privileges. Alternatively, the Hospital may use the credentialing and privileging decision of the distant site to make a final privileging decision with respect to a Practitioner if (i) the distant site is a Joint Commission-accredited institution; (ii) the Practitioner is privileged at the distant site for those services to be provided at the Hospital; and (iii) the Hospital has evidence of an internal review of the Practitioner's performance of the requested privileges and sends to the distant site information that is useful to assess the Practitioner's quality of care, treatment and services for use in privileging and performance improvement. At a minimum, this information shall include adverse outcomes related to sentinel events considered reviewable by the Joint Commission that result from the telemedicine services provided, and complaints about the distant site Practitioner from patients, members of the Medical Staff and/or Hospital staff. By applying for telemedicine privileges, a Practitioner will be deemed to have consented to the release of all relevant information to the distant site.

(3) Telemedicine privileges shall only be granted to those specialized Practitioners who are under contract to provide telemedicine services to the Hospital to fulfill a demonstrated need as requested by the Department or Executive Committee. All practitioners having telemedicine privileges must have a current, valid New Jersey license.

Section 6. Ongoing Professional Practice Evaluation

The Medical Staff will engage in ongoing professional practice evaluation in order to identify professional practice trends that impact on quality of care and patient safety. The ongoing professional practice evaluation shall not be considered corrective action as described in these Bylaws and The Bylaws and the Rules and Regulations and does not entitle the member to a hearing and/or appellate review.

Section 7. Focused Professional Practice Evaluation Standards

The Medical Staff will engage in focused professional practice evaluation in order to evaluate the privilege-specific competence of the practitioner who does not have documented evidence of competently performing the requested privilege at the organization. This process is defined in the Department policy or Rules and Regulations. The Executive Committee may also prescribe a time-limited period of FPPE to monitor a member's performance when issues affecting the provision of safe, high quality patient care are identified or upon a member's return from a leave of absence depending upon the circumstances. The FPPE shall not be considered corrective action as described in these Bylaws and Rules and Regulations and does not entitle the member to a hearing and/or appellate review. FPPE and the measures employed to resolve performance issues identified during FPPE shall be consistently implemented for all members of the Medical Staff in accordance with the requirements and criteria set forth in Department Policy or the Rules and Regulations

ARTICLE VI

OFFICERS

Section 1. Officers of the Medical Staff

The officers of the Medical Staff shall be:

(a) President (elected)

(b) Vice President (elected)

(c) Secretary (elected)

(d) Treasurer (elected)

(e) Immediate Past President

(f) Medical Staff members elected to the Joint Conference Committee for a three (3) year term

Section 2. Qualifications of Officers

Officers of the Medical Staff must be Active members in good standing and remain so during tenure of office and shall be board certified in their respective specialty.

There is a seven and one-half (7½) year restriction before any member of the Medical Staff is able to run for office of the staff. All Officers shall have sufficient time on the Medical Staff and shall have served as a member with regular attendance, for no less than five (5) years prior to seeking office, of a Medical Staff.

Any physician having contractual obligations in any hospital of the RWJ Barnabas Health System, including employment and directorships (except contract for Service Call), and contracted physicians departments such as Radiology, Radiation Oncology, Anesthesia, Emergency and Pathology, with Administration must be excluded from running for any of the following Medical Staff Leadership positions: President, Vice President, Secretary, Treasurer, Board of Trustee, Joint Conference. In addition they are excluded from running for Department Chairs and Vice Chairs unless a waiver is approved by the Medical Executive Committee.

Section 3. Election of Officers

(a) All officers shall be elected every two (2) years; voting members shall cast a vote via the use of technology 30 days before the Annual Meeting of the Medical Staff. Only members of the Active Medical Staff shall be eligible to vote.

(b) All members of the Active Staff eligible to vote may be nominated by petition of five (5%) percent or more of the members of the Active Staff eligible to vote. No member of the Active Staff may sign more than one (1) petition for each office (i.e., can only sign one petition for President, one petition for Vice-President, etc.) as well as more than one (1) petition up to the maximum of vacant positions if there are multiple open positions (i.e., Board or Joint Conference). If there are three (3) or more candidates for office and no candidate receives a majority; the candidate receiving the least number of votes shall be dropped from each successive slate until a majority vote is obtained by a successful candidate for each office.

(c) The Nominating Committee shall be convened only if, within forty-five (45) days of the election, no candidates are nominated by petition. If convened, the Nominating Committee shall consist of members of the Active Medical Staff appointed by the President of the Medical Staff. This Committee shall offer one or more nominees for each office.

(d) The nomination of candidates for officers shall be made by the Nominating Committee which shall be constituted by appointment by the President of the Medical Staff, or designee, at the September meeting of the Medical Staff prior to election year and shall consist of one member from each clinical department and two (2)

members-at-large. The Chairperson of the Nominating Committee is to be appointed by the President of the Medical Staff, or designee, in the President's absence.

(e) All nominations, including those by petition, shall be made at least thirty (30) days prior to the Annual Meeting and shall be filed with the Secretary of the Medical Staff who shall promptly notify the Medical Staff of such nominations. No nominations may be made from the floor at the time of the Annual Meeting. A petition must contain approval of the nominee for office and at least fifteen (15) signatures from the Active Medical Staff.

In the event the Nominating Committee or the Secretary of the Medical Staff fails to comply with the time limits set forth herein, the Annual Meeting shall be continued or a special meeting of the Medical Staff called by the President of the Medical Staff to permit compliance with the above time limits. Attendance at any such meeting by a member of the Medical Staff shall constitute a waiver of any defects prescribed by the Bylaws.

(f) The appointees of the Medical Staff to the governing body and the Joint Conference Committee shall be determined by the majority vote of the Medical Staff at its Annual Meeting as herein provided or any adjournment or continuance thereof. The Medical Staff appointees to the governing body by virtue of the nomination by the Medical Staff shall be declared elected to the governing body in accordance with the Bylaws of the governing body and the Community Medical Center Association.

Section 4. Term of Office

All officers shall serve a two (2) year term from their elected office date or until a successor is elected. Officers shall take office on the first day of the Medical Staff year (January 1st). Members of staff elected to the Board of Trustees will serve for three (3) year term.

Section 5. Vacancies in Office

Vacancies in office during the Medical Staff year, except for the President of the Medical Staff, shall be filled from the Executive Committee of the Medical Staff. If there is a vacancy in the office of the President, the Vice President shall serve out the remaining term and Immediate Past President shall serve in capacity as Vice President.

Section 6. Duties of Officers

(a) President: The President of the Medical Staff shall as the Chief Administrative Officer of the Medical Staff:

(i) Act in coordination and cooperation with the Hospital CEO, or designee, in all matters of mutual concern within the hospital;

(ii) Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;

(iii) Chair and serve on the Medical Staff Executive Committee at its meetings;

(iv) Serve as ex-officio member of all other standing Medical Staff committees without vote;

(v) Be responsible for the enforcement of Medical Staff Bylaws, Rules and Regulations, for implementation of sanctions where these are indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;

(vi) Appoint committee members to all standing, special, and multi-disciplinary Medical Staff committees except the Executive Committee;

(vii) Represent the views, policies, needs and grievances of the Medical Staff to the governing body and to the Hospital CEO of the hospital;

(viii) Receive, and interpret the policies of the governing body to the Medical Staff and report to the governing body on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care with the available resources of the hospital;

(ix) Be responsible for the educational activities of the Medical Staff;

(x) Be the spokesperson for the Medical Staff in its external, professional and public relations;

(xi) Have power to vote on all matters except in an ex-officio capacity;

(xii) Not be a department Chairperson during his/her term of office;

(xiii) Disqualify him or her in the decisions on any matter in which he/she is personally involved.

(xiv) Attend meetings of the Medical Staff

(xv) The President shall not seek a paid position from Hospital administration during the term of his/her presidency and for four (4) years thereafter so as to ensure there is no actual or perceived conflict of interest unless such President resigns from the Medical Staff prior to seeking such position.

(b) Vice President: In the absence of or disqualification of the President of the Medical Staff, the Vice President shall assume all the duties and have the authority of the President. He/she shall be a member of the Executive Committee of the Medical Staff and of the Joint Conference Committee. He/she shall attend meetings of the Medical Staff. He/she shall automatically succeed the President of the Medical Staff when the latter fails to serve for any reason. The Vice President shall be the Chairperson of the Credentials Committee of the Medical Staff

(c) Secretary: The Secretary shall attend meetings of the Medical Staff and shall keep and preserve minutes of the proceedings and actions taken at such meetings. The Secretary shall serve as Chairperson of the Medical Staff Quality Committee. The Secretary shall also perform the following duties: transmit all notices of meetings as required under these Bylaws; maintain a record of these Bylaws and the Rules and Regulations adopted by the Medical Staff and the various departments of the Medical Staff; and to have all powers and perform all duties commonly incident to and vested in the office of Secretary, and shall with the President, or designee, render all written opinions that represent the Medical Staff in external, professional, and public relations as delegated by the Executive Committee.

(d) Treasurer: The Treasurer shall be responsible for all financial records of the Medical Staff and to have all powers and perform all duties commonly incident to and vested in the office of treasurer. The Treasurer may be bonded in the discretion of the Executive Committee and, at the time of change of office, an independent accounting shall be rendered and reported to the Medical Staff. As a member of the Executive Committee, the Treasurer shall have the power to vote on all matters before the Executive Committee. The Treasurer will be the Chairperson of the Bylaws Committee.

(e) The Immediate Past President shall render advisory opinions to the Executive Committee of the Medical Staff with power to vote in its deliberations on all matters before it and will serve as the parliamentarian of the Executive Committee. The Immediate Past President will be the Chairperson of the Nominating Committee.

Section 7. Special Appointments

In the event of the absence or disability of an officer, the Executive Committee of the Medical Staff may assign the duties of that officer to any member of the Executive Committee. This appointment will be for a limited term as designated by the Executive Committee. The provision shall not apply to the absence or disability of the President or the Vice President.

Section 8. Removal of Officers

The removal of a Medical Staff officer from his/her position is to be determined by a three-fourth (3/4) majority vote of the Medical Staff filing for petition, and through the grievance process set forth herein or as shall be developed by the Executive Committee.

The conditions for removal of an officer include: resignation and/or suspension from the Medical Staff; chronic delinquency in attendance at meetings; incompetence in medical practice; and/or incompetence in performance of official responsibility.

Section 9. Service on the Board

Designated officers shall serve on the Board as delineated in the Bylaws of the Board.

Section 10. Program Directors

When a teaching program is implemented, there will be paid program directors who shall attend Medical Executive meetings ex officio (i.e., without voting rights) and will work cooperatively with the elected chairs. (added per Court Order 10/16/18)

ARTICLE VII

DEPARTMENTS

Section 1. Organization of Departments

Each department shall be organized as a separate part of the Medical Staff and shall have a Chairperson who shall be responsible for the overall supervision of the work within his/her department.

Section 2. Clinical Departments

The clinical departments of the Medical Staff shall be designated by the specialty of medical practice as follows:

(a) Department of Medicine;

(b) Department of Surgery;

(c) Department of Obstetrics and Gynecology;

(d) Department of Pediatrics;

(e) Department of Neurology;

(f) Department of Orthopedics;

(g) Department of Urology;

(h) Department of Ophthalmology,

(i) Department of Otolaryngology, Head and Neck Surgery

(j) Department of Family Medicine;

(k) Department of Podiatry

(l) Department of Cardiology

Section 3. Special Services Departments

The following Hospital based specialties shall be designated as follows:

(a) Department of Anesthesiology;

(b) Department of Radiology and Nuclear Medicine

(b) Department of Pathology and Laboratory;

(c) Emergency Department and Outpatient Medicine

Section 4. Subspecialties Services

Subspecialties shall be organized as a section of a department. Subsection leaders shall be appointed by the Chair of the Department. Subsection leaders shall determine the frequency and need of subsection meetings. Each section shall establish rules and regulations consistent with overall departmental, medical and hospital policy. Each section shall be directly responsible to the department within which it functions, with final approval by the Executive Committee.

Medical Directors shall be appointed as directed in the ***Policy and Procedures*** (attached).

Section 5. Qualifications, and Tenure of Department Chairpersons

(a) Each Chairperson and Vice Chair shall be a member of the Active staff qualified by training, experience, tenure and demonstrated ability for the position and accountable to the Medical Executive Committee, Medical Staff and Board of Trustees. Each Chairperson shall have served on Committees of the Medical Staff with regular attendance.

No practitioner shall be elected Chairperson or Vice-Chairperson of a Department unless certified in his/her specialty Board/s and this provision shall include Department heads appointed by Administration.

(b) Each Chairperson, Vice-Chairperson and Secretary shall be elected by a simple majority vote of the Active Staff of the department for a (2) two-year term,

subject to approval of the Executive Committee and the governing body. Should a difference of opinion occur in the election of a department Chairperson, the final decision shall be made by the Active Medical Staff of that Department.

(c) No practitioner shall be elected Chairperson or Vice Chairperson unless he/she has obtained the rank of Attending. The Chairpersons of the Department of Radiology and Nuclear Medicine, the Department of Pathology and Laboratory, and the Emergency Department and Outpatient Medicine, shall be Attending and shall be obligated to secure admission to the Medical Staff as a condition of employment. The Chairpersons of the Department of Radiology and Nuclear Medicine, the Department of Pathology and Laboratory, and the Emergency Department and Outpatient Medicine shall be appointed by the Governing Body with advice, consent and approval of the Executive Committee of the Medical Staff and the Credentials Committee.

(d) The officers of any clinical department shall serve no more than two (2) consecutive terms, each term for two (2) years. In special situations where there is no one eligible and available for the position of Chairperson of the Department, the Department, by a two-thirds (2/3) vote of its members may petition the Executive Committee to waive the two (2) year term ruling.

(e) Removal of a Chairperson during his/her term of office may be initiated by a three-fourths (3/4) majority vote of all Active staff members of the department, but no such removal shall be effective unless and until it has been ratified by the Executive Committee and the governing body. The Executive Committee may appoint an interim Chairperson until a new election by department takes place.

(f) All department elections shall be held at the annual meeting of the Department during election year.

(f) Each Department officer shall meet such other qualifications for the office as are contained in the Rules and Regulations of the department.

Section 6. Functions of Department Chairperson

(a) Each Chairperson shall:

(i) Be accountable to the Executive Committee, Medical Staff, and the Board of Trustees for all clinically-related activities of the Department and all professional and administrative activities within his/her Department unless otherwise provided by the Hospital and conform to such performance criteria as shall be developed and approved by the Executive Committee from time to time;

(ii) Be a member of the Executive Committee, giving guidance on the overall medical policies of the hospital and making specific recommendations and suggestions regarding the department in order to assure quality patient care with the resources available at the hospital;

(iii) Maintain continuing review and surveillance of the professional performance of all practitioners with privileges in his/her department and report regularly thereon to the Credentials Committee and Executive Committee;

(iv) Appoint a departmental Peer review / Quality Assurance committee to conduct the initial phase of patient care review required by these Bylaws, as well as consider, evaluate and recommend all appointments to his/her department;

(v) Be responsible for the enforcement of the hospital bylaws, of the Medical Staff Bylaws General Rules and Regulations and rules and regulations within the department;

(vi) Be responsible for implementation of actions taken by the Executive Committee of the Medical Staff within the Department.

(vii) Transmit to the Credentials Committee the Department's recommendation concerning the staff classification, the re-appointment, and the delineation of clinical privileges for all practitioners in the department;

(viii) Be responsible for the teaching, education and research programs in the Department including orientation and continuing education;

(ix) Participate in every phase of administration of his/her department through cooperation with the nursing service and the hospital administration in matters affecting patient care, including personnel, supplies, special regulations, standing orders and techniques within the available resources of the hospital;

(x) Assist in the preparation of such annual reports, including budgetary planning, pertaining to the department as may be required by the Executive Committee, the Hospital CEO or the governing body;

(xi) Assess and recommended to the relevant hospital authority off-site sources for needed patient care services not provided by the department or the Hospital;

(xii) Ensure the integration of the department into the primary functions of the hospital;

(xiii) Coordinate and integrate interdepartmental and intradepartmental services;

(xiv) Develop and implement policies and procedures that guide and support the provision of care, treatment and services;

(xv) Recommend sufficient number of qualified and competent persons to provide care treatment and service;

(xvi) Determine the qualifications and competence of department or service personnel who are not Licensed Independent Practitioners and who provide patient care services;

(xvii) Be responsible for the continuous assessment and improvement of the quality of care and services provided;

(xviii) The maintenance of quality control programs, as appropriate; and

(xix) Recommend space and other resources needed by the department.

(b) The Vice Chairperson of each Department, or designee, shall perform the functions and duties of the Chairperson of the department in the absence, disability or disqualification of the Chairperson, including attendance at the meetings of the Executive Committee and right to vote on all Executive Committee matters. He/she shall be responsible in the absence of the Chairperson of the department and shall function in this capacity. If the Chairperson of a department is disqualified, the Vice Chairperson of the department will assume the chair during the period of disqualification.

(c) The Secretary of each Department shall attend all meetings of the department and shall keep and preserve minutes of the proceedings and actions taken at such meetings of the department and of the department section and transmit same to the Executive Committee and the governing body through the Executive Committee.

Section 7. Functions of Departments

(a) Each department shall establish its own criteria, consistent with the policies of the Medical Staff and of the governing body for the granting of privileges and for the holding of office in the department, including a table of organization.

Each department shall meet a minimum of (4) four times per calendar year to discuss the regular business matters of its department.

(b) The Chairperson of each department or another Practitioner selected by the Chairperson who is qualified by training and experience to conduct a retrospective review in a particular subspecialty area shall conduct a primary retrospective review of completed records of discharged patients and other pertinent departmental sources of medical information relating to patient care for the purposes of selecting cases for presentation at the departmental meetings that will contribute to the continuing education of every practitioner and to the process of developing criteria to assure optimal patient care. Such reviews shall be conducted at a minimum of (4) four times a calendar year and should include a consideration of deaths, patients with

infections, complications, errors in diagnosis and treatment. Each department shall also participate in the peer review process adopted by the Medical Staff.

For cases involving a potential sentinel event or other high risk areas as may be identified in the Hospital's Performance Improvement Plan, reviews shall be conducted more frequently as needed.

Section 8. Assignment to Departments

The Executive Committee shall, after consideration of the recommendations of the departments as transmitted through the Credentials Committee, recommend initial departmental and section assignments for all Medical Staff members and for all other approved practitioners with privileges.

ARTICLE VIII

EXECUTIVE COMMITTEE

Section 1. Executive Committee

(a) Composition: The Executive Committee shall be a standing committee consisting of the Officers of the Medical Staff, the Chairpersons of each clinical department, and Medical Staff appointees to Joint Conference Committee and to the governing body. The Chairs of the Departments of Pathology and Laboratory, Radiology and Nuclear Medicine, Emergency Department and Medicine shall serve on the Executive Committee with vote. At all times a majority of voting Executive Committee members shall be fully licensed medical and osteopathic physicians and dentists actively practicing at the Hospital. No Medical Staff member actively practicing in the Hospital is ineligible for membership on the Executive Committee solely because of his or her professional discipline or specialty.

(b) The Hospital CEO, or designee, shall attend ex-officio without vote and shall render a report to the Executive Committee at all its meetings.

(c) Duties: The duties of the Executive Committee shall be:

(i) To represent and to act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws and to serve as the Ethics and Grievance Committee;

(ii) To coordinate the activities and general policies of the various departments;

(iii) To receive and act upon committee reports, clinical department reports and assigned activity groups reports and recommendations;

(iv) To implement policies of the Medical Staff and governing body not otherwise the responsibility of the Departments;

(v) To provide liaison between the Medical Staff and the Hospital CEO and the governing body and, in such capacity, to communicate with all levels of Hospital governance involved in policy decisions affecting patient care services at the Hospital;

(vi) To make recommendations to the Hospital CEO, or designee, on matters of medico-administrative nature;

(vii) To make recommendations to the Hospital CEO, or designee, on matters to the governing body through the Hospital CEO, or designee;

(viii) To fulfill the Medical Staff's accountability to the governing body for the medical care rendered to patients in the hospital within the available resources of the hospital and to participate in hospital deliberations affecting the discharge of Medical Staff responsibilities;

(ix) To insure that Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the hospital;

(x) To provide for the preparation of all meeting programs, either directly or through delegation to a program committee or other suitable agency;

(xi) To review the credentials of all applicants and to make recommendations for staff membership, assignments to departments and delineation of privileges directly to the governing body at least biannually;

(xii) To review periodically all information available regarding the performance and clinical competence of staff members and other practitioners with privileges and as a result of such reviews to make recommendations for re-appointments and renewal or changes in privileges;

(xiii) To take all reasonable steps to ensure professional ethical conduct and competent performance on the part of all members of the Medical Staff, including the initiation of and/or participation in Medical Staff corrective or review measures when warranted;

(xiv) To report and make recommendations at each general Medical Staff meeting;

(xv) If necessary to recommend the removal of a department Chairperson from the active list;

(xvi) To evaluate, recommend and approve all department and committee budgetary planning to the governing body;

(xvii) To act for the Medical Staff in intervals between Medical Staff meetings;

(xviii) To ensure Medical Staff participation in the Hospital's performance improvement, patient safety and patient satisfaction activities; and to oversee the Medical Staff's ongoing professional practice evaluation process. (added 4/2008) (amended March 2011)

(xix) To review and make recommendations as to Medical Staff structure; and

(xx) To oversee the evaluation of the professional performance of individual members of the Medical Staff; and to develop a policy applicable to focused professional practice evaluation. (added 4/2008)

(d) The Medical Staff has established the following standing Committees and their policies and procedures are set forth in the General Rules and Regulations.

(i) Credentials Committee
(ii) Joint Conference Committee
(iii) Medical Staff Quality Committee
(iv) Utilization Review Committee
(v) Pharmacy and Therapeutics Committee
(vi) Infection Control committee
(vii) Blood Utilization Committee
(viii) Medical Records Committee
(ix) Critical Care Committee
(x) Medical Education Committee
(xi) Radiation Safety Committee
(xii) OR Advisory Committee
(xiii) Patient Care and Incident Review Committee
(xiv) Bylaws Committee
(xv) Ethics Committee

(xvi) Bioethics Committee

(xvii) Cancer Committee

ARTICLE IX

MEDICAL STAFF MEETINGS

Section 1. Regular Meetings

The Annual Meeting of the Medical Staff shall be held following the last Quarterly Staff Meeting of the calendar year. The agenda of the Annual Meeting shall include reports of review and evaluation of the work done in the departments and the performance of the required Medical Staff functions or committees standing or otherwise. Three (3) other regular meetings of the Medical Staff shall be held during the calendar year. A Quarterly Staff or Annual Meeting may be rescheduled at the discretion of the President of the Medical Staff.

Section 2. Special Meetings

(a) The President of the Medical Staff or the Executive Committee may call a special meeting of the Medical Staff at any time. The President shall call a special meeting within fourteen (14) days after receipt by him or her of a written request for same signed by not less than ten (10%) percent of the Active staff and stating the purpose for such meeting. The Executive Committee shall designate the time and place of any special meeting.

(b) Written or printed notice stating the place, day and hour of any special meeting of the Medical Staff shall be delivered, either personally or by mail, to each member of the Active staff not less than three (3) nor more than seven (7) days before the date of such meeting, by or at the direction of the President of the Medical Staff. If mailed, the notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail addressed to each staff member at his/her address as it appears on the records of the hospital or placed in such Active member's mailbox at Community Medical Center. Notice may also be sent to such other members of the Medical Staff who have previously so requested that such notice be sent by the Secretary of the Medical Staff. The attendance of a member of the Medical Staff at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting except that in the notice calling the meeting.

Section 3. Quorum

The presence of fifty percent (50%) of the total membership of the Active, Interim and Adjunct Medical Staff at any regular or special meeting shall constitute a quorum for the purposes of amendment of these Bylaws, rules and regulations, and the presence of forty percent (40%) of such membership shall constitute a quorum for all other actions.

Section 4. Attendance Requirements

Each member of the Active, Interim and Adjunct Medical Staff shall be required to attend the regular Annual Meeting of the Medical Staff, and at least fifty percent (50%) of all other regular Medical Staff meetings in each year. A member who is compelled to be absent from any regular staff meeting shall promptly notify the President or Secretary of the Medical Staff beforehand the reason for such absence. Technology may be used to conduct meetings and satisfy meeting attendance. Members who fail to meet the minimum Attendance Requirements set forth herein during a period of reappointment, except if excused for cause, shall be required to pay a fine of One Thousand ($1,000) Dollars when submitting the member's reappointment application. In addition or in lieu of the fines set forth herein, the failure to meet the foregoing annual attendance requirements may be grounds for corrective action leading to revocation of medical membership. Reinstatement of staff members whose membership has been revoked because of absence from staff meetings shall be made only upon application and payment of any assessed fines and all such applications shall be processed in the same manner as applications for original appointment.

Section 5. Agenda

The Agenda at any regular Quarterly Medical Staff Meeting shall include a Hospital President/CEO report.

ARTICLE X

IMMUNITY FROM LIABILITY

The following shall be express conditions to any practitioner's application for, or exercise of, privileges at this hospital:

First, that any act, communication, report, recommendation, or disclosure, with respect to any such practitioner, performed or made in good faith and without malice and at the request of any authorized representative of this or any other health care facility, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extent permitted by law and is authorized and approved by the practitioner

Second, that such privilege shall extend to members of the Hospital Governing Body and any committee thereof, the Hospital CEO, the hospital's Medical Staff, its other practitioners, its president and representatives, and their designees and to third parties, who supply information to any of the foregoing authorized to receive, release, or act upon the same. For the purpose of this Article X, the term "third parties" means both individuals and/or organizations from which an authorized representative of the Governing Body or of the Medical Staff has requested information.

Third, that there shall be, to the fullest extent permitted by law, absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed privileged and, in accordance herewith, the practitioner agrees to waive all legal claims against any of the persons and entities set forth in this Article X who act in accordance with this Article X.

Fourth, that such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care institution's activities related, but not limited to: (1) applications for appointment or privileges; (2) periodic reappraisals for reappointment or privileges or upon a practitioner returning from an extended leave of absence from his/her department; (3) corrective action, including summary suspension; (4) hearings and appellate reviews; (5) medical care evaluations; (6) utilization reviews; and (7) other hospital, departmental, service or committee activities related to quality patient care, qualifications and inter-professional conduct.

Fifth, that the acts, communications, reports, recommendations and disclosures referred to in this Article X may relate to a practitioner's professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on patient care.

Sixth, that in furtherance of the foregoing, each practitioner shall upon request of the hospital execute releases in accordance with the tenor and import of this Article X in favor of the individuals and organizations specified in paragraph **Second**, subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of this State. However, the failure to request or obtain a release shall not be deemed a waiver of any provision of this article.

Seventh, that the consents, authorizations, releases, right, privileges and immunities provided by Section 1 and 2 of Appoints and Reappointments of the Rules and Regulations for the protection of this hospital's practitioners, other appropriate hospital officials and personnel and third parties, in connection with applications for initial appointment, shall also be fully applicable to the activities and procedures covered by this Article X.

ARTICLE XI

GENERAL RULES AND REGULATIONS

Section 1. The Medical Staff shall adopt such rules and regulations, including Supplemental Medical Staff Governance Documents, as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the governing body. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each practitioner in the hospital. Supplemental Medical Staff Governance Documents may also include administrative procedures related to Appointment and Reappointment, Corrective Action and Hearing and Review Procedures and Committee Structure.

Section 2. The Medical Executive Committee shall vote on the proposed amendments at a regular meeting or at a special meeting called for such purpose. Following an affirmative vote by the Medical Executive Committee, all voting members of the Medical Staff shall receive a description of the proposed amendment(s) by regular or electronic mail. At least thirty (30) days following this dissemination of the proposed amendment(s), all eligible voting members of the Medical Staff will be eligible to vote on the proposed amendment(s). This vote may be conducted via printed or electronic ballot in a manner determined by the Medical Executive Committee. Ballots marked in favor of amendment(s) or those that are not returned will be considered affirmative votes in support of the Medical Executive Committee recommendations for amendment(s). To be adopted, the proposed amendment(s) must be affirmed by a majority of the members of the voting members of the Medical staff and the governing body must subsequently ratify the amendment.

Section 3. Amendments to the Rules and Regulations may also be proposed directly to the governing body upon a petition of fifty (50) voting members of the Medical Staff. Any proposed amendments made by petition shall also be submitted to the Medical Executive Committee for review and comment. Thereafter, the procedures contained in these Bylaws shall govern.

Section 4. Departmental rules and regulation (and amendments thereto) shall be adopted by each department and submitted for approval to the Executive Committee and to the governing body. In the event of a conflict between the rules and regulations, the Supplemental Medical Staff Governance Documents and these Bylaws, the provisions of these Bylaws shall govern.

Section 5. In the event there is a documented need for an urgent amendment to these Rules and Regulations or the adoption of a new rule, regulation, or policy to comply with a law or regulation, the Medical Executive Committee may provisionally adopt, and the governing body may provisionally approve, an urgent amendment to the Rules and Regulations without prior notification to the Medical Staff. In such event, the Medical Staff shall be immediately notified of the amendment and members of the

Medical Staff may, within thirty (30) calendar days, submit to the Medical Executive Committee any comments regarding the provisional amendment. Upon petition signed by fifty (50) voting Members of the Medical Staff entitled to vote, the provisional amendment may be submitted to the conflict management process set forth in these Bylaws. The results of the conflict management process shall be communicated to the Medical Executive Committee, the voting members of the Medical staff and the governing body. Any repeal or revision of a provisional amendment shall be subject to approval by the Board.

ARTICLE XII

INDEMNIFICATION

The Board of Trustees of Community Medical Center shall indemnify and save harmless the Community Medical Center Medical Staff and each and every member of such staff in the performance of their obligations, under the Bylaws of the staff, Board of Trustees, or under any law or regulation including the cost of defending any legal action brought against the staff or member of the Medical Staff, including reasonable counsel fees and expenses, together with cost of appeal, if any, from any financial loss resulting there from, provided the staff or such individual member shall have acted in good faith and not contrary to legal advice in connection with any act or omission arising out of or in the course of the performance of their duties.

However, any outstanding insurance coverage for all such damage, injury or claim shall be first exhausted whether issued in the name of the hospital, or the individual members of the Medical Staff or Board of Trustees. Nothing contained herein shall deprive a member of the Medical Staff from retaining counsel of his/her own choosing at his/her own cost and expense and advising him/her and in defending any litigation initiated against him/her.

ARTICLE XIII

AMENDMENTS TO THE BYLAWS

Section 1. These Bylaws shall be reviewed at least every two (2) years and more often as is needed to reflect the Hospital's current practices.

Section 2. The Medical Staff shall have the initial responsibility and delegated authority to formulate, adopt and recommend to the governing body, Bylaws and amendments thereto which shall be effective when approved by the Board. These Bylaws may not be unilaterally amended by the Medical Staff or the governing body.

Section 3. Proposed amendments to these Bylaws may be submitted to the Medical Executive Committee or to the Bylaws Committee by any voting Medical Staff member. Amendments to these Bylaws may also be proposed directly to the governing body upon a Petition of fifty (50) voting members of the Medical Staff. Any proposed

Bylaws amendments made by petition shall also be submitted to the Medical Executive Committee and Bylaws Committee for review and comment. Thereafter, the procedures contained in these bylaws shall govern. The Bylaws Committee shall consider each proposed amendment and make a report to the Medical Executive Committee. The Medical Executive Committee shall consider the proposed amendment and Bylaws Committee report and shall make a recommendation which, if such recommendation results in a proposed change to the Bylaws, shall be voted on by the voting members of the Medical Staff.

Section 4. Where an amendment does not materially alter the substance of an existing Bylaws provision or are technical or regulatory modifications or clarifications, reorganization or renumbering, or amendments made necessary because of punctuation, spelling or other errors of grammar or expression, or changes made to reflect the requirements of State or Federal legislation such change may be recommended by the Bylaws Committee to the Medical Executive Committee or by the Medical Staff Executive Committee itself. Such amendments will be considered to be adopted by a majority of the Medical Executive Committee. Such amendments shall be effective immediately upon notice to the Board

Section 5. The Medical Executive Committee shall vote on the proposed amendments at a regular meeting or at a special meeting called for such purpose. Following an affirmative vote by the Medical Executive Committee, all voting members of the Medical Staff shall receive a description of the proposed amendment(s) by regular or electronic mail. At least thirty (30) days following this dissemination of the proposed amendment(s), all eligible voting members of the Medical Staff will be eligible to vote on the proposed amendment(s). This vote may be conducted via printed or electronic ballot in a manner determined by the Medical Executive Committee. Ballots that are not returned will be considered abstentions. To be adopted, the proposed amendment(s) must be affirmed by a majority of the voting members of the Medical Staff casting a vote in favor of the proposed amendment(s) and the Governing Body must subsequently ratify the amendment.

Section 6. A copy of the text of each amendment to or repeal of these Bylaws with a notation of the date of such amendment or repeal shall be maintained by the Medical Staff Office.

ARTICLE XIV
CONFLICT RESOLUTION PROCESS

CONFLICT MANAGEMENT

Section 1. In the event of a conflict between members of the Medical Staff and the Medical Executive Committee regarding the adoption of any bylaw, rule,

regulation or policy, or any amendment thereto, or with regard to any other matter, upon a petition signed by fifty (50) members of the Medical Staff entitled to vote, the matter shall be submitted to the conflict resolution process set forth herein.

Section 2. An Ad hoc Conflict Resolution Committee shall be formed consisting of up to five (5) representatives of the voting Medical Staff designated by the Medical Staff members submitting the petition and an equal number of representatives of the Medical Executive Committee appointed by the President.

Section 3. The members of the Conflict Resolution Committee shall gather information regarding the conflict, meet to discuss the disputed matter, and work in good faith to resolve the differences between the parties in a manner consistent with protecting safety and quality.

Section 4. Any recommendation which is approved by a majority of the voting Medical Staff representatives and a majority of the Medical Executive Committee representatives shall be submitted to the Board of Trustees for consideration. If agreement cannot be reached, the members of the Conflict Resolution Committee shall individually or collectively report to the Board of Trustees regarding the unresolved differences for consideration.

Section 5. In the event the dispute cannot otherwise be resolved, the Board may render a final decision.

Adopted at a Quarterly Staff Meeting of the Medical Staff and Approved by the Board of Trustees:

Amended:	4/24/95	11/27/95	4/22/96	4/27/98	9/28/98
Approved:	7/06/95	2/06/96	6/06/96	5/07/98	11/5/98
Amended:	4/26/99	9/27/99	4/24/00	11/19/01	11/24/03
Approved:	5/06/99	11/04/99	5/4/00	01/29/02	01/27/04
Revised:	4/22/05	9/24/07	4/28/08	9/21/09	
Approved:	5/23/05	11/1/07	6/5/08	1/26/10	

Revised: 4/26/10, 10/5/10, 1/24/11
Approved 7/29/10, 01/06/11, 3/3/11

Revised: 04/30/15, 09/10/15, 09/22/15

Approved by Medical Staff:	06/27/11	11/26/12
Approved by Board:	06/29/11	01/15/13
Approved by Medical Staff	03/02/15	09/28/15
Approved by Board of Trustees	01/19/16	
Approved by Medical Staff	11/03/17	
Approved by Board of Trustees	11/15/17	
Approved by Medical Staff	01/17/18	
Amended by Consent Order	11/19/18	
Approved by Board of Trustees	11/29/18	
Approved by Medical Staff	01/06/19	
Approved by Board of Trustees	01/31/19	
Approved by Medical Staff	11/12/20	
Approved by Board of Trustees	12/04/20	