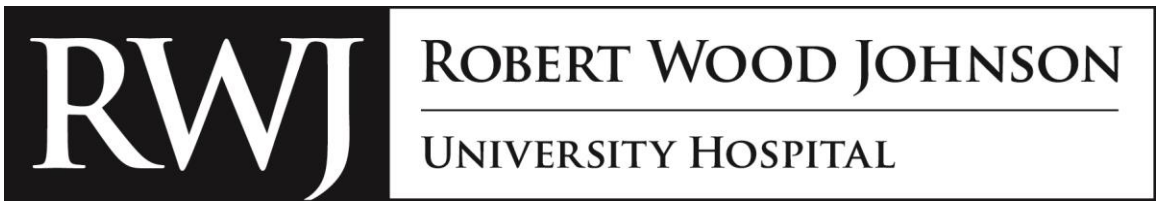

MEDICAL STAFF BYLAWS

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ADOPTION

These Bylaws are adopted and made effective upon approval of the Board of Directors, superseding and replacing any and all previous Bylaws, and henceforth all activities and actions of the Medical Staff at this Hospital shall be taken under and pursuant to the requirements of these Bylaws.

First Reading by the Professional Affairs Committee on October 27, 2015.
Second Reading by the Medical Board on October 29, 2015.
Adoption by the Medical Staff on January 14, 2016.
Approved and adopted by the Board of Directors on February 3, 2016.

PRACTITIONER BILL OF RIGHTS

This Practitioner Bill of Rights describes the specific rights of individual Practitioners as defined in the Medical Staff Bylaws. This Bill of Rights is a summary of more specific procedures contained in the Bylaws.

1. All Medical Staff members have the right to attend and speak at all general meetings of the Medical Staff. Active Staff members have a right to attend and vote at all general meetings of the Medical Staff.

2. Each Active Staff member has the right to one (1) audience with the MEC on any matter except with respect to an existing Investigation, adverse recommendation or corrective action, litigation with the Medical Staff, Hospital and/or its related and affiliated entities or their representatives, or the expiration, modification or termination of an agreement between the Hospital and the individual Practitioner or the Practitioner's group. Active Staff members may request this meeting after attempts to resolve the issue with his/her Service Chief, the Medical Staff President, or the CMO are unsuccessful. This audience must be requested in writing and will be scheduled by the MEC as convenient based upon its schedule and the urgency of the matter.

3. Any Active Staff member has the right to initiate a recall election of a Medical Staff Officer following the procedure outlined in these Bylaws.

4. Any Active Staff member may call a general Medical Staff meeting by presenting a petition to the Medical Staff President signed by ten (10%) percent of Active Staff members. This meeting will be held within two (2) weeks on the presentation of the petition and only the business defined in the petition shall be discussed.

5. Any Active Staff member may challenge any rule or policy established by the MEC by submitting a petition signed by ten (10%) percent of the Active Staff members. The MEC shall provide information clarifying the rule or policy and schedule a meeting with the petitioners to discuss the issue.

6. Any Active Staff member may propose amendments to these Bylaws by submitting a petition in accordance with the provisions of these Bylaws.

7. Any Medical Staff member may call a Service meeting upon petition signed by the simple majority of that Service's Active Staff members when such simple majority believes the Service has not acted appropriately.

8. In most instances, and to the extent contained in the Medical Staff Bylaws, any Active Medical Staff member has a right to a hearing/appeal of adverse actions taken against them pursuant to the processes defined in these Bylaws.

9. In the event of any inconsistency between the Practitioner Bill of Rights and the Bylaws, the provisions of the Bylaws shall control.

DEFINITIONS

1. Affiliation Agreement

   Affiliation Agreement means the documents detailing the relationship among Rutgers the State University of New Jersey, Rutgers Robert Wood Johnson Medical School and the Hospital dated as of June 1, 2015, as modified from time to time. In the event of any inconsistency between the Bylaws and Article V of the Affiliation Agreement, the provisions of the Affiliation Agreement shall control.

2. Allied Health Professional

   Allied Health Professional or AHP means an individual other than a Physician who may or may not hold a doctoral degree in clinical health care profession, and who may be licensed, certified or registered in his/her profession or occupation by the State of New Jersey, whose practice in the fields of patient care, public health, and/or health research consists of providing services upon the order of a Physician, dentist or Limited Licensed Practitioner, and which services assist, supplement, facilitate or complement the patient care services rendered by Practitioners. Examples of AHP's include, but are not limited to: Physicians Assistants, Advanced Practice Nurses (including APN's/Anesthesia and Nurse Midwives), RN First Assistants (RNFA), Neurophysiologists (Ph.D.), and clinical Psychologists (Ph.D. or Psy.D).

3. Board of Directors

   Board of Directors, Board Governing Body or Board means the governing body of the Hospital.

4. Chief Executive Officer

   Chief Executive Officer or CEO means the individual appointed by the Board to act on its behalf in the overall management of the Hospital.

5. Clinical Privileges

   Clinical Privileges or Privileges means the permission granted to a member of the Medical Staff to render specific diagnostic, therapeutic, medical, dental or surgical services within the Hospital.

6. Corrective Action

   Corrective Action means the formal process for recommending termination or suspension of Medical Staff membership and/or termination, suspension or reduction of Clinical Privileges and other recommendation arising out of such process.

7. Ex Officio

   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.

8. Hospital

Hospital or RWJUH means Robert Wood Johnson University Hospital.

9. House Staff

House Staff means all resident Physicians, fellows and post-graduates who have graduated from approved or recognized schools of medicine, dentistry or osteopathy and who are participating in programs at the Hospital conducted under the auspices of the Hospital or the School and who have been authorized specified practice Privileges in the Hospital, under supervision of members of the Medical Staff. All House Staff have no rights under these Bylaws and while they may have limited Clinical Privileges, they are not members of the Staff.

10. Licensed Independent Practitioner

Licensed Independent Practitioner or LIP means any individual permitted by law and the Medical Staff to provide care, treatment, and services, without direct supervision within the scope of the individual's license and consistent with individually granted Clinical Privileges.

11. Medical Administrative Officer

Medical Administrative Officer, Chief Medical Officer, or CMO means a Physician, employed by or otherwise serving the Hospital on a full or part time basis, whose duties include certain responsibilities which are both administrative and clinical in nature. Clinical responsibilities are defined as those involving professional capacity as a Practitioner, such as to require the exercise of clinical judgment with respect to patient care and include the supervision of professional activities of Practitioners under his direction.

12. Medical Executive Committee

Medical Executive Committee, or MEC, means the organized body which shall act on behalf of the entire Staff and coordinate the professional activities and general policies of the various clinical Services and Divisions of the Hospital and have such other functions and responsibilities as are provided in these Bylaws.

13. Medical School

Medical School or School or Rutgers–RWJMS means the Rutgers-Robert Wood Johnson Medical School, Rutgers University.

14. Medical Staff

Medical Staff or Staff means the formal organization of all licensed Physicians, dentists, podiatrists, Licensed Independent Practitioners and Allied Health Professionals who are privileged through the Medical Staff process and who are subject to the Medical Staff Bylaws, to attend or provide care to patients of the Hospital.

15. Medical Staff Year

Medical Staff Year means the period from January 1 to December 31.

16. Notice

Notice means written notification stating the place, day and hour of any meeting of the Staff or one of its component committees. Any Notice shall be mailed or sent by facsimile transmission, email or other electronic means to each person entitled to be present no later than five (5) days nor more than twenty (20) days before the date of such meeting, except in the event of an urgent matter as determined by the President, CMO or MEC when lesser notice or Verbal Notice may be provided or when Special Notice is specifically requested.

17. Organized Health Care Arrangement

Organized Health Care Arrangement means a clinically integrated care setting in which individuals typically receive health care from more than one Practitioner and which is defined in 45 C.F.R. §164.501 commonly known as the HIPAA Privacy Regulations.

18. Organized Medical Staff

Organized Medical Staff means the self-governing entity accountable to the Board that operates under a set of Bylaws, Rules and Regulations and policies developed and adopted by the voting members of the Organized Medical Staff and approved by the Board of Directors. The Organized Medical Staff is comprised of doctors of medicine and osteopathy and, in accordance with these Bylaws, may include other Practitioners.

19. Physician

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

20. Practitioner

Practitioner means, unless otherwise expressly limited, any Physician, Licensed Independent Practitioner or Allied Health Professional applying for or exercising Clinical Privileges in this Hospital who is responsible for managing and coordinating patient care, treatment and services.

21. Prerogative

Prerogative means a participatory right granted to a Staff member subject to the conditions imposed in these Bylaws and in other Hospital and Medical Staff policies.

22. President

President means the President of the Medical Staff.

23. Professional Affairs Committee

Professional Affairs Committee means the Professional Affairs Committee as defined under the Bylaws of the Hospital.

24. Quorum

Quorum means a simple majority of the membership (50% + 1) of the body unless otherwise specified in these Bylaws.

25. Service Chief

Service Chief means the individual responsible for Practitioners and Allied Health Professionals in the individual's clinical Service.

26. Special Notice

Special Notice means written notification sent by certified mail, return receipt requested, by verified overnight mail, or by hand delivery with receipt requested. Special Notice shall be considered to be received on the date of verified delivery to the address for delivery contained in these Bylaws or, if none, to the recipient's home or office if sent by overnight mail or hand delivery or on the date the certified slip was signed for if by certified mail.

27. Verbal Notice

Verbal Notice means notification conveyed other than in writing. Verbal Notice is acceptable in extraordinary circumstances but such circumstances must be documented on the attendance sheet along with the manner of notification that was given to each person.

28. Vote

Vote means a vote by voice, show of hands, email or other electronic means or hand written ballot unless otherwise specified in these Bylaws. Proxy voting is not permitted unless specified in these Bylaws.

PREAMBLE

These are the Bylaws of the Medical Staff of Robert Wood Johnson University Hospital. This document defines the relationship between the Hospital and the Medical Staff. It contains the mechanisms for individual Medical Staff members, the Medical Staff governing body, and Hospital governing body, to govern, resolve conflicts and, above all, to assure excellence in medical care.

It is the goal of this document that the members of the Medical Staff be organized into a self-governing Medical Staff that will oversee the quality of care provided by all clinical Practitioners privileged by the processes herein defined.

This document also defines the rights of each individual Practitioner. It is the goal of these Bylaws to create a framework within which Medical Staff members can act with a reasonable degree of freedom and confidence.

Where Bylaws have associated details, which may reside in other documents, rules, regulations or policies, the Bylaws define the location of the documents containing such associated details. These Bylaws have been adopted by an affirmative vote of the Medical Staff. Details in other documents may be adopted, as appropriate, by other bodies.

These Bylaws are divided into Sections. First, there is a definition of the responsibilities of individual Practitioners. Within this Section are the qualifications, methods for obtaining and maintaining credentials, the rights of Practitioners and individual responsibilities. Second, the Bylaws separately define the structure of governance and leadership of the Medical Staff as well as the clinical function of Services and Divisions and their leaders. Finally, the process for conflict resolution, corrective action and appeal are defined in detail.

Robert Wood Johnson University Hospital has more than a century long tradition of service, teaching and research. These Bylaws support the traditions of service, teaching and research by defining the rules and responsibilities of the Medical Staff as it continues to assure excellence in patient care, high quality medical education, and community service.

ARTICLE I - NAME

The name of this organization is "The Medical Staff of Robert Wood Johnson University Hospital."

ARTICLE II - PURPOSE

2.1 General Purposes of Medical Staff

2.1.1 The Medical Staff has the primary responsibility to provide oversight of patient safety and of the quality of medical care, treatment and services delivered by Practitioners who are credentialed and privileged through Medical Staff processes.

2.1.2 The Medical Staff is the formal organization through which the rights and responsibilities of membership may be obtained by individual Practitioners and obligations of membership may be fulfilled.

2.1.3 The Medical Staff shall assure that all patients receive the highest quality of and uniform care where possible, without regard to age, race, creed, sex, color, religion, national original, affectional or sexual preference, disability, ancestry, marital status, familial status, nationality or the ability to pay.

2.1.4 We believe that, working together within the defined Medical Staff, structure, we will provide our patients with the highest quality of medical care.

2.2 Specific purposes and responsibilities of the Medical Staff:

2.2.1 To ensure that all patients cared for at the Hospital receive appropriate and quality care.

2.2.2 To review the quality of patient care including patient care policies, serve as a forum for discussing patient care issues, engage in performance improvement activities, and utilization management programs.

2.2.3 To ensure that all members of the Medical Staff are properly credentialed by the Medical Staff.

2.2.4 To serve as the primary source of accountability to the Board for professional performance and ethical conduct of the Medical Staff.

2.2.5 To assure that the rights of individual Practitioners are protected, as well as to maintain a formal mechanism to address impaired Practitioners.

2.2.6 To give Practitioners a voice in the governance of the Medical Staff and the Hospital.

2.2.7 To provide exemplary medical education programs.

2.2.8 To provide mechanisms through which the Medical Staff, the Hospital Board and the administration of the Hospital may discuss matters of mutual concern.

2.2.9 To be responsible for quality medical care and patient safety in the Hospital, understanding that the Hospital Board, as governing body, is ultimately accountable for the safety and quality of care, treatment and services.

2.2.10 To coordinate and integrate inter-departmental and intra-departmental services.

2.2.11 To maintain policies compliant with state and federal regulations.

2.2.12 To be part of an Organized Health Care Arrangement with the Hospital.

ARTICLE III - QUALIFICATIONS AND RESPONSIBILITIES FOR MEMBERSHIP

3.1 Nature of Medical Staff Membership

3.1.1 Membership on the Medical Staff, or the exercise of Temporary Privileges, shall be extended only to professionally competent Practitioners who meet the qualifications, standards and requirements set forth in these Bylaws. Appointment to and membership on the Medical Staff shall permit only the exercise of such Clinical Privileges as have been granted in accordance with these Bylaws. No Practitioner shall admit or provide services to patients in the Hospital unless that Practitioner is a member of the Staff with appropriate Clinical Privileges, or unless that Practitioner has been granted Temporary Privileges in accordance with the procedures set forth in these Bylaws.

3.1.2 No aspect of Medical Staff Membership shall be denied, modified or granted based on race, creed, sex, color, religion, national original affectional or sexual preference, ancestry, marital status, familial status or nationality.

3.1.3 Appointments or Reappointments to the Medical Staff will be granted only to professionally competent Practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws.

3.2 Qualifications for Membership

3.2.1 Practitioners licensed to practice in the State of New Jersey may be accepted for membership on the Medical Staff only if they:

3.2.1.1 Document their current license status, demonstrate current clinical competence and ability, experience, background, training, clinical judgment, individual character and physical and mental health status in order to show to the Medical Staff and the Board that any patient treated by them will receive care at the generally accepted professional level of quality and efficiency;

3.2.1.2 Establish, on the basis of documented references, that they have adhered to the ethics of their respective professions, worked cooperatively with others in the performance of Hospital related activities as necessary to effectuate appropriate patient care, and participate appropriately in the discharge of Staff responsibilities.

3.2.1.3 Specifically, Practitioners wishing to be on the Medical Staff and/or hold Clinical Privileges must:

(a) Possess a current, unrestricted license to practice their profession in the State of New Jersey;

(b) Maintain current, unrestricted CDS registration and DEA licensure with exception of appointments in the specialties of Pathology and Diagnostic Radiology;

(c) Demonstrate eligibility for clinical faculty status at the Medical School, in accordance with the standards for clinical faculty status then in existence;

(d) Maintain current, valid professional liability insurance for care given at the Hospital having a minimum coverage of $1 million/$3 million dollars or such greater amount as required by the State of New Jersey. Such liability insurance shall be provided by an insurer approved by the New Jersey Department of Banking and Insurance;

(e) Demonstrate a satisfactory malpractice and claims loss history as determined by the MEC;

(f) Not be suspended or excluded from participating in state or federal health care reimbursement programs and supply a current New Jersey Medicaid billing or non-billing registration number and current enrollment or opt-out status in the Medicare program, or participate in Medicare and Medicaid, if applicable, to the applicant's specialty;

(g) Have never been convicted of or pled guilty or no contest to any felony or indictable crime relating to controlled substances, illegal drugs, insurance fraud or abuse or violence;

(h) Demonstrate that no physical or mental health problems exist that affects their ability to perform the Clinical Privileges requested, provide evidence of required health screenings and mandatory vaccinations as determined by the Medical Staff, and agree to comply with the health screening, evaluation and examination requirements of the Medical Staff before exercising any Privileges;

(i) Identify satisfactory patient coverage arrangements with other members of the Medical Staff with appropriate Clinical Privileges;

(j) Not be seeking only those Clinical Privileges that are subject to an exclusive contract/exclusive employment arrangement at Hospital unless they are party to such arrangement/contract;

(k) Physicians shall have successfully completed a graduate medical education program in the applicant's primary specialty approved by the Accreditation Council for Graduate Medical Education recognized by the American Board of Medical Specialties or the American Osteopathic Association or the American Dental Association or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association or a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical; and

(l) Not be seeking Clinical Privileges to treat patients or conditions for which the Hospital lacks necessary equipment, facilities, or other resources or for which there is no need based on the Hospital's strategic or Medical Staff development plans.

3.2.2 Board Certification or board qualification is a requirement for appointment to the Medical Staff. At present, RWJ accepts certifying boards recognized by the American Board of Medical Specialties or the American Osteopathic Association, unless otherwise provided for below. It should be noted that the organized Medical Staff is amenable to determining a mechanism for reviewing alternative boards at future points in time.

3.2.2.1 If an applicant is board 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 the applicant's highest level of post-graduate training to achieve board certification.

3.2.2.2 Subject to the provisions of subsections 3.2.2.6 and 3.2.2.7, below, failure to achieve board certification within the time limit described in subsection 3.2.2.1 will result in automatic termination of Medical Staff appointment and Privileges without right of appeal effective at the end of the current period of appointment. Any review will be limited to the issue of whether the individual meets the board certification requirement. Decisions made under subsections 3.2.2.6 and 3.2.2.7 are not subject to any review or appeal.

3.2.2.3 The provisions of subsection 3.2.2.1 requiring board certification or recertification shall not apply to Physicians who were on the Medical Staff prior to 1990 and have remained members in good standing with no interruption of Medical Staff membership.

3.2.2.4 For non-Physicians, Dentists and Podiatrists the MEC will determine which boards or certifications, if any, will be required for Medical Staff membership.

3.2.2.5 For the purpose of re-certification, unless granted a lifetime exemption from recertification pursuant to the requirements of the applicable certifying boards, Members may retain their Medical Staff status by maintaining either specialty or subspecialty board

certification in the primary discipline practiced. Medical Staff Members whose board certification has expired may receive a one (1) examination cycle extension if current clinical competence and citizenship are exemplary and demonstrated at the Service Chief's discretion and/or for the reasons set forth in subsection 3.2.2.7 with MEC and Board approval. Failure to achieve recertification as set forth herein will result in automatic termination of Medical Staff Appointment and Privileges without right of appeal, effective at the end of the current period of appointment. Physicians who joined the Staff after February 1, 2016, must maintain certification at the highest level of the primary discipline they practice and for which they have been granted Clinical Privileges.

3.2.2.6 In unusual circumstances, an extension may be granted by the MEC for a period not to exceed two (2) years.

3.2.2.7 The Medical Staff member may, with the recommendation of the respective Service Chief, request the MEC assess and recommend the waiver of requirement for board certification or board qualification based on extraordinary clinical or academic need.

3.2.2.8 Medical Staff members who recertify shall do so in accordance with the requirements of the applicable specialty and sub-specialty boards.

3.3 Basic Responsibilities of Individual Staff Membership

3.3.1 Each member of the Medical Staff shall according to his/her Staff category, Privileges and restrictions:

3.3.1.1 Provide his/her patients with care at the generally accepted professional level of quality and efficiency;

3.3.1.2 Abide by the Hospital and Medical Staff Bylaws, Rules and Regulations, and by all other lawful standards, policies and rules of the Hospital reasonably related to quality of care, professional competence, or necessary administrative functions;

3.3.1.3 Perform such Staff, Service/Division, committee and Hospital functions for which that Practitioner is responsible by Staff category assignment, appointment, election or otherwise;

3.3.1.4 Prepare and complete in timely fashion the medical and other required records for all patients Practitioner admits or in any way provides care to in the Hospital;

3.3.1.5 Admit or care for a sufficient number of patients with accepted professional quality and ethical standards of the Practitioner's profession to allow evaluation of continuing competence. Absent sufficient patient care activity at the Hospital, provide verification of competence from another Hospital or appropriate peers or training program;

3.3.1.6 Perform and document a physical exam and medical history after each admission for each patient as required by Hospital policies and state and federal rules and regulations;

3.3.1.7 Provide, with or without request, new and updated information within ten (10) days of its occurrence to Medical Staff Administration, pertinent to any question found on the initial application or reappointment forms and/or which bears upon eligibility and qualifications as described in these Bylaws including, without limitation, separation from the Medical School;

3.3.1.8 Complete in a timely manner, as required by Medical Staff and Hospital policies, all medical and other required records, inputting all information required;

3.3.1.9 Satisfy continuing medical education requirements for licensure and as may be required under policies adopted from time to time by the Medical Staff and applicable law;

3.3.1.10 Supervise the work of any non-Physician Practitioner under his/her direction;

3.3.1.11 Assist other Practitioners in the care of their patients when asked in order to meet an urgent patient need or assure the well-being of a patient; and

3.3.1.12 Obtain and document written informed consent for procedures and treatment.

3.3.1.13 Furthermore, each member of the Medical Staff by accepting Medical Staff appointment and/or reappointment agrees:

(a) If there is any material misstatement in, or material omission from, an application for appointment or reappointment, the Medical Staff may stop processing the application (or, if appointment has been granted prior to the discovery of a misstatement or omission, appointment and Privileges may be deemed by the Board to be automatically relinquished). In either situation, there shall be no entitlement to a hearing or appeal;

(b) To participate in and collaborate with the peer review, risk management, performance improvement, and utilization management activities of the Medical Staff and Hospital. These include monitoring and evaluation tasks performed as part of the Medical Staff and Hospital efforts to meet quality standards including those established by applicable accrediting agencies, the Centers for Medicare and Medicaid Services ("CMS"), and other governmental agencies and private insurers;

(c) To provide patient care and management only within the parameters of his or her professional competence, as reflected in the scope of Clinical Privileges granted to the Practitioner;

(d) To undergo any type of mental, behavioral and/or physical health evaluation by a designated clinician or program, including "for cause" drug and/or alcohol testing, as required by the President, CEO, CMO, and/or MEC when it appears necessary to protect the well-being of patients and/or others or when requested by the MEC as part of an evaluation of the member's ability to exercise Privileges safely and competently, or as part of a post-treatment monitoring plan consistent with the provisions of any Medical Staff and Hospital policies addressing Physician health or impairment;

(e) To participate in any type of competency evaluation when determined necessary by the MEC and/or Board in order to properly delineate and/or assess that Member's Clinical Privileges;

(f) To hold harmless and agree to refrain from legal action against any individual, the Medical Staff, or

Hospital that shares peer review and performance information with a legitimate health care entity (including, but not limited to Hospitals, insurance companies, managed care organizations, and credentialing verification organizations) or a state committee assessing the credentials of the Member;

(g) To abide by any applicable codes of conduct and citizenship policies adopted by the Medical Staff and/or Hospital;

(h) To abide by all local, state and federal laws and regulations, applicable accreditation standards, and state licensure and professional review regulations and standards, as applicable to the Practitioner's professional practice; and

(i) To provide continuous and timely patient care and treatment to all patients for whom the Practitioner has responsibility.

3.4 Health Status

3.4.1 Health Requirements. Practitioners must maintain the physical and mental ability to deliver quality patient care.

3.4.2 Notification of Health Status. A Practitioner holding Clinical Privileges at Hospital must immediately report in writing to his/her Chief, the President or the CMO when he or she has a mental or physical condition that has the potential or likelihood to impair judgment or affect functional capability to perform granted Privileges safely.

3.4.3 Health Examination. At any time that there is any reason to question whether a Medical Staff member has the necessary physical and/or mental health required to care for patients safely and with an appropriate level of care and skill, the President, CEO, CMO, or MEC may require that member to undergo an appropriate health evaluation. The nature and scope of the exam evaluation (including for cause drug or alcohol testing) and the examining clinician will be determined at the discretion of the Physician's Health Committee, MEC and/or Board. Where there is a concern that a Practitioner may be impaired by use of or addiction to drugs or alcohol, such examination may include the imposition of drug or alcohol testing. Refusal of a Medical Staff member to comply with a request to submit to a health examination and/or drug or alcohol testing will be considered a voluntary resignation from the Medical

Staff and relinquishment of Privileges without right to a hearing or appellate review.

ARTICLE IV - CATEGORIES OF MEDICAL STAFF MEMBERSHIP

4.1 Categories of the Medical Staff The categories of the Medical Staff shall consist of Active, Affiliate, Allied Health, Telemedicine, Emeritus and Honorary Staff.

4.1.1 Active Staff shall consist of Physicians in active practice who demonstrate substantial commitment to the Medical Staff and Hospital. These Practitioners may admit patients to the Hospital, write orders, and perform procedures. They may vote at Medical Staff meetings and hold positions on the Medical Staff.

4.1.2 Affiliate Staff shall consist of Physicians and Allied Health Practitioners who engage in the active practice of medicine at some location and desire a formal relationship with the Hospital to enable coordination of care for their patients. Affiliate Staff members may attend meetings of the Medical Staff, but may not vote or serve as an Officer on the Medical Staff. They may not admit patients to the Hospital but may visit patients and view their medical records. They may not make entry into the medical record, write orders or perform procedures. Affiliate Staff shall not be granted Clinical Privileges.

4.1.3 Allied Health Staff shall consist of individuals other than Physicians, as defined in the definitions Section of these Bylaws, who wish to provide care and treatment to Hospital patients within their areas of competence, as set forth in their delineated scope of practice and/or collaboration agreement to the extent permitted by applicable law. They may write orders only to the extent established by the MEC, but not beyond the scope of their license, certificate, registration or other legal credential. They may attend meetings of the Medical Staff and the Service assigned but may not serve as an Officer on the Medical Staff or vote, except for the AHP representative to the MEC, who shall have a vote.

4.1.4 Telemedicine Staff shall consist of Licensed Independent Practitioners who wish to consult on Hospital patients or practice "telemedicine," through an agreement to provide telemedicine services with the Hospital. Telemedicine Staff are responsible for the care, treatment, and services of the patient via telemedicine link subject to the credentialing and privileging process of the Hospital. They may write in the medical record, write orders and perform procedures. They may not admit patients to the Hospital. They may

attend meetings of the Medical Staff, but may not vote or serve as an Officer on the Medical Staff.

4.1.5 Emeritus Staff shall consist of Practitioners who previously were Active members of the Medical Staff, who no longer maintain an active clinical practice at the Hospital, and who desire to continue to be recognized as members of the Medical Staff. They may but are not required to attend meetings of the Medical Staff, and may not vote or serve as an Officer on the Medical Staff. They may not admit patients to the Hospital, review medical records, write in the medical record, write orders or perform procedures. They shall not be granted delineated Clinical Privileges. Emeritus members shall not be required to pay Medical Staff dues.

4.1.6 Honorary Staff status may be conferred in recognition of an individual's achievements and/or service to the Hospital and may be granted to other than Physicians. Unless a member of the Honorary Staff is concurrently a member of the Active Staff, he/she may not vote.

4.2 Change in Staff Category. Pursuant to a request by a Practitioner, the MEC may recommend a change in the Medical Staff category of a member consistent with the requirements of these Bylaws. The Board shall consider any such change in category. Determinations regarding the assignment of Staff category are not subject to review under ARTICLE XIV of these Bylaws.

ARTICLE V - ALLIED HEALTH PROFESSIONALS

5.1 Qualifications. Only Allied Health Professionals holding a license, certificate or other legal credentials as required by state law, and who can demonstrate the qualifications for membership described in Article III, as applicable to their category, are eligible to apply for and obtain Medical Staff membership and to exercise Clinical Privileges.

5.2 Procedure for Specification of Services. An application shall be submitted by an AHP for permission to perform specified services at the Hospital, and acted upon by the MEC, in the same manner as is required for the submission of applications for Clinical Privileges or duties by Physicians. An AHP shall be individually assigned to the clinical Service appropriate to that AHP's professional training and shall be subject in general to the same terms and conditions as specified for Medical Staff appointments.

5.3 Responsibilities of AHP Members

5.3.1 Meet the same basic responsibilities as required for Medical Staff members as defined in Sections 3.3 and 3.4 of these Bylaws;

5.3.2 Provide within that AHP's area of professional competence, care and supervision of each patient in the Hospital for whom that AHP is providing services, or arrange a suitable alternative for such care and supervision;

5.3.3 Participate as appropriate in the patient care audit and other quality review, evaluation and monitoring activities required of the Staff, and in such other Staff functions as may be required from time to time; and

5.3.4 Satisfy the requirements for attendance at meetings of the Service, Division and committees to which an AHP is assigned.

ARTICLE VI - Procedure for Appointment & Reappointment

6.1 General Procedure

6.1.1 Duration of Appointment

6.1.1.1 Duration of Initial Appointments

(a) The initial appointment will be for one (1) year that will serve as an observation period.

(b) At the end of this one (1) year period, a recommendation shall be made to terminate or continue the observation period as described in (d) below.

(c) If the recommendation is made to terminate the observation period, a recommendation shall be made by the Service Chief and President whether to grant Active Staff status.

(d) If Active Staff status is not granted, the observation period may be extended for up to one (1) additional year or may be denied as determined by the MEC and Board.

6.1.1.2 Reappointments

(a) Reappointment to any category of membership on the Medical Staff and any grant of Clinical Privileges, shall be for a period of not more than two (2) years.

(b) In the event that a decision is made to reappoint a Medical Staff Member for less than two (2) full

years, the appointee shall not be entitled to any of the procedural rights afforded in these Bylaws in regards to the decision.

6.1.2 General. The goal of the Medical Staff appointment and reappointment process is to provide the Medical Staff and Hospital with the information required to decide in a comprehensive, transparent and fair manner whether an applicant is qualified to be a member of the Medical Staff. Each decision for appointment or reappointment shall be based upon the documented evidence of each applicant's:

6.1.2.1 Professional ability and performance;

6.1.2.2 Competence and clinical judgment, and technical skills;

6.1.2.3 Professional ethics;

6.1.2.4 Discharge of Staff obligations;

6.1.2.5 Compliance with Medical Staff Bylaws, Rules and Regulations and policies;

6.1.2.6 Compliance with Hospital policies;

6.1.2.7 Elements of Medical Staff citizenship;

6.1.2.8 Willingness to contribute to efforts of quality patient care, outreach, research and education in the Hospital;

6.1.2.9 Completion of required CME;

6.1.2.10 Board certification status; and

6.1.2.11 Hospital staffing needs and available resources.

6.2 The Primary Application

6.2.1 Application Packet. Practitioners wishing to join the Medical Staff must complete an application packet provided by the Medical Staff Administration. This packet requires multiple documents and supporting materials. A credentials file will be opened and maintained on each Practitioner. The Medical Staff recognizes that the application process can be complex and frustrating, and it is our goal to assist each Practitioner as much as possible to work through the process smoothly. However, it is the applicant's responsibility to supply needed documents, references and other information in a timely manner. The application cannot be presented for review until

it is complete, fully signed in all required places and returned unaltered to Medical Staff Administration. By applying for appointment to the Medical Staff, the applicant agrees to appear for interviews as required, and consents to Medical Staff and Hospital representatives consulting with others who may have information regarding the applicant. The applicant also consents to Medical Staff and Hospital representatives obtaining and inspecting or releasing all information, records and documents that may be material to the application and/or the Practitioner's exercise of Clinical Privileges. Deliberately false, misleading or deliberately incomplete materials in the application or supporting documents will result in immediate denial of Membership and Clinical Privileges.

6.2.2 The completed application packet shall include, but may not be limited to:

6.2.2.1 Instructions for applicant form;

6.2.2.2 Appointment application cover letter;

6.2.2.3 Application for Appointment form;

(a) Demographic data;

(b) Record of education and experience (without time gaps);

(c) Photograph of applicant;

(d) Professional recognition and memberships (societies, awards, boards);

(e) Licenses, DEA & CDS certificates;

(f) References (2), if applicable;

(g) Health statement;

(h) Malpractice Coverage certificate; and

(i) Professional sanctions.

6.2.2.4 Bylaws received and reviewed signature form;

6.2.2.5 Medical Staff Rules and Regulations reviewed signature form;

6.2.2.6 Hospital Staff Citizenship and Code of Professional Conduct policy reviewed signature form;

6.2.2.7 Federal Insurance participation pledge form;

6.2.2.8 HIPAA confidentiality signature form;

6.2.2.9 Privilege Request and Delineation form;

6.2.2.10 Releases, Acknowledgments and Agreements as are required in these Bylaws;

6.2.2.11 Attestation of maintenance of New Jersey State requirements for continuing education (CME); and

6.2.2.12 Nonrefundable fees/dues.

6.3 The Application Process

6.3.1 The application shall include:

6.3.1.1 Acknowledgment and Agreement. A statement that the applicant has received (or has had access to) and read these Bylaws and Rules and Regulations of the Medical Staff and that the Practitioner agrees to abide by the terms thereof if granted membership and/or Clinical Privileges, and to abide by the terms thereof in all matters relating to consideration of that Practitioner's application without regard to whether or not the Practitioner is granted membership and/or Clinical Privileges and to promptly provide Medical Staff Administration with a written update concerning all information on his/her membership application if and when changes occur. The application shall also include a statement that the applicant will abide by all Hospital policies, Rules and Regulations, that apply to that Practitioner's activities as a Medical Staff member or otherwise.

6.3.1.2 Qualifications. Detailed information concerning the applicant's qualifications, including information in satisfaction of the basic eligibility, responsibilities and qualifications specified in Article III and of any additional qualifications specified in these Bylaws for the particular Staff category to which the applicant requests appointment. This information shall include data from professional practice review by organization(s) that

currently privilege the applicant(s), if available. Applicant shall supply a chronological history listing all of the applicant's employment history and past Medical Staff memberships and associated Privileges, including the full addresses of the hospitals and other health care institutions at which such memberships or Privileges were held and/or applied for.

6.3.1.3 Requests. Requests stating the Medical Staff category, Service and Clinical Privileges for which the applicant wishes to be considered.

6.3.1.4 References. The names of at least two (2) independent persons not related by financial or familial relationship who have recently worked with and directly observed that Practitioner's professional performance over a reasonable period of time and who can and will provide reliable information regarding the applicant's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, professionalism, ethics, character and ability to work with others. At least one of the references must be from a person who has supervised the applicant. If the application is for practice in a subspecialty field, at least one reference must be in the same subspecialty. If the applicant is within five (5) years of completing residency or other training, one (1) reference must include the director of the training program.

6.3.1.5 Professional Sanctions. Information as to whether any of the following have ever been, or are currently pending, voluntarily or involuntarily revoked, suspended, reduced, non-renewed, subject to restrictions or limitations not applicable to all other Practitioners in the same Medical Staff category, or not renewed at any hospital, health care institution, or health plan, including whether any of the following has ever been voluntary or involuntarily suspended, revoked, or denied:

(a) Membership or Clinical Privileges at any hospital or health care institution including ambulatory surgery centers; and/or;

(b) Membership/fellowship in any local, state or national professional organization(s);

(c) Specialty board certification;

(d) License to practice any profession in any jurisdiction including entry into consent orders and reprimands not specifically designated as private;

(e) Federal and State Drug Enforcement Administration and CDS registration; and

(f) Medicare, Medicaid or other federal program participation.

6.3.1.6 Signed agreement by the applicant that the applicant will refrain from admitting, or providing services at the Hospital to Medicare or Medicaid patients, in the event the applicant is suspended or excluded from the Medicare or Medicaid program.

6.3.1.7 Agreement by the applicant to cooperate with the Hospital in complying with technical and substantive requirements of third party payors, pursuing appeals or reconsideration of denial of reimbursement, and in all other dealings with third party payors.

6.3.1.8 Professional Liability Information. All particulars regarding medical malpractice claims ever filed against the applicant, any adverse and/or pending malpractice decisions or settlements, and any cancellation, non-renewal, or limitation of malpractice insurance coverage including the name of the carrier, the policy number and the amount of professional liability insurance carried by the Practitioner, which shall be not less than the minimum amount of coverage required by law or these Bylaws. Written evidence of the existence of such professional liability insurance coverage shall be submitted to the Hospital, together with the application for appointment or reappointment to the Medical Staff. The application shall include a consent for release of information by the applicant's present and past professional liability insurance carriers, and a statement from the applicant's present carrier that, if permitted under the policy terms, ten (10) days prior notice will be given to the Medical Staff Administration before the applicant's policy is canceled, modified, or not renewed.

6.3.1.9 Criminal Proceedings. Information as to whether the applicant has ever been convicted of or pled guilty or no

contest to any felony or indictable crime or submitted a plea of guilty or no contest to any felony or indictable crime relating to controlled substances, illegal drugs, insurance fraud or abuse or violence and/or whether the applicant has been indicted or arrested and the matter is unresolved.

6.3.1.10 Suspension or Exclusion Information. regarding whether the applicant has been suspended or excluded from state or federal healthcare reimbursement programs including, without limitation, Medicare and/or Medicaid and applicant's current New Jersey Medicaid enrollment number and current enrollment or opt out status in the Medicare program.

6.3.1.11 Contact information. Home and office address, mobile phone number, pager number, and email address.

6.3.1.12 Miscellaneous Information: Such other information relating to evaluation of the applicant's professional qualifications, ethical character and professional conduct, current competence, and prior professional experience, including utilization of Hospital resources, as may be deemed necessary.

6.3.1.13 Identification. A government issued photo identification document and a reproducible digital image of the Practitioner.

6.3.1.14 Notification of Release and Immunity Statement. Such releases, waivers, and authorizations as are presented to the applicant by the Medical Staff Administration. These will include a statement signed by the applicant authorizing and allowing Medical Staff and Hospital representatives to provide other hospitals, health care institutions, medical associations, licensing boards, and other organizations concerned with provider performance and the quality and efficiency of patient care with any relevant information the Hospital or Medical Staff may have concerning the applicant. This statement will also release from liability the Hospital, its Medical Staff, and their representatives for sharing with appropriate health care, accrediting and licensing entities information concerning the professional competence, ethics, and other qualifications of the applicant for Staff appointment and Privileges, both during the time of

appointment and reappointment and at any time thereafter while on Staff including information otherwise privileged or confidential, to the full extent permitted by New Jersey law.

6.3.1.15 Health Status. A statement that no mental or physical health problems exist that could affect the applicant's ability to perform the Privileges requested, along with evidence of required health testing and evidence of mandatory vaccinations as defined by the Medical Staff.

6.3.1.16 Professional Liability Insurance. Evidence of current professional liability insurance as required in these Bylaws in limits no less than the amount mandated by applicable law or by these Bylaws.

6.3.1.17 Covering Practitioner(s). Name and contact information of covering Practitioner(s).

6.3.1.18 Pledge. The following statement shall be contained in the application for Medical Staff membership, and shall be separately executed by each applicant:

(a) As a condition of my appointment and my subsequent reappointment to the Medical Staff, I hereby pledge to comply with the professional standards of the medical profession and I hereby agree to:

(i) Refrain from fee splitting or other inducements relating to patient referrals;

(ii) Provide for continuous care of all patients, any portion of whose care for which I am responsible, while at this Hospital;

(iii) Provide for such care without regard to race, religion, creed, or ability to pay;

(iv) Delegate, in my absence, the responsibility for diagnosis or care of my patients only to a Practitioner who is qualified to undertake this responsibility, or who is adequately supervised, in accordance with these Bylaws;

(v) Seek consultation whenever I deem it to be necessary and in accordance with generally accepted standards of patient care;

(vi) Refrain from providing "ghost" surgical or medical services;

(vii) Abide by the Bylaws of the Medical Staff and of the Hospital, and all Rules and Regulations and policies applicable to members of the Medical Staff including without limitation the Medical Staff Citizenship and Code of Conduct Policy and Hospital Compliance Code of Conduct;

(viii) Refrain from engaging in gender based discrimination or sexual harassment of other Staff members or employees of the Hospital;

(ix) Not discriminate on the basis of age, sex, nationality, sexual or affectional orientation, ancestry, marital status, familial status, disability, ability to pay, race, creed, color, national origin or religion against any patients, other Staff members and Hospital employees; and

(x) Immediately self-report to the Service Chief, President or CMO and forthwith seek treatment should I become impaired or unable to care for my patients.

6.4 Processing the Application

6.4.1 Applicant's Burden. The applicant shall have the burden of providing adequate information for evaluation of the applicant's experience, background, training and ability and mental and physician health. The applicant is required to provide information resolving any conflicts, time gaps or confusion in the applicant's record. The applicant shall have the burden of providing evidence that all statements made are, and information given is, accurate.

6.4.2 Delivery of Application. The applicant will deliver a completed and unaltered application to Medical Staff Administration. An application shall be complete when all questions have been answered, all documentation supplied, and all information verified, including the need for new or clarifying information. An application

will not be processed if it is altered and/or until it is deemed complete by Medical Staff Administration. Any application which remains incomplete thirty (30) days after the applicant has been notified of the deficiency shall be deemed withdrawn.

6.4.3 Communication and Process. Medical Staff Administration will endeavor to communicate absences, deficiencies or concerns regarding the application in a timely manner to the applicant. Delays in the process described below will not be a sufficient reason to bypass elements of the application process. The process will occur in the specific order described below, except for such deviations as may be approved by the President. At any point in the process, the reviewing authority, in order to request or obtain additional information, may defer the application. In addition, any reviewing authority may, at their discretion, refer the application back to the immediately preceding authority, Medical Staff Administration or the applicant.

6.4.4 Verification. Medical Staff Administration shall verify, using primary source documentation, in writing, all licenses, certifications, education, background, malpractice history and coverage and all elements of the applicant's work history. Medical Administration shall query the National Practitioner Data Bank for the applicant's profile. Medical Staff Administration shall verify that the applicant is the same person identified in the credentialing document by viewing a current picture, Hospital I.D. card and/or valid picture I.D. issued by a state or federal entity. Medical Staff Administration may also query any local, regional, national or international organization, previous or current employer, any hospital or health care entity where the applicant had previously applied for and/or had been granted Clinical Privileges, educational entities, certifying Boards and other persons and entities, as is deemed prudent in order to complete a comprehensive screening and evaluation of elements in the applicant's application.

6.4.5 Service and Division Chief Action. Upon Medical Staff Administration's processing of a complete application including primary source verification, the application and supporting documents, as well as the requested Privilege Delineation form, will be reviewed by the appropriate Service and Division Chiefs and/or their designees who: may request additional information from the applicant or elsewhere as needed to carry out his/her evaluation of the applicant, shall conduct a personal interview with the applicant within thirty (30) days of receipt of a complete application whenever possible, and who shall transmit to the President a written report and recommendation as to Staff appointment and, if

appointment is recommended, as to Staff category, Service, Division, Clinical Privileges to be granted, and any special conditions to be attached to the appointment. The applicable Chief may also recommend to the President that the MEC defer action on the application. In the event that the Chief has a conflict with respect to an applicant, he/she shall defer making a recommendation to the President. The reason for each recommendation shall be stated in writing and supported by reference to the completed application and all other documentation considered by the Chief, all of which shall be transmitted with the report.

6.4.6 MEC Action

6.4.6.1 After review by the Service and/or Division Chief, the application, along with such Chief's recommendation(s) will be forwarded to the President. The President or designee will personally interview the applicant within thirty (30) days and review all elements of the application as noted above. Based on the standards of the Medical Staff as specified in these Bylaws the President shall recommend in writing, the application for appointment in the requested Staff Category, recommend appointment with modifications, and/or recommend rejection of the application. The President may also recommend that the MEC defer action on the application.

6.4.6.2 Applications, which have received recommendations, will be presented to the MEC. The MEC will review the application as presented and shall issue a recommendation that is objective, evidenced based and supported by reference to the application and all other documentation considered. The MEC shall recommend to the Board in writing, regarding appointment and/or Clinical Privileges and shall recommend whether the applicant's request should be accepted, accepted with modification or rejected. The MEC may table the application pending a request for further information.

6.4.7 Board Action

6.4.7.1 Subject to the provisions of Section 6.4.7.3 below for recommendations adverse to an applicant, at its next meeting after receipt of the report and recommendation of the MEC regarding an application for membership and/or Clinical Privileges, the Board shall consider and act on such recommendations. If the Board decides to

defer action on the application pending further consideration by the MEC, or if the Board does not accept the recommendation of the MEC, it shall refer the application back to the MEC for further consideration, subject to the requirement that a final recommendation be provided to the Board by the MEC within ninety (90) days. At the meeting next following the receipt of the report of the MEC, the Board shall render its final decision regarding the application provided that it has sufficient time, in it discretion, to review the report.

6.4.7.2 If the Board accepts a favorable MEC recommendation it shall act to grant the requested membership and/or Clinical Privileges.

6.4.7.3 If the recommendation of the MEC is adverse to the applicant, as defined under these Bylaws, the Board shall postpone its final decision on the applicant, pending the applicant's decision to utilize or waive procedural rights. If an eligible applicant waives his or her right to a fair hearing and appellate review, the Board will then determine its final decision on the request for membership and/or Clinical Privileges. If an eligible applicant requests a fair hearing pursuant to Article XIV of these Bylaws, the Board will make a determination on the applicant's request following a final recommendation from the MEC, which takes into consideration the findings of the Hearing Committee. Where the applicant further requests an appellate review by the Board, its final determination will result from the decision made by the review Panel.

6.4.8 Notice of Final Decision

6.4.8.1 Notice of the Board's final decision shall be given in writing through the CEO or his designee, to the applicant within thirty (30) days after the Board acts.

6.4.8.2 Notice shall include the Staff Category, Service, and Clinical Privileges the applicant is granted as well as the duration of the appointment.

6.4.8.3 If an applicant is denied an initial, reappointed or continued membership and/or Clinical Privileges after waiver or conclusion of the appeals process, he/she shall not be eligible to reapply for membership and/or such

denied Clinical Privileges for two (2) years as set forth in these Bylaws.

6.5 The Reappointment Application

6.5.1 Process. Although the reappointment process uses information available from the original application, in order to promote efficiency, a Practitioner who is reapplying may not bypass the requirement to provide complete information and supporting documents. In addition, a Practitioner applying for reappointment must evidence the same standard of excellence applied to initial appointments and be in good standing with the Medical Staff and Hospital. When not self-evident or contained in these Bylaws, Rules and Regulations or any applicable Hospital or Medical Staff policy, "good standing" will be defined by a majority vote of the MEC.

6.5.2 Notification of Reappointment. The Medical Staff shall endeavor to notify each Staff member of the need to apply for reappointment three (3) months before the expiration of the Practitioner's Clinical Privileges. However, the responsibility to present a timely reappointment application will be the Practitioner's and failure to present an application will be deemed a voluntary withdrawal from the Medical Staff without right of appeal, to take effect upon expiration of the prior period of appointment.

6.5.3 Reappointment Application. Medical Staff Administration shall provide to each member of the Medical Staff a Reappointment Application. The reappointment application shall include at a minimum, the information and documentation required of new applicants to the Medical Staff as set forth in Section 6.2 and 6.3 of the Bylaws.

6.5.4 Applicant's Burden. The applicant's burden in reappointment shall mirror the applicant's burden in the initial appointment process.

6.5.5 Verification. Medical Staff Administration shall verify the information presented in the reappointment application using primary source documentation, in writing, all new or renewed New Jersey licenses, certifications, malpractice history and coverage and all new elements of the applicant's work history. Medical Administration shall query the National Practitioner Data Bank. Medical Staff Administration may also query any person or entity as is deemed prudent in order to complete a comprehensive screening and evaluation of elements in the applicant's application, including the New Jersey Division of Consumer Affairs Health Care Professional Clearing House.

6.5.6 Service and Division Chief Action. The completed reappointment application and all supporting documents will be forwarded to the Service and/or Division Chief as appropriate for review and recommendation. One or more of the Chiefs may, at his/her discretion, interview the Practitioner. After review, the Chief(s) will forward in writing a recommendation regarding reappointment and, if reappointment is recommended, as to Staff category, Service, Division, Clinical Privileges to be granted and any special conditions to be attached to the reappointment. The applicable Chief may also recommend to the President that the MEC defer action on the reapplication. The reason for each recommendation shall be stated in writing and supported by reference to the completed application and all other documentation considered by the Chief, all of which shall be transmitted with the report.

6.5.7 MEC Action

6.5.7.1 The MEC shall process the reappointment application in the same manner as for an initial appointment.

6.5.7.2 he MEC may at its discretion require the President to interview the Practitioner and/or may table the re-application pending a request for further information.

6.6 Board Action. The Board shall take such action as is described in Sections 6.4.7 – 6.4.8.

6.7 Leave of Absence

6.7.1 Leave Process. Medical Staff members must request a leave of absence for any anticipated absence from the Hospital that exceeds six (6) months. The request for leave must be in writing addressed to the President in advance of the anticipated leave and must state the reason for the leave and the time of the leave. In an emergency situation, leaves may be granted by the President effective upon notice by the Member, subject to later review and recommendation by the MEC and final approval by the Board. The leave must not exceed one (1) year, although the MEC, for extraordinary circumstances, may grant an additional extension of up to one (1) year. The request for leave, after review and recommendation by the MEC, shall be transmitted for final approval to the Hospital Board. Except in the case of an emergency, a request for leave of absence shall not be considered until all obligations to the Hospital have been met, including completion of all medical records, payment of any outstanding dues, and fulfillment of any Emergency Department or other call obligations.

6.7.2 Leave Reporting. Medical Staff Administration shall notify the New Jersey State Board of Medical Examiners, the Medical Practitioner Review Panel and/or the National Practitioner Data Bank, if and as required, of leaves granted and, of termination of the leave and return to regular Medical Staff membership, if/as applicable.

6.7.3 Termination of Leave

6.7.3.1 A Staff member may request reinstatement of Privileges by submitting a written notice, to that effect, to the President for transmittal to the MEC. The Staff member shall submit a written summary of relevant activities during the leave along with supporting documentation if so requested by the Service Chief or MEC. The MEC may recommend reinstatement subject to the final decision of the Board. The Practitioner may be subject to Focused Professional Practice Evaluation upon his/her return, depending upon the circumstances.

6.7.3.2 If the requested return date is past the time for the member's reappointment, he or she must submit a reapplication form and be reappointed by the Board before resuming his or her Staff position and Privileges.

6.7.3.3 Failure, without good cause, to request reinstatement or to provide a requested summary of activities and supporting documents if requested, shall be deemed a voluntary resignation from the Staff and shall result in automatic termination of Staff membership. A request for Staff membership subsequently received from a Staff member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

6.7.3.4 A leave of absence will not impact or interfere with any adverse action or recommendation made with respect to the Medical Staff Member requesting the leave.

6.8 Resignation from Medical Staff. A Practitioner who does not desire to remain a member of the Medical Staff may voluntarily resign at any time and shall be required to complete outstanding medical records and other outstanding Medical Staff responsibilities and to arrange for the care and treatment of his/her patients in the hospital prior to such voluntary resignation taking effect. Such a request must be submitted in writing to the Medical Staff President and must state the effective date of the resignation. If a Medical Staff Member does not apply for reappointment at the end of a regular period

of appointment, this will be deemed a voluntary resignation. If a Practitioner submits a request for resignation while a review of the Practitioner's conduct or patient care at the Hospital is ongoing, the Medical Staff will report this request to the New Jersey State Board of Medical Examiners and/or National Practitioner Data Bank, to the extent required. Such a resignation from the Medical Staff will be deemed "non-voluntary." A Practitioner who has resigned from the Medical Staff and who wishes to rejoin the Medical Staff must apply as per the procedures for initial appointment. The MEC and Board will be notified of the Practitioner's resignation.

6.9 Confidentiality of Medical Staff Credentials File

6.9.1 The Credentials File (hereinafter "File") of each Practitioner is confidential. No unauthorized access of the File will be permitted. Authorized access to such File may be permitted under the procedures stated in this Section 6.9.

6.9.2 Each File shall be maintained by Medical Staff Administration in a place and manner that reasonably prevents unauthorized access to the File. The office containing the Files shall be locked when not occupied. Electronic files shall be password protected to prevent unauthorized access.

6.9.3 Access to each File shall be afforded to the following duly elected and appointed officers or committees of the Medical Staff in the exercise of the responsibilities of their positions: MEC, President, CMO, Treasurer of the Medical Staff and the Chiefs of Services/Divisions in which the Practitioner has been granted or is applying for Clinical Privileges and to such committees as may be investigating or reviewing the Practitioner including, without limitation, a duly constituted investigative or Fair Hearing committee.

6.9.4 Access to a File may be granted to individuals or committees not listed above when it is jointly determined, by the President and the CMO, that such access is necessary to comply with State and/or Federal laws, regulatory requirements and/or accrediting standards, or with the performance improvement program, peer review processes, and/or privileging and credentialing processes and/or for the Practitioner's or another person's health or safety and/or policies of the Hospital or Medical Staff.

6.9.5 A Practitioner, or a designated representative of the Practitioner, may view the Practitioner's File, redacted of peer review materials, upon written request made to the Medical Staff Administration with

sufficient notice to allow for a Medical Staff Administration member to be present during the review process.

6.9.6 Copying of any portion of the File will be performed by the Medical Staff Administration which will ensure that the File is not altered or modified in any way or that items are not added to or removed from the File. Review by a Practitioner of the Practitioner's own File shall be witnessed in the same manner. Normal and customary costs for this service will be charged to the requesting party.

6.9.7 The provisions of this Section 6.9 are subject to the Hospital's obligations under State and Federal laws regarding the reporting and confidentiality of certain peer review actions and activities of the Hospital regarding an individual Practitioner.

ARTICLE VII - DETERMINATION OF CLINICAL PRIVILEGES

7.1 Exercise of Clinical Privileges. Practitioners providing clinical services at this Hospital by virtue of Medical Staff membership or otherwise shall be entitled to exercise only those Clinical Privileges or specified services specifically authorized by the Board. These Privileges and services must be within the scope of the license, certificate or other legal credential authorizing the Practitioner to practice in New Jersey and consistent with any restrictions thereon. A Medical Staff member with admitting Privileges may only admit patients to his or her service or to the service of another Practitioner with such Practitioner's consent.

7.2 Delineation of Clinical Privileges in General

7.2.1 Each application for appointment and reappointment to the Medical Staff must contain a request for the specific Clinical Privileges as determined by Staff category desired by the applicant.

7.2.2 A request for an expansion of previously granted Clinical Privileges must be made in writing to Medical Staff Administration and be supported by documentation of training and/or experience supportive of the request.

7.2.3 Privilege requests will not be processed where the applicant does not meet the eligibility requirements.

7.2.4 Basis for Privileges Determination

7.2.4.1 Requests for Clinical Privileges shall be evaluated on the basis of the Practitioner's education, training, experience, demonstrated clinical competence and ability, judgment, and the recommendations of the member's professional

peers. The basis for Clinical Privileges determinations made in connection with periodic reappointment or otherwise shall include observed clinical performance and the documented results of the patient care audit and other quality review, evaluation and monitoring activities to be conducted at the Hospital.

7.2.4.2 Each Service is delegated the authority to promulgate rules and regulations governing the exercise of Clinical Privileges in such Service. The recommendation for Clinical Privileges shall be made in accordance with the guidelines set forth in the respective Service's Rules and Regulations as hereinafter appended, if any, and these Bylaws, and shall also be based on pertinent information concerning clinical performance obtained from other sources, including other institutions and health care settings where a Practitioner exercised Clinical Privileges.

7.2.4.3 Clinical Privileges delineation forms and criteria within each Service shall be reviewed no less than bi-annually.

7.2.5 Procedure

7.2.5.1 All requests for Clinical Privileges shall be processed pursuant to the procedures outlined in these Bylaws.

7.2.5.2 Requests for Privileges will not be processed where the Board has made a determination that the Hospital will not support or authorize the exercise of a particular privilege for any Practitioner at the Hospital where the privilege requested is covered by an exclusive contract granted by the Board and the requesting Practitioner is not a party to the contract or provider under the contract; or where the requesting Practitioner does not meet the eligibility requirements to request or exercise a privilege as described in the Hospital's Delineation of Privileges documents.

7.2.5.3 In the event a Practitioner requests a Clinical Privilege for which the Hospital has not adopted criteria (e.g., for a new technology or procedure), the request may be tabled for a reasonable period of time, usually not in excess of ninety (90) calendar days. During this time the appropriate Service and Division will review the request and make a recommendation to the MEC of the patient

care need, resources (such as space and equipment) and other requirements that must be met before such Clinical Privileges may be exercised safely at the Hospital. The MEC and Board will review the recommendation and the community, patient, and Hospital need for the Clinical Privilege and determine if the institution can make available the necessary resources to adequately support the exercise of that privilege. The MEC will research appropriate eligibility criteria for the safe and effective exercise of the requested privilege and establish, with the approval of the Board, the necessary education, training, experience, and evidence of current competence that will be required to request and be granted the privilege. Once these steps are taken, a request for the Clinical Privilege will be evaluated.

7.3 Clinical Privileges of Dentists

7.3.1 Privileges Granted To Dentists. Privileges granted to Dentists shall be based upon their training, experience and demonstrated competence and judgment. Surgical procedures performed by Dentists shall be under the overall supervision of the Chief of Dentistry or the Chief's designee. Dentists shall not have the privilege to admit patients and shall be limited to the practice of dentistry.

7.3.2 Basis for Privileges Determination. Patients admitted for dental care shall be given the same medical appraisal as patients admitted for surgical services. There shall be a dual responsibility of the Dentist and medical Physician, each limited to his/her respective field, with the Dentist having responsibility for the dental, and the medical Physician having responsibility for the medical, aspects of the patient's care.

7.4 Clinical Privileges of Podiatrists

7.4.1 Privileges Granted To Podiatrist. Privileges granted to Podiatrists shall be based upon their training, experience and demonstrated competence and judgment. Podiatrists shall not have the privilege to admit patients and shall be limited to the practice of podiatry.

7.4.2 Procedures Performed By Podiatrists. All procedures performed by Podiatrists shall be under the supervision of the Chief of the Surgery Service or the Chief's designee.

7.5 Special Conditions for Allied Health Professionals

7.5.1 Requests for the provision of specified patient care services by AHPs shall be processed in the manner specified for Medical Staff members as set forth in these Bylaws An AHP, subject to any licensure requirements or other legal limitations, may exercise independent judgment within the areas of the AHP's professional competence, and may participate directly in the medical management of patients only under the supervision of or collaboration with a Physician who has been accorded Clinical Privileges to provide such care and who has, and shall continue to exercise, ultimate responsibility for the patient's care.

7.5.2 AHPs may admit to the service of a member of the Active Staff and provide care under the supervision or direction of a Physician member of the Medical Staff. AHPs may issue orders in accordance with New Jersey law and the Hospital and Medical Staff Rules and Regulations and policies, but not beyond the scope of an AHP's license, certificate or other legal credentials.

7.6 Temporary, Disaster and Emergency Privileges

7.6.1 Temporary Privileges – Circumstances

7.6.1.1 Upon written request from the appropriate Service Chief and with the approval of, the President or CMO in the absence of the President, the CEO, or designee acting on behalf of the Board, may grant Temporary Privileges in the following circumstances:

(a) Urgent Patient Care Need. Upon receipt of a written request for specific Temporary Privileges, and after making such inquiries as may be required by law, an appropriately licensed Practitioner of documented expertise who is not an applicant for membership may be granted Temporary Privileges to meet an important, urgent patient care, treatment or service need for the care of one or more specific patients for a period not to exceed one hundred twenty (120) days; or

(b) Pendency of Application. After the President's receipt and approval of a verified, complete application for Staff appointment, which has been approved by the Chief that raises no concerns, including a request for specific Privileges, an appropriately licensed applicant may be granted Temporary Privileges for a period not to exceed one

hundred twenty (120) days. In exercising such Privileges, the applicant shall act under the supervision of the Chief of the Service; or

(c) Special expertise such as proctoring. Upon receipt of a written request for specific Temporary Privileges, and after making such inquiries as may be required by law, an appropriately licensed Practitioner of documented expertise who is not an applicant for membership may be granted Temporary Privileges. Special expertise needs include, but are not limited to, the applicant's furnishing of special expertise, support or proctoring to a Practitioner. Such Privileges shall be restricted to a time period of no more than thirty (30) days in any one year by any Practitioner;

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

(i) Current, unrestricted licensure;

(ii) Relevant training and experience;

(iii) Current competence;

(iv) Ability to perform the Privileges requested;

(v) A query and evaluation of the NPDB report;

(vi) A complete application;

(vii) No current or previously successful challenge to licensure or registration;

(viii) Not subject to involuntary termination of medical staff membership at this or any other hospital or healthcare institution;

(ix) Professional Liability insurance;

(x) For Practitioner's requesting Temporary Privileges pursuant to (b) above, professional references that meet the requirements of Section 6.3.1.4;

(xi) Not subject to involuntary limitation, reduction, denial or loss of Clinical Privileges at this or any other hospital or healthcare institution; and

(xii) Unrestricted Federal DEA and New Jersey CDS license if applicable.

7.6.1.2 Temporary Privileges – Granting. Temporary Privileges shall be granted only when the information available reasonably supports a favorable determination regarding the requesting Practitioner's qualifications, ability and judgment to exercise the Privileges requested and current licensure and competence are verified and only after the Practitioner has satisfied the requirements of these Bylaws regarding professional liability insurance. Special requirements of consultation and reporting may be imposed by the Chief of the Service responsible for supervision of a Practitioner granted Temporary Privileges. Before Temporary Privileges are granted, the Practitioner must acknowledge in writing that the Practitioner has received, or been given access to the Medical Staff Bylaws, Rules and Regulations and that the Practitioner agrees to be bound by the terms thereof and the Hospital Bylaws, Rules and Regulations, and policies, in all matters relating to the Practitioner's Temporary Privileges and the Practitioner's activities at the Hospital, and that the Practitioner consents to the submission, investigation, and verification of information concerning the Practitioner's qualifications and experience and to the authorization and releases set forth in the Medical Staff Bylaws.

7.6.1.3 Temporary Privileges – Termination. On the discovery of any information or the occurrence of any event of a nature that raises question about a Practitioner's professional qualifications or competence to exercise any or all of the Temporary Privileges granted, the CMO or the President may, after consultation with the Service Chief responsible for supervision, terminate any or all of such Practitioner's Temporary Privileges, provided that, where the life or well-being of a patient is determined to be endangered by continued treatment by the Practitioner, the termination may be effected forthwith by any person entitled to impose precautionary suspensions under these Bylaws. In the event of any such

termination, the Practitioner's patients then in the Hospital shall be assigned to another Practitioner by the Service Chief responsible for supervision. The wishes of the patient shall be considered, where feasible, in choosing a substitute Practitioner.

7.6.1.4 Temporary Privileges - Rights of the Practitioner. A Practitioner who is refused Temporary Privileges or who has Temporary Privileges terminated or suspended, whether in whole or in part, shall not be entitled to any of the procedural rights afforded under these Bylaws unless such termination or suspension was based on a determination of demonstrated incompetence or unprofessional conduct.

7.6.2 Disaster Privileges

7.6.2.1 Disaster Privileges – Circumstances. In an officially declared local, state or national emergency or disaster, after the Hospital's emergency management plan has been implemented and activated, and the Hospital is unable to meet immediate patient care needs, the President, CMO or the CEO or their designees have the option to grant disaster Privileges to volunteer Practitioners to assist the members of the Medical Staff.

7.6.2.2 Disaster Privileges – Conditions. Disaster Privileges shall be granted only:

(a) After the volunteer Practitioner has completed a Disaster Privileges form and signed a statement attesting that the information provided on such form is accurate;

(b) The information available reasonably supports a favorable determination regarding the volunteer Practitioner's qualifications (including licensure or certification in the State of New Jersey), ability and judgment to exercise the Privileges requested; and

(c) The volunteer Practitioner has acknowledged in writing that he/she has received, or been given access to the Medical Staff Bylaws and Rules and Regulations and that the Practitioner agrees to be bound by the terms thereof and the Hospital Bylaws, Rules and Regulations, and policies of the Hospital and Medical Staff.

7.6.2.3 Eligibility for Disaster Privileges. Licensed Independent Practitioners may be granted disaster Privileges upon demonstration of a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:

(a) A current Hospital photo identification card that clearly identifies professional designation;

(b) A current medical license;

(c) Primary source verification of the license;

(d) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) or other recognized state or federal organization or group;

(e) Identification indicating that the Physician has been granted authority to render patient care, treatment and services in disaster circumstances (such authority having been granted by a federal, state or municipal entity); or

(f) Confirmation by a Licensed Independent Practitioner currently privileged by the Hospital or by a Staff member with personal knowledge of the volunteer Practitioner's ability to act as a licensed independent Practitioner during a disaster.

7.6.2.4 Identification. Practitioners granted Disaster Privileges shall be identified with a Hospital identification tag.

7.6.2.5 Oversight of Professional Performance of Practitioner Granted Disaster Privileges. The professional performance of those Practitioners who have been granted Disaster Privileges shall be supervised by a member of the Medical Staff by direct observation, retrospective chart review or mentoring.

7.6.2.6 Verification of Credentials. As soon as the disaster is under control, Medical Staff Administration shall verify the credentials, including primary source verification of licensure, of those volunteer Practitioners who are not

members of the Medical Staff who have been granted Disaster Privileges. Such verification shall be completed within seventy-two (72) hours from when the volunteer Licensed Independent Practitioner presents to the organization. The President, CMO, CEO or their designees shall make a decision, based on the information obtained regarding the professional practice of the volunteer Licensed Independent Practitioner, within seventy-two (72) hours from when the volunteer Licensed Independent Practitioner presents to the Division, related to the continuation of the Disaster Privileges initially granted.

7.6.2.7 Termination of Disaster Privileges. When the emergency management plan has been deactivated and patients placed under the care of a member of the Medical Staff, Disaster Privileges will automatically terminate or on the discovery of any information or the occurrence of any event of a nature which raises question about a volunteer Practitioner's professional qualifications or competence to exercise any or all of the Disaster Privileges granted, the President, CMO or the CEO may terminate any or all of such volunteer Practitioner's Disaster Privileges, provided that, where the life or well-being of a patient is determined to be endangered by continued treatment by the Practitioner, the termination may be effected immediately by any person entitled to impose precautionary suspensions under these Bylaws. In the event of any such termination, the volunteer Practitioner's patients then in the Hospital shall be assigned to another Practitioner by the Service Chief responsible for supervision. Otherwise, any grant of Disaster Privileges shall terminate when an emergency situation no longer exists.

7.6.2.8 Disaster Privileges - Rights of the Practitioner. A Practitioner who is refused Disaster Privileges shall not be entitled to any of the procedural rights afforded under these Bylaws.

7.6.3 Emergency Privileges (Not Disaster) for Medical Staff Members.

7.6.3.1 In case of an emergency, any Medical Staff member attending a patient shall be expected and permitted to do everything in his/her power and to the degree permitted by his or her license and training, to save the life of the

patient or prevent significant and disabling morbidity regardless of the member's Medical Staff status, Service affiliation or Privileges. This duty shall be subject to the Medical Staff member's concurrent duty to take into account or abide by a patient's directive under the New Jersey law to withhold or withdraw life-sustaining procedures, or to take into account and abide by the requirements of sound medical practice. For purposes of this Section, an emergency is defined as a condition or set of circumstances in which any delay in administering treatment would increase the danger to the patient's life or the danger of serious harm. When such an emergency situation no longer exists, the patient shall be assigned to an appropriate member of the Medical Staff who holds Privileges appropriate to address the patient's medical conditions.

7.7 Telemedicine Privileges

7.7.1 All Licensed Independent Practitioners who are responsible for the care, treatment, and services of a patient via telemedicine link must be credentialed and privileged to do so at the Hospital and will be assigned to a specific Service.

7.7.1.1 The Licensed Independent Practitioner is privileged at the distant site for those services to be provided at the Hospital.

7.7.1.2 The Hospital has evidence of an internal review of the Licensed Independent Practitioner's performance of these Privileges and sends to the distant site information that is useful to assess the quality of care, treatment and services for use in privileging and performance improvement.

7.7.1.3 At a minimum, this information shall include all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services provided, and complaints about the Licensed Independent Practitioners from patients, other Practitioners and Medical Staff Members.

7.7.1.4 The Hospital's Medical Staff may use a copy of the distant site's credential packet for privileging purposes 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 ; (iii) the distant site provides the Hospital with a current list of licensed independent Practitioners' Privileges; (iv) 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; and (v) an attestation signed by the distant site indicating that the packet is complete, accurate, and up to date.

7.7.1.5 The Hospital shall provide to the distant site, information that is useful to access the Licensed Independent Practitioner's quality of care, treatment, and services for use in privileging and performance improvement which includes, at a minimum, all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that results from the telemedicine services provided and complaints about the distant site's Licensed Independent Practitioner from patients, licensed independent Practitioners, or Staff at the originating site.

7.8 Physical Examination and Medical History

7.8.1 Each patient shall receive a medical history and physical examination no more than thirty (30) days prior to, or within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services, except in an extreme emergency.

7.8.2 For a medical history and physical examination that was completed within thirty (30) days prior to registration or inpatient admission, an update documenting any changes in the patient's condition is completed within twenty-four (24) hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. The update includes confirmation that the history was reviewed and the patient was examined with documentation of any changes or the absence of changes.

7.8.3 This history and physical must be completed and documented by an attending Physician or designee if credentialed to do so through the Medical Staff processes and within the limitations contained in State law and as set forth in these Bylaws and applicable Hospital and Medical Staff polices and Rules and Regulations.

7.8.4 The minimum contents of the history and physical examination are set forth in applicable Hospital and Medical Staff polices and Rules and Regulations.

7.8.5 The Medical Staff shall monitor the quality of medical histories and physicals.

7.9 Ongoing Professional Practice Evaluation ("OPPE")

7.9.1 Each member of the Medical Staff shall be subject to an Ongoing Professional Practice Evaluation in accordance with policies adopted by the MEC.

7.9.2 The Ongoing Professional Practice Evaluation shall not be considered an adverse professional action and does not entitle the member to a hearing and appellate review in accordance with these Bylaws.

7.10 Focused Professional Practice Evaluation ("FPPE")

7.10.1 A period of Focused Professional Practice Evaluation shall be implemented in accordance with the policies adopted by the MEC for all initially requested Clinical Privileges during a Practitioner's initial observation period and where the Practitioner has requested a new Clinical Privilege where there is no documented evidence of the Practitioner having performed competently the Clinical Privilege at the Hospital.

7.10.2 The Division Chief, Service Chief, President, CMO and/or MEC may also prescribe a period of Focused Professional Practice Evaluation in accordance with its policies, to monitor a Practitioner's performance when issues affecting the provision of safe, high quality patient care are identified. Reports of such FPPE shall be supplied to the MEC.

7.10.3 The FPPE shall not be considered an adverse professional action and does not entitle the member to a hearing and appellate review in accordance with these Bylaws.

7.10.4 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 this Section and in the applicable Medical Staff policies and Rules and Regulations.

ARTICLE VIII - OFFICERS OF THE MEDICAL STAFF

8.1 The Officers of the Medical Staff shall be:

8.1.1 President of the Medical Staff;

8.1.2 Chief Medical Officer;

8.1.3 Secretary of the Medical Staff, which such position may be vacant in the discretion of the MEC;

8.1.4 Treasurer of the Medical Staff; and

8.1.5 Immediate past President.

8.2 Additional Responsibilities of the Officers

8.2.1 The Officers will meet on a regular basis to prepare the MEC agenda, advise the MEC and Medical Staff; prepare/review materials for MEC meetings and meet with stakeholders at the invitation of the President. This core leadership group will further the goals of the Medical Staff by encouraging an open and collegial environment. Persons other than Officers shall not be permitted to attend unless invited.

8.3 Qualifications of Officers

8.3.1 Officers must be Physician members in good standing of the Active Medical Staff at all times and meet the following additional qualifications:

8.3.1.1 The President shall have served as an At-large member of the MEC for at least two (2) years;

8.3.1.2 The Secretary and Treasurer shall have served on the MEC for at least one (1) year;

8.3.1.3 Disclose to Medical Staff Administration any actions pending before or taken by the State Board of Medical Examiners;

8.3.1.4 Be willing to discharge faithfully the duties and responsibilities of the position;

8.3.1.5 Not serve as, a member of a MEC, Medical Staff Officer, or department/Division Chief in another hospital except for a hospital owned or controlled by Hospital or under common control with Hospital;

8.3.1.6 Be in compliance with any and all policies of the Medical Staff and Hospital regarding Conflicts of Interest;

8.3.1.7 Candidates for President shall have been a member of the Medical Staff in good standing for no less than five (5) years, have served as an At-large member of the MEC for at least two (2) years, and shall not be a full-time employee or contractor of the Medical School;

8.3.1.8 The MEC may waive any of the foregoing qualifications in the event that there are no candidates for Office who meet the requirements contained herein.

8.4 Appointment and Election of Officers

8.4.1 Chief Medical Officer. The CEO shall appoint the CMO.

8.4.2 President.

8.4.2.1 The President shall be elected by the Active Staff at the final general Medical Staff meeting every three (3) years.

8.4.2.2 Nominations for President shall be submitted to the Medical Staff no less than ten (10) days before the day of the meeting. Each nomination must be supported by no less than ten (10) signatures of current Active Staff members. Election requires a majority vote of those Active Staff present and voting. In the absence of a majority, a second ballot shall be cast including two (2) candidates receiving the largest number of votes. Any Active Staff member who knows at least two (2) days before the meeting that he/she shall be unavailable at the time of election may submit an absentee ballot to Medical Staff Administration prior to the date of the election.

8.4.2.3 Unless uncontested, the President shall be elected using a secret ballot which will be distributed to members of the Active Staff at a general Medical Staff meeting. The mechanics of distributing ballots and counting votes will be determined by the MEC in consultation with the Director of the Medical Staff Administration. The winner of an election shall be the individual who receives the majority of votes from Active Medical Staff members who voted. Voting by proxy is not permitted.

8.4.3 Secretary/Treasurer. The Secretary and Treasurer of the Medical Staff shall be elected by a vote of the MEC from among the elected

representatives of the MEC. In the event of a tie, the President shall decide.

8.4.4 Immediate Past President. The Immediate Past President of the Medical Staff shall automatically serve in such capacity for a term coterminous with his or her successor. In the event the Immediate Past President is unable to serve, the position shall be vacant and shall not be filled by his/her predecessor.

8.5 Term of Office

8.5.1 The CMO shall serve at the discretion of the CEO.

8.5.2 The President shall serve for three (3) years and may be re-elected for one (1) three (3) year term. With the expected service time total of six (6) years, the candidate can be elected to a single third non-sequential term after sitting out for at least one (1) year prior to re-election.

8.5.3 The terms of office of the Secretary and Treasurer shall be for two (2) years subject to re-election without limit.

8.5.4 Elected officers will take office on the first day of the calendar year following the election.

8.6 Removal of Elected Officers

8.6.1 A recall election of an Officer may be held, for cause, if requested through a signed, written petition of not less than one hundred (100) members of the Active Staff.

8.6.2 Notwithstanding the recall rights described above, the MEC may remove the Secretary and/or Treasurerand/or call a recall election of the Active Staff to remove an Officer.

8.6.3 In the event of a recall election pursuant to Section 8.6.2 above, Officers may be removed by a majority vote of the Active Staff present at any special meeting called pursuant to Section 9.8.3 provided that a quorum of at least a majority of the Active Staff is present at such meeting.

8.6.4 No vote of the Active Staff shall be taken unless the MEC and the effected Officer have been given a copy of the petition, including a statement of the reasons supporting removal. Special Notice by the MEC shall be provided at least two (2) weeks prior to the date of the meeting at which the Staff will consider the removal of the Officer.

The effected Officer may address the Staff concerning his or her removal prior to the vote.

8.7 Vacancies

8.7.1 Vacancies in the office of the President shall be filled by the MEC at a regular or special meeting chaired by the CMO. The CMO shall assume the duties of the President until the vacancy is filled by the MEC. The Practitioner elected by the MEC shall serve until a special meeting of the Active Staff can be held in which his successor can be elected for the balance of the term of his/her predecessor.

8.7.2 Vacancies in the office of the Secretary and/or Treasurer shall be filled by appointment of the MEC for the balance of the unoccupied term. Notwithstanding the foregoing, the MEC may leave the office of Secretary vacant.

8.7.3 Service as an Officer filing any vacancy shall not be counted towards any term limit.

8.7.4 Automatic removal will occur (without need for a vote) in the event any of the following effects the Officer in question:

8.7.4.1 Loss or suspension of the Officer's medical license in the State of New Jersey; or

8.7.4.2 Loss or suspension (other than routine medical records suspension) of the Officer's Clinical Privileges at Hospital; or

8.7.4.3 Failure to meet the qualifications contained in Section 8.3.

8.8 Duties of Officers

8.8.1 Chief Medical Officer.

8.8.1.1 To serve as ex-officio member, with vote, on all Medical Staff committees including the MEC.

8.8.1.2 To oversee and reinforce Medical Staff Bylaws, Medical Staff Rules and Regulations, Hospital Staff policies and Procedures and Rules and Regulations of Service Divisions.

8.8.1.3 To administer the policies of the Board and report to the Board on the performance, maintenance and quality of

medical care with respect to the Medical Staff's delegation of responsibility to provide medical care.

8.8.1.4 To monitor the fulfillment of all aspects of the Affiliation Agreement between the Hospital and the Medical School pertaining to professional medical activities.

8.8.1.5 To add items to the agendas of the MEC and the general Medical Staff meetings without veto by President.

8.8.1.6 To jointly appoint with the President, the Chairs and Co-Chairs and other members of all Medical Staff Committees except for the MEC. In the event the President and CMO do not agree upon such appointment, the MEC, by a majority vote, shall select applicable Chairs, Co-Chairs and/or members of the Medical Staff Committees.

8.8.1.7 To fulfill the duties of the President in the President's absence.

8.8.2 President:

8.8.2.1 To act as Chairman of the MEC.

8.8.2.2 To call and to chair all general meetings of the Medical Staff, and be responsible for the preparation of an agenda for all such meetings.

8.8.2.3 To be responsible for the preparation of an agenda for the MEC.

8.8.2.4 To represent the Medical Staff to the Hospital Board, the CEO and the CMO.

8.8.2.5 To serve as ex-officio member, with vote, on all Medical Staff Committees.

8.8.2.6 To jointly appoint with the CMO, the Chairs and Co-Chairs and other members of all Medical Staff Committees except for the MEC. In the event the President and CMO do not agree upon such appointment, the MEC, by a majority vote, shall select the applicable Chairs, Co-Chairs and/or members of the Medical Staff Committees.

8.8.2.7 In the absence of the CMO, to assume all duties and have the authority of the CMO only with respect to the CMO's

duties in connection with operations of the MEC and the Professional Affairs Committee.

8.8.2.8 To represent the Medical Staff at the Hospital annual meeting.

8.8.2.9 To periodically consult with Hospital Board regarding Medical Staff functions and quality of medical care provided to patients of the Hospital.

8.8.2.10 The President shall receive an annual stipend from the Medical Staff; which amount is subject to approval by the MEC.

8.8.3 Secretary and Treasurer of the Medical Staff.

8.8.3.1 The Secretary and Treasurer shall attend regular meetings of the Medical Staff Officers as set by the President and, under the order of the President, undertake such other duties as would ordinarily pertain to the Office.

8.8.3.2 The Treasurer shall take responsibility for the financial records of the Medical Staff and for other duties under the order of the President, as may be required.

ARTICLE IX - MEDICAL STAFF COMMITTEES AND MEDICAL STAFF MEETINGS

9.1 Medical Executive Committee. The MEC shall be comprised of Practitioners who utilize the institution and who shall be members of the Medical Staff in good standing. The majority of voting MEC members shall be fully licensed Physician members of the Medical Staff actively practicing at the Hospital. The President shall serve as Chairman of the MEC. The CMO shall chair the MEC in the absence of the President.

9.2 Composition

9.2.1 Voting members of the MEC shall include:

9.2.1.1 The President;

9.2.1.2 The CMO;

9.2.1.3 Ten (10) At-Large members of the Medical Staff elected pursuant to the provisions of Section 9.2.3; and

9.2.1.4 Service Chiefs and/or Institute Directors including Medicine, Emergency Medicine, Anesthesiology, Family

Medicine, Dental, Neurology, Obstetrics/Gynecology, Ophthalmology, Pathology, Pediatrics, Psychiatry, Radiation Oncology, Radiology, Dermatology and Surgery and the Institute Director of CINJ. Additional Service Chiefs shall be added to the MEC as new Services are added to the Hospital.

9.2.2 The CEO, the Dean of the Medical School, one (1) Senior Resident chosen by the Dean, the Vice President of Quality and Patient Safety, the Chief Nursing Officer and one (1) At-Large member of the Medical Staff appointed by the President and CMO shall serve as ex-officio members of the MEC without vote. In the event the President and CMO do not agree upon such appointment, the MEC, by a majority vote, shall select the At-Large member of the Medical Staff to serve without vote.

9.2.3 In order to provide representation in approximate proportion to the active membership distribution of the Medical Staff, the ten (10) elected At-Large representatives shall be distributed and elected as follows:

(a) Four (4) Physicians from private practice;

(b) Two (2) Physicians from faculty practice;

(c) Three (3) Physicians from either private or faculty practice;

(d) One (1) AHP;

(e) No more than four (4) At-Large Physicians may be from any single Service; and

(f) Service and Division Chiefs shall not be eligible to serve as At Large Members of the MEC.

9.2.4 At-Large Physician members may be nominated only by members of the Active Staff. The Allied Health Professional At-Large member may be nominated only by Allied Health Professionals.

9.2.5 All Active Staff are eligible to vote for At Large Members including the AHP At-Large member. Allied Health Professionals may vote for the AHP At-Large member only.

9.2.6 Each Service Chief and Institute member of the MEC may appoint a dedicated representative from his/her Service to attend and vote for meetings in his or her absence as required by providing Notice to

Medical Staff Administration. At Large Members may not have representatives attend the MEC in their place.

9.3 Election of At-Large MEC Members

9.3.1 Election of the At-Large Members will take place at the final general Medical Staff Meeting of each calendar year.

9.3.2 The signatures of at least ten (10) members of the Active Medical Staff must support nominations for At-Large Physician Members. The signatures of at least ten (10) AHP's must support nominations of the Allied Health Professional At-Large member. The nominating petition shall be submitted to Medical Staff Administration no later than ten (10) business days before the date of the meeting.

9.3.3 The nominees with the highest number of votes shall be members. In event of a tie, a second ballot will be cast.

9.3.4 If there are insufficient candidates to fill the At-large positions, vacancies shall be filled by the President subject to approval by the MEC. Each member of the MEC will have one (1) vote.

9.3.5 The MEC will provide for a fair election process on site and will provide absentee ballots.

9.4 Term of Service

9.4.1 The term of service of At-Large MEC members shall be for a period of two (2) years subject to re-election.

9.4.2 At-Large members will take office on the first day of the calendar year following the election.

9.4.3 Members of the MEC will automatically and immediately be ineligible to remain a MEC member if removed from their position as an Officer, unless remaining as an At-Large member or Service Chief and/or Institute Director, as described elsewhere in these Bylaws or if such member of the MEC resigns from the Medical Staff. At-Large members of the MEC may further be removed by an affirmative vote of a majority of the MEC membership. Grounds to be considered include, but are not limited to:

9.4.3.1 Failure to attend at least fifty (50%) percent of MEC meetings in each calendar year except excused for good cause;

9.4.3.2 Disruptive conduct at MEC meetings; or

9.4.3.3 Failure to carry out assigned duties as an MEC member.

9.4.4 Members of the MEC will be considered to have voluntarily resigned from the MEC if any of the following occur:

9.4.4.1 Termination or suspension of the member's license to practice in the state of New Jersey;

9.4.4.2 Loss of qualifications to be on the Medical Staff;

9.4.4.3 Loss of membership on the Active category of the Medical Staff or, in the case of the AHP member, loss of Allied Health Professional membership/duties;

9.4.4.4 Suspension or termination of Clinical Privileges; or

9.4.4.5 Election or appointment as an officer, MEC member or department/service chief or equivalent at another hospital outside of RWJ Somerset.

9.5 MEC Duties and Responsibilities

9.5.1 The duties of the MEC shall include but not be limited to the following:

9.5.1.1 Provide oversight to and support the provision of, the quality of medical care at the Hospital;

9.5.1.2 Receive and act upon reports and recommendations of services, committees, and offices of the Staff concerning quality review, evaluation and monitoring functions and the discharge of delegated administrative responsibilities and recommend to the Board specific programs and systems to implement these functions;

9.5.1.3 Coordinate the activities of and policies adopted by the Staff, Services and Committees;

9.5.1.4 Report to the Board and to the Medical Staff regarding the overall quality and efficiency of patient care in the Hospital;

9.5.1.5 Supervise and assure professional and ethical conduct of the Medical Staff and competent clinical performance on the part of Staff members, including, but not limited to, initiating investigations and initiating and pursuing corrective action/peer review, when warranted; and

9.5.1.6 Oversee the activities related to the self-governance of the Medical Staff and to the improvement of professional services provided by individuals with Clinical Privileges.

9.5.2 MEC functions

9.5.2.1 The MEC shall provide for the monitoring of Medical Staff functions as required in these Bylaws:

(a) Conduct, coordinate and review patient care monitoring and performance improvement activities;

(b) Conduct, coordinate, review and oversee the conduct of utilization management;

(c) Make recommendations to the Board concerning individuals applying for Medical Staff membership and reappointment and regarding delineated Clinical Privileges, renewed and changes to such Clinical Privileges for each eligible individual privileged through the Medical Staff;

(d) Review and evaluate the qualifications of each Allied Health Professional applying to perform specified services, and in connection therewith to obtain and consider the recommendations of the appropriate Service;

(e) Investigate, review and report on matters, including the clinical or ethical conduct of any Practitioner;

(f) Monitor and evaluate care provided to and develop clinical policy to show quality of care within the Hospital;

(g) Adopt credentialing and privileging criteria and delineation of privilege forms based on recommendation of Service and Division representatives;

(h) Provide continuing education drive for performance improvement activities state-of-the-art developments and other perceived needs;

(i) Assure completeness and timeliness of patient medical records and support information and technology efforts;

(j) Assist the Hospital in planning for disaster preparedness;

(k) Direct Staff organization activities;

(l) Coordinate Medical Staff activities with nursing Service and other Divisions of the Hospital;

(m) Assist the Hospital and the Medical School in the review and approval of ongoing monitoring of Hospital- based research;

(n) Oversee corrective action and fair hearing processes as set forth in these Bylaws;

(o) Formulate, adopt and recommend to the Hospital and/or Medical Staff, Bylaws, Rules and Regulations, policies and amendments thereto, in accordance with the Bylaws;

(p) Assure continuing medical education of the Medical Staff; and develop, plan and participate in continuing medical education, evaluate the need for continuing medical education, act upon continuing medical education needs of the Medical Staff or other committees, and maintain a record of education activities;

(q) Assure completeness, accuracy, timeliness, legibility and clinical pertinence of patient medical records, as created by members of the Medical Staff including reviewing Medical Staff and Hospital policies and medical regulations related to medical records, monitor and enforce timeliness in medical records including discipline for incomplete or delinquent medical records; and

(r) Oversee pharmacy and therapeutic functions, develop and maintain surveillance over drug utilization policies and practice and pharmacy and therapeutic drug utilization policies in order to assist in broad professional policies, advise the Medical Staff on Hospital pharmacy pertaining to

utilization of drugs and medications, make recommendations regarding the supply of drugs within the Hospital Services, establishing standards for use and control of investigative drugs, periodically review a formulary or drug list for use in the Hospital and maintain a record of all activities related to pharmacy and therapeutic functions in order to coordinate with the Medical Staff and Hospital Services; and

(s) Utilization Management and Quality Function:

(i) Maintain a utilization plan appropriate to the Hospital and as required by law,

(ii) Maintain, support and supervise the utilization management plan, and

(iii) Supervise and evaluate such findings and recommendations, as delineated by the utilization management plan; and

(t) Infection Prevention Function:

(i) Oversee and maintain surveillance over the Hospital infection prevention program; and

(ii) Act upon recommendations related to infection prevention received from the CMO, the Services and other Staff and Hospital committees.

9.5.3 MEC Meetings. The MEC shall meet at least ten (10) times per year and shall maintain a permanent record of its proceedings and actions which shall be reported, as appropriate, to the Board.

9.6 Other Medical Staff Committees

9.6.1 Establishment of Medical Staff Committees

9.6.1.1 Medical Staff Committees shall be established by the MEC to perform one or more Staff functions or as determined by MEC.

9.6.1.2 Medical Staff Committees shall be comprised of members of the Medical Staff and others in the hospital community

as appropriate, and will be chaired by a member of the Medical Staff.

9.6.1.3 The CMO and the President shall jointly appoint the chair and co-chair of each committee, if applicable. The CMO, the President and the Chairman of that committee shall jointly appoint the other Medical Staff members of the committee. In the event the President and CMO do not agree upon such appointment, the MEC, by a majority vote, shall select the applicable Chairs, Co-Chairs and/or members of the Medical Staff committees.

9.6.1.4 The CMO, President, and CEO or designee shall serve as ex officio members, with vote, on all committees.

9.7 Reporting Requirements of Committees

9.7.1 All standing and special committees shall be responsible to the MEC.

9.7.2 Whenever these Bylaws require that a function be performed by, or that a report or recommendation be submitted to:

9.7.2.1 A named Medical Staff Committee where no such committee exists, the MEC shall perform such function or receive such report or recommendation or shall assign the functions of such committee to a new or existing committee of the Staff or to the Staff as a whole; or

9.7.2.2 The MEC, if a standing or special committee has been formed to perform the function: the committee so formed shall act in accordance with the authority delegated to it.

9.8 General Medical Staff Meetings

9.8.1 There shall be no less than two (2) general meetings of the entire Medical Staff in each year. While there are no requirements for attendance, Medical Staff members are strongly encouraged to attend Medical Staff meetings.

9.8.2 Notice of time, date and place of these meetings shall be provided to all Medical Staff members not less than ten (10) days prior to the date fixed for each meeting. The meeting can transact any business that may come before it.

9.8.3 The agenda of business at the meetings shall be determined by the President after an Officers meeting.

9.8.4 Special meetings of the Medical Staff may be called by the President, the MEC, the Board, the CMO or by no less than ten (10%) percent the Active Staff filing a written petition with the President. The time and place of Special Meetings shall be determined by the President. No business shall be transacted at a special meeting except as stated in the meeting notice.

9.9 Quorum

9.9.1 General Medical Staff meetings. The presence of one hundred (100) members of the Active Staff at any regular or special meeting shall constitute a quorum.

9.9.2 MEC Meetings. A quorum for MEC meetings shall consist of at least fifty (50%) percent of the current voting membership of the MEC in attendance in person or by designated alternate. Service, Division and other Committee Meetings. Unless set forth to the contrary in the Rules and Regulations of a Service or Division, forty (40%) percent of the voting members of a Service, Division or Committee, but not less than two (2) members, shall constitute a quorum.

9.9.6 Once a quorum is present at a meeting, the failure to maintain a quorum throughout the meeting shall not inhibit any subsequent action from being taken at that meeting.

9.9.7 The President may declare, after two (2) consecutive meetings of either the MEC or general Medical Staff without a quorum, the creation of a special quorum of not less than twenty (20%) percent of the voting members at subsequent meeting(s) if, at such meeting a standard quorum is not present. Special quorum meetings will have the same effect as standard meetings. This special status will be immediately dissolved if a standard quorum occurs.

9.10 Manner of Action. Except as otherwise specified, the action of a simple majority of the members present and voting at a meeting at which a quorum is present shall constitute the action of the group. Each member of the Active Staff is entitled to one (1) vote on matters to be voted on by the general Medical Staff. All voting shall take place in person unless there is an emergency or other urgent situation which makes such in person voting impracticable as determined by the President or the MEC.

9.11 Minutes and Records. The Minutes of all meetings at which a vote occurs, shall be prepared and shall include the record of and the vote taken on each matter. Copies of such minutes shall be signed by the recording Member, forwarded to Medical Staff Administration and shall be available to the Members of the Medical Staff unless these Bylaws or state or federal law

require anything to the contrary. A permanent file of the Minutes of each meeting shall be maintained by Medical Staff Administration.

9.12 Meeting Attendance Requirements

9.12.1 Regular Attendance. Each member of the Active Staff shall be required to:

9.12.1.1 Comply with the attendance requirements of the Service and Division assigned;

9.12.1.2 Attend at least fifty (50%) percent of all meetings of the committees of which that Practitioner is a member, except for good cause; and

9.12.1.3 With respect to business and educational meetings of the Department to which a Practitioner is assigned, a Practitioner shall not miss more than four (4) consecutive meetings except as excused for good cause.

9.13 Absence from Meetings. Any member who is compelled to be absent from any Staff, Committee or Service meeting shall promptly provide to the Chair or regularly presiding Officer the reason for such absence.

9.14 Special Appearance. A Practitioner whose patient's clinical course of treatment is scheduled for discussion at a Service, Division or other meeting must be so notified. Failure of a Practitioner to appear after being given Special Notice thereof, at any two (2) consecutive meetings with respect to such patient's clinical course of treatment shall, unless excused by the President or the Service Chief upon a showing of good cause, result in disciplinary action being taken pursuant to these Bylaws.

9.15 Robert's Rules. Meetings will be organized consistent with the spirit, traditions and protocol of Robert's Rules of Order newly revised 10th Edition or as modified as set by President.

9.16 Medical Staff Dues

9.16.1 The Officers of the MEC in consultation with the Director of Medical Staff Administration shall have the power to set the amount of the application fee and the dues for each category of Staff membership.

9.16.2 Unless excused by the MEC from the obligation to pay dues or fees, each member of the Staff shall be obligated to pay such fees as a condition of his/her continued membership on the Staff.

9.16.3 For initial appointments, the failure to pay such dues within a period of ninety (90) days from the date of appointment shall be grounds for suspension from the Staff, and from the exercise of Clinical Privileges or specified services.

9.16.4 For reapplication, dues payment must accompany the Medical Staff Reappointment Application and failure to remit payment will deem the reappointment application incomplete. Reappointment to the Staff will not be processed until such payment is received.

9.16.5 Members of the Staff or Allied Health Professionals who are suspended because of the foregoing shall not be entitled to any of the procedural rights afforded in these Bylaws.

ARTICLE X - CONFIDENTIALITY, IMMUNITY AND RELEASES

10.1 Special Definitions. For purposes of this Article, the following definitions shall apply:

10.1.1 Information means record of proceedings, minutes, records, reports, memoranda, statements, recommendations, data and other disclosures whether in written or oral form relating to any of the subject matter specified in these Bylaws.

10.1.2 Malice means the intentional doing of a wrongful act without justification or excuse.

10.1.3 Representative means the Board, any individual member of the Board, or any committee of the Board, the CEO or the CEO's designees, any member of the administrative staff, the Medical Staff, the MEC, and any member or officer thereof, the CMO, any Service, Division or Staff committee, and any individual authorized by any of the foregoing to perform specific information gathering or disseminating functions.

10.1.4 Third parties means both individuals and organizations providing information to any representative.

10.2 Authorization and Release

10.2.1 Each Practitioner and Allied Health Professional shall execute general and specific releases and provide documents when requested by the President, MEC, the CEO or CMO or their respective designees in order to evaluate a Practitioner's credentials or quality of care. Failure to execute such releases or provide requested documentation shall result in an application for appointment, reappointment, and/or Clinical Privileges being deemed voluntarily

withdrawn, and it shall not be further processed. By submitting an application for Medical Staff appointment or reappointment, or by applying for or exercising Privileges or providing specified patient care services within the Hospital, all Practitioners, without limitation:

10.2.1.1 Authorize representatives of the Hospital and of the Medical Staff to solicit, procure, provide, and/or act upon information bearing on or reasonably believed to bear upon the practitioner's professional abilities and qualifications;

10.2.1.2 Agree to be bound by the provisions of the Hospital and Medical Staff Bylaws, Rules and Regulations and policies regardless of whether membership or Clinical Privileges are granted or subsequently restricted;

10.2.1.3 Acknowledge that the provisions of this Article are express conditions to an application for, or acceptance of, staff membership, and the continuation of such membership and/or the exercise of Clinical Privileges or provision of specified patient care services at the Hospital;

10.2.1.4 Agree not to sue and to release from legal liability and hold harmless Hospital, its affiliates, its Medical Staff, and any representative of the Hospital or Medical Staff who acts to carry out Medical Staff or Hospital policies or functions, including all persons engaged in credentialing, peer review, and performance improvement activities and authorizes and consents to the Hospital and Medical Staff representatives and their designees providing other hospitals, medical associations and other health care providers where the Practitioner seeks or exercises Clinical Privileges, payers and insurance companies, potential employers and other organizations concerned with provider performance and the quality and efficiency of patient care with any information relevant to such matters that the Hospital and Medical Staff and their designees may have concerning the Practitioner, whether in an oral or written form. In addition, all Practitioners agree that their sole remedy for any credentialing, corrective action or peer review action taken or recommended by the MEC for failure to comply with or meet the requirements of these Bylaws or Medical Staff policies, will be the right to seek injunctive relief, but only

after they have exhausted the administrative remedies in these Bylaws;

10.2.1.5 Agree not to sue and to release from legal liability and hold harmless any individual who or entity which provides information (including peer review information) regarding the Practitioner to the Hospital, the Medical Staff or its representatives, including otherwise privileged or confidential information, and consent to and direct the production of information related to the Practitioner, whether in a written or oral form;

10.2.1.6 Agree to consent to evaluation related to the Practitioner's mental or physical status and/or for drug and/or alcohol testing when requested by the MEC, the President or CMO because of a suspicion of improper use of a restricted or illegal substance and/or impairment of ability to safely care for patients. Practitioner agree that a failure to consent to such evaluation or testing may be considered an immediate voluntary resignation of membership and relinquishment of Clinical Privileges;

10.2.1.7 Authorize the Hospital and its designees to consult with and query the New Jersey Division of Consumer Affairs Health Care Professional Information Clearing House for the purpose of evaluating the Practitioner for hiring, continued employment or continued Clinical Privileges and otherwise in connection with the application and exercise of Clinical Privileges;

10.2.1.8 Certify, if the Practitioners utilize an electronic signature for Medical Staff medical record keeping purposes, the that the unique password and PIN required for documents to be signed electronically have been in the sole possession of the signing Practitioner, and acknowledge that unauthorized use or misuse of this password or PIN may result in disciplinary procedures up to and including loss of Clinical Privileges; and

10.2.1.9 Credentialed through the Medical Staff processes as described in these Bylaws and such Practitioner are subject to supervision or collaboration as described in these or Hospital Bylaws, Rules and Regulations, and/or policies and/or as required by law, and such Practitioners agree that the appropriate Medical Staff

Committee, Medical Staff Administration and/or the CEO or designee may discuss any Practitioner's application and reappointment application and/or any concerns regarding such Practitioner with the Practitioner's collaborating or supervising Attending Physician.

10.3 Confidentiality. Information with respect to any Practitioner submitted, collected or prepared by any representative of this or any other health care institution or organization or Medical Staff, for the purpose of evaluating and improving quality patient care, reducing morbidity or mortality, promoting efficiency, or contributing to medical education or clinical research, shall, to the fullest extent permitted by law and the policies of the Hospital and Medical Staff, be confidential. Confidential information shall not be disseminated to anyone other than a representative(s) of the Hospital or of the Medical Staff with a legitimate need for access in order to carry out required functions or third party health care entities performing legitimate credentialing and peer review activities. Such confidentiality shall also extend to information of like kind that may be provided by third parties.

10.4 Immunity from Liability

10.4.1 For Actions Taken. Representatives of the Hospital and the Medical Staff shall have absolute release from any and all liability in any judicial proceeding for damages or other relief for any action taken or statement or recommendation made within the scope of their duties as such representatives and, which were undertaken in good faith.

10.4.2 Providing Information. Representatives of the Hospital, the Medical Staff and any third party shall have absolute release from any and all liability in any judicial proceeding for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative of the Hospital or of the Medical Staff or to any other hospital, organization or health professionals, or other health-related organizations, concerning Practitioners who are or have been an applicant to or member of the Staff or who did or does exercise Clinical Privileges or provide specified services at this Hospital.

10.5 Activities and Information Covered

10.5.1 Activities

10.5.1.1 The provisions of this Article shall apply to acts, communications, reports, evaluations, recommendations, or disclosures in connection with this or any other

health-related institution's or organization's activities concerning, but not limited to:

10.5.1.2 Applications for appointment, Clinical Privileges or specified services;

10.5.1.3 Periodic appraisals for reappointment, Clinical Privileges, or specified services;

10.5.1.4 Disciplinary measures, including warnings and reprimands;

10.5.1.5 Corrective actions/peer review;

10.5.1.6 Hearings and appellate reviews;

10.5.1.7 Performance improvement activities including the creation and dissemination of performance profiles;

10.5.1.8 Peer review activities, including external peer review;

10.5.1.9 Utilization and claims reviews; and/or

10.5.1.10 Other Hospital or committee activities related to monitoring and maintaining of quality patient care and appropriate professional conduct.

10.5.2 Information The acts, communications, reports, letters, evaluations, performance data, disclosures and other information referred to in this Article may relate to a Practitioner's professional qualifications, clinical or procedural abilities, judgment, character, physical and mental health, emotional stability, professional ethics, professional conduct or any other matter that might directly or indirectly affect patient care and/or the effective and efficient operation of the Hospital and Medical Staff.

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

ARTICLE XI - ADOPTION AND REVISION OF BYLAWS

11.1 Initiation of Review or Revision Process

11.1.1 The Board, CEO, President, CMO, MEC or Bylaws Committee may recommend revisions to the Staff Bylaws. Should there be no revisions recommended within the calendar year, the President will

have the Bylaws of the Staff reviewed no less than annually, or as necessary.

11.1.2 Amendments to these Bylaws may also be proposed by any member of the Active Staff upon written request to the President.

11.1.3 Recommendations to revise the Bylaws will be referred by the President to the Bylaws Committee, which will consider such recommendations and provide the MEC with its advice regarding the adoption of same. Thereafter, the initially recommended revision or revisions, together with the report and advice of the Bylaws Committee, shall be presented to the MEC for its consideration and approval. The MEC may consider proposed recommendations notwithstanding the lack of a recommendation by the Bylaws Committee when the Bylaws Committee has failed to report on a timely basis. The MEC shall vote on proposed amendments at a regular meeting, or at a special meeting called for such purpose.

11.1.4 Following an affirmative vote by the MEC, all members of the Active Staff shall receive a description of the proposed amendment(s) by email. At least thirty (30) days following this dissemination of the description of the proposed amendment(s), all Active Staff will be permitted to vote on the proposed amendment(s). This vote may be conducted via printed or electronic ballot in a manner determined by the MEC. Ballots not returned will be considered abstentions which will be counted towards quorum requirements. To be adopted, the proposed amendment(s) must be affirmed by a majority of the members of the Active Staff and the Board must subsequently ratify the amendment.

11.1.5 If the MEC does not vote affirmatively to present a proposed amendment for vote by the Medical Staff, individuals supporting the amendment can nevertheless request such a vote by presenting the President with a supportive petition signed by ten (10%) percent of the Active Staff. Upon receiving such a petition, the President will proceed to arrange a vote by the entire Active Medical Staff following the procedures above for an amendment proposal voted on affirmatively by the MEC.

11.1.6 Amendments to these Bylaws may also be proposed directly to the Board upon a petition of ten (10%) percent of the members of the Active Staff. Any proposed Bylaws amendments made by petition shall also be submitted to the MEC for review and comment.

11.1.7 No revision to these Staff Bylaws shall become effective unless and until approved by the Board. Failure of the Board to act on any revision of the Bylaws within one hundred eighty (180) days of submission of the amendment to the Board shall be deemed an adoption of such amendment.

11.1.8 Neither the Staff nor the Board may unilaterally amend these Bylaws.

11.2 Urgent Amendments. In the event there is a documented need for an urgent amendment to the Bylaws, Rules and Regulations, policies, or manuals or the documented need to adopt a new Bylaws provision, Rule and Regulation or policy to comply with a law or regulatory requirement, the MEC may provisionally adopt, and the Board may provisionally approve, an urgent amendment to the Bylaws, Rules and Regulations and/or policy 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 MEC any comments regarding the provisional amendment. Upon petition signed by one hundred and fifty (150) 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 MEC, the voting members of the Medical Staff and the Board. Any repeal or revision of a provisional amendment shall be subject to approval by the Board.

11.3 Technical and Legal Changes to Medical Staff Documents

11.3.1 Adoption of Amendments. The MEC may adopt such amendments to Medical Staff Bylaws, manuals, Rules and Regulations, and policies that are, in the MEC's judgment, technical or legal modifications or clarifications, consist of reorganization or renumbering of material, or are needed due to punctuation, spelling, or other errors of grammar or expression. Such amendments must be ratified by the Board.

11.4 Successor in Interest. These Bylaws and Clinical Privileges of Practitioners under these Bylaws are binding on the Medical Staff and the Board of any successor in interest of the Hospital, except where Medical Staffs are being combined.

11.5 Equally Binding. These Bylaws shall, when approved by the Board, be equally binding upon the Hospital and the Medical Staff and/or, as applicable, binding upon Allied Health Professionals.

11.6 Medical Staff Rules and Regulations

11.6.1 Subject to approval by the Board, the MEC shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found in these Bylaws and the policies and Procedures of the Hospital. These shall relate to the proper conduct of Medical Staff organizational activities as well as the quality of practice and the standards of performance required of each Practitioner. Such Rules and Regulations shall constitute a supplement to these Bylaws, and shall be binding on all members of the Medical Staff, and all persons exercising Clinical Privileges or specified services at the Hospital. The Rules and Regulations may be amended or repealed at any regular meeting of the MEC at which a quorum is present and without previous notice, or at any special meeting on notice, by a two thirds (2/3) vote of those present and eligible to vote. Such changes shall become effective when approved by the Board.

11.6.2 Neither the Board nor the MEC may unilaterally amend the Rules and Regulations.

ARTICLE XII - DESIGNATION OF CLINICAL SERVICES AND DIVISIONS

12.1 Organization of Services and Divisions

12.1.1 Each Service shall be organized as a separate part of the Medical Staff and shall have a Chief who is selected and has the authority, duties and responsibilities as specified below.

12.1.2 Each Division shall be organized as a specialty unit within a Service and shall be directly responsible to the Service within which it functions, and shall have a Chief who is selected and has the authority, duties and responsibilities as specified below.

12.1.3 The designation of Services and Divisions shall be set forth in the Schedule attached to these Bylaws.

12.1.4 Members of the Staff shall be assigned to one or more Services and may also be assigned to one or more Divisions to which such Practitioner is qualified to serve.

12.1.5 The exercise of Privileges and specified functions within each Service and Division shall be in accordance with these Bylaws and subsequent authority of the respective Chiefs.

12.1.6 Each Division must meet at least annually. Each Service and shall meet at the discretion of the applicable Chief or as set forth in Section 12.1.7 below.

12.1.7 Meetings of the Service or Division may be called by the applicable Chief, the President, CMO, the MEC or upon the presentation of a petition signed by no less than ten (10%) percent of the voting members of a Service or Division.

12.2 Primary Responsibility of Services/Divisions

12.2.1 The primary responsibility of each Service and Division is to optimize the quality and efficiency of the delivery of patient care provided by members of such Service. To carry out this responsibility, each Service and Division shall:

12.2.1.1 Review patient care on a regular basis; recommend to the MEC such rules and regulations as is appropriate for the proper management of the Service or Division including those related to the assignment of service call, the granting of Clinical Privileges and the performance of specified functions within each Service or Division;

12.2.1.2 Conduct and participate in review of evaluation of monitoring activities and recommend and implement continuing education programs;

12.2.1.3 Monitor adherence to Medical Staff Bylaws, Medical Staff Rules and Regulations, Hospital policies and Procedures, and rules and regulations of the appropriate Service and its Divisions;

12.2.1.4 Monitor on a continuing basis, adherence to sound principles of clinical practice;

12.2.1.5 Monitor on a continuing basis measures of quality;

12.2.1.6 Coordinate the patient care provided by the Service/Division members within the multi-disciplinary services of the Hospital;

12.2.1.7 Hold regular meetings and maintain minutes of meetings, provide to Medical Staff Administration for distribution to MEC;

12.2.1.8 Establish such committees or other mechanisms that are necessary and desirable to properly perform the functions assigned to it; and

12.2.1.9 Monitor and maintain adequate clinical coverage for ongoing inpatient and outpatient care in each Service's and Division's specialty.

12.2.2 Functions of Services and Divisions

12.2.2.1 Each Service and Division shall upon approval of the MEC and Board perform the functions assigned to it by the appropriate Service Chief. Such functions may include, without limitation, retrospective patient review, the continuous monitoring of patient care, outreach, research, and education practice, credentials review and Clinical Privileges delineation, and continuing medical education programs all with the primary goal of maintaining quality patient care.

12.2.2.2 Any rules and regulations proposed by a Service or Division shall be consistent with the Bylaws and MAA and shall be submitted through the Service Chief to the MEC and the Board for approval, and when adopted, such rules and regulations shall be incorporated within that Service's or Division's Rules and Regulations. Notwithstanding the foregoing, proposed Division rules and regulations shall be also be provided to the Service Chief for comment.

12.3 Qualifications of Chiefs

12.3.1 Each Chief shall be a member of the Active Staff who shall be qualified by training, experience, interest and demonstrated current ability in the clinical area of his Service or Division and be board certified in at least one (1) clinical area within the Service and, if serving as the Chief of a Division, be board certified in the appropriate sub-specialty, shall perform his/her primary hospital service at RWJUH and shall be willing and able to discharge the administrative responsibilities of the Chief's office. Each Chief shall devote a major portion of the Chief's time to functions of that Service.

12.3.2 Chiefs may not serve as a member of a MEC or chair a service or division or equivalent in another hospital except for a hospital owned or controlled by Hospital or under common control with Hospital.

12.3.3 Chiefs must meet the qualifications contained in the Affiliation Agreement.

12.4 Selection and Removal of Service and Division Chiefs

12.4.1 Each Service and Division Chief, except for the Service Chief of Dental Services who is appointed by the Board, shall be selected and removed pursuant to the Affiliation Agreement.

12.4.2 The Service Chief of Dental Services shall serve at the will and pleasure of the Board.

12.4.3 An interim Service Chief may serve for up to one (1) year if such Chief does not meet the qualifications described in 12.3 above.

12.5 Responsibilities of Service and Division Chiefs

12.5.1 Responsible for the quality of medical care in the Chief's Service or Division, as well as continuous assessment of quality improvement;

12.5.2 Responsible for the appropriate and efficient utilization of Hospital facilities by Service or Division members;

12.5.3 Responsible for the development, regular annual review and updating the rules and regulations for the Service or Division;

12.5.4 Responsible for teaching programs of all students at all levels of the Chief's Service or Division;

12.5.5 Enforce all Hospital and Medical Staff Bylaws, Medical Staff Rules and Regulations, Hospital policies and Procedures and Rules and Regulations of the Chief's Service or Division;

12.5.6 Implement all actions and policies adopted by the MEC, as they apply to the Service or Division;

12.5.7 Transmit to the MEC recommendations from the Chief's Service or Division concerning Clinical Privileges;

12.5.8 Participate in every phase of administration of the Chief's Service or Division and cooperate in all matters affecting patient care, outreach, research and education;

12.5.9 Assist in preparation of annual reports including budgetary and budgetary planning which the MEC may require;

12.5.10 Perform other duties, which may be required by the Service or Division and may be required by the MEC;

12.5.11 Participate in the determination of the qualifications and competence of Allied Health Professionals;

12.5.12 Responsible for continuing education of all persons on the Chief's Service or Division;

12.5.13 Recommend the sufficient number of qualified and competent persons to provide quality care, outreach, research and education in the Service or Division;

12.5.14 Responsible for continuing surveillance of the professional performance of all individuals on the Service or Division;

12.5.15 Regularly review and update Delineation of Privilege forms;

12.5.16 Institute and review OPPE's and FPPE's; and

12.5.17 Responsible to fulfill such duties as are set forth in the Affiliation Agreement.

ARTICLE XIII - Disciplinary, Investigation and Fair Hearing Process

13.1 Collegial Intervention. It is the policy of the Medical Staff to work collegially with its members to assist them in delivering safe and good quality medical care, to continually improve their clinical skills, to comply with Medical Staff and Hospital policies, and to meet all performance expectations as established from time to time by the Medical Staff and Hospital. Medical Staff policies, including those on peer review, performance improvement, professional conduct, and Physician health and impairment describe some of the collegial interventions available to Medical Staff leaders. The provisions of these Bylaws describe the steps that the Medical Staff and Hospital will undertake when collegial efforts fail or are insufficient to protect the well-being of patients, Staff, and colleagues. While collegial intervention is encouraged, it is not mandatory and shall be within the discretion of Medical Staff leadership.

13.2 Investigations

13.2.1 Criteria for Initiation

13.2.1.1 Any person or committee may provide information to any member of the MEC, Service or Division Chief, Officer of the Medical Staff or CMO about the conduct, performance, or competence of Medical Staff members when reliable information indicates a member may have made or exhibited acts, statements, demeanor, or conduct, either within or outside of the Hospital, and is reasonably likely to be:

(a) Detrimental to patient safety, the delivery of quality patient care, research, the stewardship of resources or brings into question the professional competence of the Practitioner;

(b) Unethical or illegal;

(c) Contrary to the Medical Staff Bylaws, Hospital or Medical Staff rules, regulations, and/or policies;

(d) Harassing or intimidating to Staff, colleagues, patients or their families;

(e) Disruptive of Hospital or Medical Staff operations;

(f) Below applicable professional standards;

(g) The cause of intensified review of the Hospital by any governmental or private reviewing agency; and/or

(h) Violative of the concept of good citizenship as defined by the Medical Staff, MEC Code of Conduct and/or citizenship policies.

13.2.1.2 A request for an Investigation or action against such member may be initiated by the President, the MEC, the Service or Division Chief in which the Practitioner holds membership or exercise Clinical Privileges, CMO, CEO or by the Board and supported by reference to the specific activities or conduct which constitutes the grounds for the request.

13.2.1.3 The purpose of the Investigation is to determine if a MEC recommendation to the Board for Corrective Action is warranted or to determine what additional information should be gathered or collegial interventions attempted before making such a recommendation. Routine peer review and performance monitoring will not be considered "Investigations" as described in this Article.

13.2.1.4 An Investigation will be automatically initiated by the MEC whenever it affirms that a Practitioner should be subject to a precautionary suspension as described in Section 13.3.

13.2.2 Procedure

13.2.2.1 If it is determined that an Investigation is warranted, the MEC will conduct the Investigation itself, or may assign the task to an appropriate Medical Staff Officer, Service, standing or ad hoc committee of the Medical Staff, and/or adopt all or part of an Investigation performed by a Service or Division or by the Hospital. The MEC or the investigating person or entity with the approval of the President may engage an external peer review consultant to assist in the Investigation.

13.2.2.2 The Investigation shall proceed in a prompt manner with a written report of the Investigation submitted to the MEC as soon as practicable. The report may include recommendations for appropriate Corrective Action. The member shall be notified that the Investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The individuals or body conducting an Investigation may require the Practitioner who is the subject of the Investigation to provide any records or documents necessary to complete the Investigation, including records or documents from the Practitioner's office practice or other medical settings where he/she is or was clinically active (e.g., other hospitals or ambulatory centers). The individuals or body investigating the matter may, but is not obligated to, conduct interviews with persons knowledgeable about the Practitioner under review. Despite the status of any Investigation, at all times the MEC shall retain authority and discretion to take whatever action it feels may be warranted by the circumstances to protect patients, the Hospital, its Staff and its employees, including suspension or limitations on the exercise of Privileges.

13.2.3 Completion of Investigation

13.2.3.1 When the individual or entity carrying out the Investigation submits its written report to the MEC, the MEC will determine if it is complete and sufficient for the MEC to determine whether Corrective Action should be recommended.

13.2.3.2 If the Investigation is triggered by imposition of a precautionary suspension, the results of the Investigation should be submitted to the MEC for consideration within fourteen (14) days from the suspension's imposition, if

possible, so that the MEC has sufficient information before it, prior to making its recommendation to the Board.

13.2.3.3 In all other cases, the Investigation should be concluded within ninety (90) days.

13.2.3.4 If the MEC believes extenuating circumstances require a longer period to complete the Investigation, it may authorize up to an additional ninety (90) days in which to receive a written report.

13.2.4 MEC Action after an Investigation

13.2.4.1 A record of the Investigation shall be placed in the Practitioner's Medical Staff Quality file along with any actions the MEC undertakes as a result. A record of the final action taken against a Practitioner as contained in any letters to the Practitioner setting forth the final action shall be placed in the Practitioner's Medical Staff file. As soon as practicable after the conclusion of the Investigation the MEC shall take action that may include, without limitation:

(a) Determining no action be taken;

(b) Deferring action if the MEC believes more information is needed. However, such deferral should be consistent with the timelines described above;

(c) Issuing letters of reprimand or warning, although nothing herein shall be deemed to preclude Service or Division Chiefs from issuing informal written or oral warnings outside of the mechanism for Corrective Action. In the event such letters are issued by the MEC, the affected Practitioner may make a written response, which shall be placed in the Practitioner's Medical Staff file;

(d) Recommending a disciplinary suspension for less than fourteen (14) days;

(e) Recommending appointment or reappointment for less than two (2) years or reduction of present period of appointment;

(f) Referral to the Professional Assistance Program of New Jersey or for physical or mental health examination to determine 'fitness' to exercise Privileges safely.

(g) Recommending suspension pending medical consultation;

(h) Recommending special limitations upon continued Medical Staff membership or exercise of Clinical Privileges, including, without limitation, requirements for co-admissions, co-management of patients, and mandatory consultations;

(i) Recommending denial, restriction, reduction, or suspension for more than fourteen (14) days or revocation of Clinical Privileges;

(j) Recommending suspension, revocation, or probation of Medical Staff membership; and/or

(k) Taking other actions deemed appropriate under the circumstances.

13.2.4.2 Any recommendation by the MEC pursuant to Section 13.2.4.1 (h), (i) and/or (j) shall entitle the Practitioner to the procedural rights as provided in Article XIV and the President or his/her designee shall provide Written Notice to the Practitioner of such rights and the MEC recommendation shall not be provided to the Board until the Practitioner has waived or exhausted his/her administrative remedies.

13.2.4.3 If the MEC recommended action other than those giving rights to a hearing as described in Section 13.2.4.2 above, such recommendation(s) together with all supporting documentation, shall be transmitted to the Board. Action to adopt such MEC recommendation(s) without substantive modification shall conclude the matter and notice of final decision shall be given as provided in Sections 6.4.7-6.4.8.

13.2.4.4 If the Board's proposed action on the MEC recommendation(s) will substantively modify the MEC's recommendation(s), the provisions of Section 6.4.8 shall be followed. If the Board's action is one that gives rights to a hearing as described in Section 13.2.4.2 above, the

CEO or designee shall promptly so inform the Practitioner by Special Notice, and the Practitioner shall be entitled to the procedural rights as provided in Article XIV.

13.2.4.5 If the MEC fails to act in timely fashion in processing and recommending action on the request for peer review, the Board (or an appropriate committee thereof) may, after notifying the MEC and providing an additional opportunity for the MEC to conclude its processing and recommendation(s), proceed in accordance with Sections 6.4.7-6.4.8.

13.3 Imposition of Precautionary or Disciplinary Suspension of Privileges or Membership

13.3.1 Authority to Precautionarily Suspend Privileges. The MEC or any two of the individuals from the following list, at least one of whom must be a Physician: the President; the CMO, the CEO and/or the Practitioner's Service Chief shall have the authority to temporarily suspend, in the nature of a precautionary suspension, all or any portion of the Clinical Privileges of a Medical Staff appointee or Practitioner holding Privileges or an Allied Health Professional whenever he/she perceives a reasonable possibility that failure to do so may pose danger to the health and/or safety of any individual or to the orderly operations of the Hospital or when the Practitioner refuses to submit to evaluation or testing related to the Practitioner's mental or physical status including refusal to submit to any testing related to drug or alcohol use. Such a precautionary suspension shall be deemed an interim action and not a professional review action and remain in effect only until the next MEC meeting. It shall not imply a final finding of responsibility for the situation that caused the suspension. Unless otherwise indicated, this suspension will take place immediately.

13.3.2 Notice of Precautionary Suspension

13.3.2.1 The President, CMO or CEO shall provide immediate verbal notice to the affected Practitioner and shall subsequently provide Written Notice to the Practitioner, which states the scope of the precautionary suspension. Such Written Notice shall describe the right of the Practitioner to be afforded an interview by the MEC pursuant to Section 13.3.4 below.

13.3.2.2 The President, Hospital CEO, CMO and applicable Service Chief will be promptly informed of the suspension. The President, CMO, CEO and/or their designees shall also advise those with a need to know including, but not limited to, Medical Records, Security, Medical Staff Administration, and OR Scheduling, about the suspension so as to maintain orderly Hospital operations.

13.3.2.3 The term "precautionary suspension" should be considered synonymous with the term "precautionary suspension" as this terminology is used in state and federal statutes and regulations.

13.3.3 Assignment of Patients. Where any or all of the Privileges of a Practitioner are suspended, terminated, revoked, or restricted, such that the Practitioner can no longer treat all or some of his/her patients at the Hospital for any period of time, such patients who are then in the Hospital shall be assigned for the period of such termination, revocation, or restriction to another Practitioner by the Service Chief or designee. Where feasible, the wishes of the patient shall be considered in choosing a substitute Practitioner.

13.3.4 Interview

13.3.4.1 When a Practitioner has had Privileges or membership status precautionarily suspended, the Practitioner will be afforded a meeting with the MEC, if so requested by the Practitioner. The meeting shall not constitute a hearing, shall be informal in nature, and shall not be conducted according to the procedural rules provided with respect to hearings under Article XIV of these Bylaws.

13.3.4.2 A written request to meet with the MEC must be made within five (5) calendar days of notification of the precautionary suspension. Such request shall be delivered to the President or CMO c/o Medical Staff Administration. The requested meeting with all available members of the MEC, even if less than a quorum, will be scheduled as soon as practicable, but not later than ten (10) days, after imposition of the suspension. The MEC will defer action to review, affirm and/or recommend the continuation, termination and/or modification of the precautionary suspension until after the Practitioner has met with the MEC or has been deemed to have waived his/her rights to such meeting.

13.3.4.3 Each of the MEC and Practitioner may be represented by an attorney-at-law or by a member of the Medical Staff during this meeting. Such attorney at law may privately advise his/her client but shall not speak at the interview.

13.3.5 MEC Action

13.3.5.1 As soon as feasible, but no longer than fourteen (14) days after a precautionary suspension pursuant to Section 13.3.1, a special meeting of the MEC shall be convened to review and consider the action taken. The MEC may vote to terminate, continue or modify the terms of the precautionary suspension.

13.3.5.2 No more than fourteen (14) days after the imposition of a precautionary suspension, the MEC shall recommend to the Board whether the suspension should be modified, continued or terminated, including whether further Corrective Action should be taken or whether there is a need for further Investigation. Unless the MEC immediately lifts the precautionary suspension, such recommended action by the MEC shall take immediate effect and remain in effect pending a final decision by the Board. The MEC shall give notice to the affected Medical Staff member of its recommendation(s) as soon as possible or within five (5) days of the adoption of such recommendation(s).

13.3.5.3 If the MEC's action pursuant to Section 13.3.5.1 is to terminate the suspension, such action shall be transmitted immediately, together with all supporting documentation, to the Board. Thereafter, the procedure to be followed shall be as provided in Sections 6.4.7-6.4.8, as applicable. The terms of the precautionary suspension as originally imposed shall remain in effect pending a final decision by the Board, except that the Board shall not wait until its next regular meeting, but shall convene a special meeting for purposes of discussing the recommendation that the suspension be terminated.

13.3.5.4 Whenever a Practitioner has been suspended for unprofessional conduct or concerns about clinical competence for more than fourteen (14) days, or when the MEC makes a recommendation for suspension of more than fourteen (14) days the Practitioner will be

entitled to request a fair hearing as described in Article XIV.

13.3.6 Disciplinary Suspension

13.3.6.1 The MEC may, with approval of the Board, institute one or more disciplinary suspensions of a Practitioner for a cumulative period up to but not to exceed fourteen (14) consecutive days in a calendar year. Disciplinary suspensions shall commence the first day after the next month of the Board meeting following the Board's institution of the disciplinary suspension (for example, if a disciplinary suspension is instituted by the MEC on January 1, and approved by the Board on February 1 it will be effective on March 1). A disciplinary suspension may be instituted only under the following circumstances:

(a) When the action that has given rise to the suspension relates to non-compliance with a Medical Staff or Hospital Bylaw provision, Rule, Regulation or policy on professional conduct; after having received at least two (2) written warnings within the last twenty-four (24) months regarding the non-compliance at issue. Such warnings must state the conduct or behavior that is questioned, specify or refer to the applicable Bylaw, Rule, Regulation or policy, and state the consequence(s) of repeat violations of the policy, including the possibility of a disciplinary suspension; or

(b) When it has been determined, after an Investigation pursuant to Section 13.2, that the Practitioner has exhibited acts, demeanor or conduct reasonably likely to be (1) contrary to the Medical Staff Bylaws, Hospital or Medical Staff Rules and Regulations and/or policies; (2) harassing or intimidating to staff, colleagues, patients or their families; (3) disruptive to Hospital or Medical Staff operations; (4) below applicable professional standards as established or determined by the Medical Staff; (5) causes intensified review of the Hospital by any governmental or private reviewing agency; and/or (6) violates the concept of good citizenship as defined by the Medical Staff.

13.3.6.2 The affected Practitioner shall be offered an opportunity to meet with the MEC prior to the meeting of the Board to review the Disciplinary Suspension. Failure on the part of the Practitioner to request a meeting will constitute a waiver of the affected Practitioner's right to meet with the MEC. The imposition of a Disciplinary Suspension shall not entitle the Practitioner to a Fair Hearing as described in Article XIV.

13.4 Automatic Suspension, Limitation, or Voluntary Relinquishment or Resignation of Medical Staff Membership and/or Privileges

13.4.1 The actions described in Section 13.4 are not based on determinations of competence or unprofessional conduct, and are not entitled to the hearing or appeal procedures provided under these Bylaws.

13.4.1.1 Loss, Suspension or Termination of License, CDS or DEA

(a) A Practitioner whose license, certification, or other legal credential authorizing practice in the State of New Jersey, DEA and/or CDS is revoked or terminated, shall have his/her Staff membership and Clinical Privileges immediately and automatically revoked. This will not be considered a professional review action, but an administrative action for noncompliance with the Medical Staff eligibility requirements for membership and/or Privileges. The Practitioner shall not be entitled to any of the procedural rights afforded in these Bylaws.

(b) A Practitioner whose license, certificate or other legal credential authorizing practice in New Jersey, DEA and/or CDS is suspended or lapsed, shall be immediately and automatically suspended pending final resolution and outcome by the licensing, certifying or credentialing agency. During this time, the Practitioner will be considered ineligible to exercise the prerogatives of Medical Staff membership or Privileges and will not be entitled to any of the procedural rights afforded in these Bylaws. If the licensing and/or credentialing agency reinstates the Practitioner without any limitations or conditions, the suspension will be lifted. If the licensing and/or credentialing agency reinstates Practitioner's license with limitations or conditions,

the suspension will remain in effect pending an interview with the MEC and recommendation from the MEC for action by the Board. If the suspension is not lifted by the end of the Practitioner's then current period of appointment, the Practitioner shall be ineligible to apply for reappointment. The Practitioner may apply as a new appointee if and when he/she meets the qualifications for Medical Staff membership contained in these Bylaws. Notwithstanding the foregoing, the Practitioner shall be deemed to have voluntarily resigned from the Staff without right to any of the procedural rights afforded in these Bylaws if the Practitioner fails to provide Medical Staff Administration with evidence of demonstrated renewal within ninety (90) days of expiration or lapse.

13.4.2 Conviction of a Felony or Indictable Crime. A Practitioner who has been convicted of, or entered a plea of guilty or no contest to a felony or an indictable crime, relating to controlled substances, illegal drugs, insurance fraud or abuse, or violence, the Practitioner's Staff membership and Clinical Privileges shall be immediately and automatically revoked. This will not be considered a professional review action, but an administrative action for noncompliance with the Medical Staff eligibility requirements for membership and/or Privileges. The Practitioner shall not be entitled to any of the procedural rights afforded in these Bylaws.

13.4.3 Suspension for Failure to Complete Medical Records

13.4.3.1 An administrative suspension of Privileges to admit new patients or to schedule new procedures or to operate, consult or treat patients shall be imposed for failure to complete medical records or peer review requirements within the periods established by the MEC.

13.4.3.2 Such suspension shall not apply to patients already admitted or scheduled at the time of the suspension, to emergency patients, or to attendance at imminent deliveries.

13.4.3.3 The administrative suspension shall be lifted upon completion of the delinquent records except that subsequent administrative suspensions within the period of appointment shall be lifted upon completion of the

delinquent records or thirty (30) days thereafter, whichever period is greater.

13.4.3.4 Suspension of Privileges for medical records delinquency after the second administrative suspension shall require the Practitioner to meet with the MEC to address why the Practitioner cannot complete his/her outstanding medical records.

13.4.3.5 Suspension of Privileges for medical records which are greater than ninety (90) days or for more than five (5) times in any period of appointment shall be deemed Practitioner's voluntary automatic resignation from the Medical Staff without right to the procedural due process rights outlined in these Bylaws. Thereafter, such Practitioner may apply for membership and Privileges as if a new applicant at any time no less than thirty (30) days after such automatic resignation, subject to payment of the applicable fees.

13.4.4 Failure to Attend Specially Noticed Committee or Service Meeting When Requested. A Practitioner who fails to appear at a meeting where his or her special appearance is required under the Medical Staff Bylaws, shall automatically be suspended from exercising all Clinical Privileges unless he/she can establish good cause to the satisfaction of the President for missing the meeting. Failure to appear for a rescheduled meeting on more than one occasion shall be considered a voluntary resignation from the Medical Staff and the Practitioner shall not be entitled to any of the procedural rights afforded in these Bylaws.

13.4.5 Failure to Maintain or Demonstrate Liability Insurance. A Practitioner's Medical Staff appointment and/or Privileges shall be immediately suspended for failure to maintain the minimum amount of professional liability insurance required pursuant to these Bylaws or to demonstrate current liability insurance. Affected Practitioners may request reinstatement during a period of ninety (90) calendar days following suspension upon presentation of proof of adequate insurance unless the Practitioner's current period of appointment has then lapsed. After such ninety (90) day period, the Practitioner shall be deemed to have voluntarily resigned from the Staff without entitlement to any of the procedural rights afforded in these Bylaws and may apply for Medical Staff membership and Privileges as if a new applicant.

13.4.6 Exclusion or Suspension from Federal Insurance Programs or Conviction for Insurance Fraud

13.4.6.1 Whenever a Practitioner appears on the list of Excluded Individuals/Entities maintained by the HHS Office of Inspector General, or is excluded from any federal insurance programs such as Medicare, Medicaid, TriCare and/or CHAMPUS, the Practitioner shall be considered to have automatically resigned from Medical Staff membership and/or Privileges and there will be no entitlement to the procedural due process rights outlined in these Bylaws. Similarly, any Practitioner convicted of violations of the federal False Claims Act or of insurance fraud shall be considered to have automatically relinquished his/her Medical Staff membership and/or Privileges and there will be no entitlement to any of the procedural rights afforded in these Bylaws.

13.4.6.2 Whenever a Practitioner has been suspended from participation from any federal insurance programs such as Medicare, Medicaid, TriCare and/or CHAMPUS, the Practitioner shall be automatically suspended from the exercise of Clinical Privileges, effective immediately upon, and for at least the term of such suspension and there will be no entitlement to the procedural due process rights outlined in these Bylaws. Affected Practitioners may request reinstatement during a period of ninety (90) calendar days following suspension upon presentation of termination of the suspension unless the Practitioner's current period of appointment has then lapsed. After such ninety (90) day period, the Practitioner shall be deemed to have voluntarily resigned from the Staff without entitlement to any of the procedural rights afforded in these Bylaws and may apply for Medical Staff membership and Privileges as if a new applicant.

13.4.6.3 Whenever a Practitioner fails to obtain a current NJ Medicaid enrollment number; and/or current enrollment or opt-out status in the Medicare program, the Practitioner shall be automatically suspended from the exercise of Clinical Privileges, effective immediately upon, and for at least the term of such failure and there will be no entitlement to the procedural due process rights outlined in these Bylaws. Affected Practitioners may request reinstatement during a period of ninety (90)

calendar days following suspension upon presentation of enrollment and/or opt-out status unless the Practitioner's current period of appointment has then lapsed. After such ninety (90) day period, the Practitioner shall be deemed to have voluntarily resigned from the Staff without entitlement to any of the procedural rights afforded in these Bylaws and may apply for Medical Staff membership and Privileges as if a new applicant.

13.4.7 Failure to Participate in an Evaluation or Assessment. A Practitioner who fails or refuses to participate in an evaluation or assessment of his or her qualifications for Medical Staff membership and/or Privileges as required, including an evaluation of Health Status pursuant to Section 3.4 if, within thirty (30) days of the suspension the Practitioner agrees to and participates in the evaluation or assessment, the Practitioner shall be reinstated, subject to such other and further action as the MEC may deem appropriate based upon the results of the evaluation or assessment. After thirty (30) days, the Practitioner shall be deemed to have voluntarily resigned from the Staff without entitlement to any the procedural rights afforded in these Bylaws.

13.4.8 Failure to Become Board Certified or to Maintain Board Certification. Where applicable under these Bylaws, whenever a Practitioner's time period in which to become board certified expires without achieving certification or when such Practitioner fails to maintain board certification as required in these Bylaws, that individual will be deemed to have voluntarily resigned from the Staff effective as of the last date of the current period of appointment without entitlement to any of the procedural rights afforded in these Bylaws.

13.4.9 Failure to Notify Medical Staff of Disciplinary or Final Malpractice Actions

13.4.9.1 A Practitioner who fails to notify the Medical Staff Administration in writing within thirty (30) days of any of the following shall be automatically suspended:

(a) If his/her Privileges in any Hospital or health care entity have been revoked or limited in any way other than routine medical records suspension;

(b) If proceedings have been initiated to revoke or limit Privileges in any way at another health care facility or institution;

(c) If a professional malpractice action has been resolved with an adverse outcome including settlements_ and judgments;

(d) If there is a change in his/her license to practice medicine or prescribe drugs in any state;

(e) If removed or not renewed as an insurance plan provider due to quality of care issues;

(f) If he/she has been indicted, convicted or pled guilty or no contest to any felony or indictable crime related to controlled substances, illegal drugs, insurance fraud or abuse or violence;

(g) If he/she fails to notify the Hospital of any action taken by any state licensing board (such as but not limited to New Jersey State Board of Medical Examiners) against the Practitioner (including but not limited to probation, suspensions, or revocations or entry into a consent agreement or an order of reprimand, which is not private);

(h) Such other actions as shall be pertinent to the Practitioner's continued eligibility and qualifications as set forth herein; and

(i) Suspension pursuant to this Section may be lifted by the MEC when the Practitioner provides adequate documentation to the MEC of the circumstances that triggered the suspension. Failure to provide this information in fourteen (14) days after receipt of written notice to do so will be considered a voluntary resignation from the Staff without entitlement to any of the procedural rights afforded in these Bylaws.

13.4.10 Failure to Return from a Leave of Absence. If a Practitioner granted a leave of absence does not request reinstatement or an extension before the leave expires, he or she will be considered to have voluntarily resigned his or her Medical Staff membership and/or Privileges. Thereafter, such Practitioner shall be deemed to have voluntarily resigned from the Staff without entitlement to any of the

procedural rights afforded in these Bylaws and may apply for Medical Staff membership and Privileges as a new applicant.

13.5 Reporting Requirements. Reporting of all suspensions and resignations shall be made consistent with the requirements of the National Practitioner Data Bank and other state and federal regulatory entities.

ARTICLE XIV - FAIR HEARING

14.1 Grounds for Hearing

14.1.1 Except as otherwise provided in these Bylaws, a recommendation by the MEC for one or more of the following adverse actions or imposition, and, if, based on a determination of clinical incompetence or unprofessional conduct, shall constitute grounds for a hearing:

14.1.1.1 Denial of initial appointment to the Medical Staff;

14.1.1.2 Denial of reappointment to the Medical Staff;

14.1.1.3 Revocation of appointment to the Medical Staff except for automatic revocations described in Section 13.4;

14.1.1.4 Denial of some or all requested Clinical Privileges;

14.1.1.5 Revocation of some or all Clinical Privileges;

14.1.1.6 Suspension of some or all Privileges for more than fourteen (14) days except for automatic suspensions described in Section 13.4; or

14.1.1.7 Restriction of some or all Privileges for more than fourteen (14) days (e.g., mandatory concurring consultation requirement, or an increase in the stringency or a pre-existing mandatory concurring consultation requirement, when such requirement only applies to an individual Medical Staff member).

14.1.2 The following will not constitute grounds for a hearing. This list is nonexclusive and other grounds may exist as defined by the MEC:

14.1.2.1 Having a letter of guidance, warning, or reprimand issued to the Practitioner or placed in the credentials or performance improvement file of the Practitioner;

14.1.2.2 Automatic suspension or relinquishment of Privileges or membership as described in Section 13.4 above;

14.1.2.3 Imposition of a precautionary or disciplinary suspension that does not last for more than fourteen (14) days;

14.1.2.4 Denial of a request for a leave of absence or for an extension of a leave of absence;

14.1.2.5 A decision not to process an application under the available procedures for expedited review;

14.1.2.6 Assignment to a particular Medical Staff Service, Division, or category;

14.1.2.7 Imposition of a proctoring or monitoring requirement where such does not include a restriction on Privileges, Focused Professional Practice Evaluation or Ongoing Professional Practice Evaluation;

14.1.2.8 Failure to process a request for a Clinical Privilege when the applicant/member does not meet the eligibility requirements to hold that Privilege;

14.1.2.9 Conduct of focused peer review (including external peer review) or a formal Investigation;

14.1.2.10 Requirement to appear for a special meeting under the provision of the Medical Staff Bylaws;

14.1.2.11 Termination or limitation of Temporary Privileges unless for demonstrated incompetence or unprofessional conduct;

14.1.2.12 Determination that an applicant for membership does not meet the requisite qualifications or criteria for membership;

14.1.2.13 Ineligibility to request membership or Privileges or continue the exercise of Privileges because a relevant specialty is closed under a Medical Staff development plan adopted by the Board or covered under an exclusive provider agreement approved by the Board;

14.1.2.14 Any recommendation voluntarily accepted by the member because of collegial peer review;

14.1.2.15 Removal or limitation of call obligations;

14.1.2.16 Any requirement by the MEC or Board to complete an educational assessment or obtain additional education;

14.1.2.17 Any requirement by the MEC or Board to determine health status and/or to undergo a physical or mental evaluation;

14.1.2.18 Appointment or reappointment of a duration less than twenty-four (24) months;

14.1.2.19 Suspension or removal for failure to complete medical records; and

14.1.2.20 Actions taken by the affected Practitioner's licensing agency or any other governmental agency or regulatory body.

14.1.3 Notice to Practitioner of Action. A Practitioner with respect to whom adverse action listed in Section 14.1.1 above has been taken shall promptly be given Special Notice thereof by the CMO, President or his/her designee within ten (10) business days. This Special Notice will include a description of the adverse action and the reasons for it, a copy of these Medical Staff Bylaws, and an offer to provide the Practitioner with a hearing. The Special Notice will also inform the Practitioner that the adverse action or recommendation, if finally adopted by the Board, may result in a report to the state licensing authority (or other applicable state agencies) and the National Practitioner Data Bank. The Physician shall have thirty (30) calendar days following the date of receipt of such Special Notice within which to request a hearing.

14.1.4 Practitioner's Request for Hearing. A Physician's request for a hearing shall be made by means of Special Notice to the CMO, President or his/her designee as stated in such notice.

14.1.5 Waiver of Hearing by the Practitioner

14.1.5.1 A Practitioner who fails to request a hearing within the time required and in the manner specified waives any right to a hearing and appellate review to which he/she might otherwise have been entitled.

14.1.5.2 The Practitioner may waive the right to a hearing by signed statement submitted to the CMO, President or his/her designee as stated in such Notice.

14.1.6 Stay of Adverse Decision. A request for a hearing does not automatically operate to stay any adverse recommendation of the MEC or adverse decision of the Board, including the imposition of a precautionary suspension, and such recommendation or decision shall remain in effect pending the final decision of the Board.

14.1.7 Representation. The Practitioner who requested the hearing shall be entitled to be accompanied and represented by a Member of the Medical Staff in good standing or by a member of the Practitioner's local professional society. The Practitioner shall also be entitled to be represented by an attorney-at-law of the Practitioner's choosing; provided that the Practitioner shall advise Medical Staff Administration of the name and address of the attorney within seven (7) days of the request for a hearing or retention of an attorney, whichever is earlier. The MEC or Board, depending on which recommendation or action prompted the hearing, shall appoint an individual or individuals to present the facts in support of its adverse recommendation or action, and to examine witnesses. All participants in the hearing, including the Hearing Officer and Hearing Committee, shall be entitled to counsel who shall be permitted fairly and reasonably to participate in the hearing. The Hearing Officer or the Chair of the Hearing Committee may exclude any representative who is disruptive from the hearing.

14.1.8 Notice of Time and Place for Hearing

14.1.8.1 Upon receipt of a timely request for hearing, Medical Staff Administration shall inform the CMO, President, CEO, MEC and Service Chief.

14.1.8.2 Within thirty (30) days after receipt of such request, the President or designee shall schedule and arrange for a hearing.

14.1.8.3 At least thirty (30) days before the hearing, the Practitioner will be sent a Written Notice of the time, place, and date of the hearing, together with a statement of the matters to be considered and a list of witnesses (if any) expected to testify at the hearing on behalf of the MEC and the Hospital. The hearing date shall be not less than thirty (30) days or more than sixty (60) days from the date of receipt of the request for hearing, unless the affected Practitioner and President or designee mutually agree to a different date. Once the date is set, the parties shall mutually agree to any change in the hearing date,

however, neither party may change the date more than one time, except for good cause.

14.1.9 Limited Right of Discovery

14.1.9.1 There shall be no right to discovery except as specifically provided in these Bylaws.

14.1.9.2 The President will provide the names of any Hearing Panel members, Hearing Officer, and/or Presiding Officer to the Practitioner requesting the hearing within five (5) days of their appointment.

14.1.9.3 Each party to a fair hearing shall furnish a list, in writing, of the names and addresses of the individuals, to the extent then reasonably known, who will be called as witnesses on his/her behalf at least thirty (30) days prior to the hearing or at such other date determined by the Hearing Officer or Presiding Officer.

14.1.9.4 There shall be no right to discover the name of any individual who has produced evidence relating to the charges made against the Practitioner who requested the hearing unless such individual is to be called as a witness at the hearing or unless the deposition or other written statement of such individual is to be evidence at the hearing.

14.1.9.5 There shall be no right to the discovery of credentials or quality files of other members of the Medical Staff, or peer review minutes of any Medical Staff committee or activity unless specifically created and limited to addressing the competence and/or conduct concerns related to the Practitioner requesting the hearing. No information will be provided regarding other practitioners.

14.1.9.6 Each party acknowledges that neither party nor the Hearing Panel, Presiding Officer nor Hearing Officer has the right to subpoena or compel the testimony of witnesses and that it is the obligation of the person seeking to compel testimony to obtain relief from a court of competent jurisdiction.

14.1.9.7 Neither the Practitioner who requested the hearing or any other person acting on his/her behalf, may contact Hospital employees whose names appear on the Medical

Staff's witness list or in documents provided pursuant to this Section concerning the subject matter of the hearing, until the Hospital has been notified and has contacted the employees about their willingness to be interviewed, The Hospital will advise the Practitioner once it has contacted such employees and confirmed their willingness to meet. Any employee may agree to decline to be interviewed by or on behalf of the Practitioner who requested the hearing, with the Practitioner's rights to compel testimony limited as set forth in Subsection 14.1.9.6 above.

14.1.10 Hearing Panel, Presiding Officer, Hearing Officer

14.1.10.1 Appointment of Hearing Panel Members.

(a) The President shall appoint a Hearing Panel and a Presiding Officer or a Hearing Officer. A Hearing Panel shall be composed of not fewer than three (3) and not more than five (5) voting members, including the Presiding Officer, who meet the qualifications below. The Practitioner requesting the Hearing will be notified of the Hearing Panel members appointed and will have five (5) business days from receipt of notice to lodge in writing, with the President, any objections on the basis of conflict of interest, to any appointee except the Presiding Officer, to a cumulative maximum of two (2) objections. Final authority to appoint Panel members, a Presiding Officer, or a Hearing Officer will rest with the President in consultation with the CMO and the Practitioner requesting the hearing is not entitled to veto any appointee's participation.

(b) Qualification of Members. Voting members of the Hearing Panel shall be a majority of Physicians or the Medical Staff or emeritus category of the Staff who shall not have previously participated in the deliberations on the matter involved. Not all members of the Hearing Panel need be members of the Medical Staff at Hospital. If the Practitioner requesting the hearing is other than an MD/DO, at least one (1) member of the Hearing Panel shall be of the same specialty and need not be a Medical Staff member or a privileged Practitioner at the Hospital. Knowledge of the matter involved

shall not preclude a person from serving as a member of the Hearing Panel. Employment by, or contractual arrangement with, the Medical School, Hospital or an affiliate will not preclude an individual from serving on the Hearing Panel. No member of the Hearing Panel may be a direct competitor of the member under review. Membership in the same clinical Service or Division or maintenance of the same or similar Clinical Privileges does not automatically meant that a member of the Hearing Panel is a direct competition.

(c) Notwithstanding the foregoing, nothing in this provision shall prohibit the Hearing Panel from being comprised of one or more persons who previously served as a panelist in a hearing on the same underlying facts. Solely as means of example, a panelist who served on a Fair Hearing Panel to consider a member's appeal of a precautionary suspension shall not be prohibited from serving as a member of a Fair Hearing Panel with respect to a member's subsequent appeal of an adverse recommendation to terminate or permanently suspend Privileges arising from the action that was the basis of the precautionary suspension.

(d) Presiding Officer. The President will appoint a Presiding Officer to chair the Panel, set procedure for the Hearing, and conduct all business before the Panel. If this individual is not a licensed Physician, he/she will not be a voting member of the Panel but may take part in its deliberations and support it in an advisory capacity. Any cost incurred for a Presiding Officer will be borne by the Hospital.

(e) Hearing Officer. The President, in consultation with the CMO, may appoint a single Hearing Officer in lieu of a Hearing Panel. The Hearing Officer may not be: internal legal counsel to the Hospital, in direct economic competition with the Practitioner requesting the Hearing, and/or previously involved in the deliberations triggering the Hearing. The Hearing Officer will not act as a prosecuting officer or as an advocate for either side at the Hearing. The

cost of utilizing a Hearing Officer will be borne by the Hospital.

14.1.11 Hearing Procedure

14.1.11.1 Personal Presence. The personal presence of the Practitioner who requested the hearing shall be required. A Practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his/her rights and thereby to have voluntarily accepted the adverse action that triggered the hearing.

14.1.11.2 Presentation. The hearings provided for in these Bylaws are for the purpose of intra professional resolution of matters bearing on professional conduct or competency. Accordingly, the Presiding Officer shall have the discretion to limit the role of legal counsel for either side. This means that the Presiding Officer may rule that the person requesting the hearing shall be required to have his/.her case presented at the hearing only by a Physician who is licensed to practice medicine in the State of New Jersey and who, preferably, is a member in good standing of the Medical Staff. Where this is the case, the Hospital shall appoint a representative from the Medical Staff to present its recommendation and to examine witnesses. The foregoing shall not be deemed to deprive the Practitioner or Hospital of the right to utilize legal counsel, at his/her/its own expense, in preparation for the hearing and such counsel may be present at the hearing, advise his or her client, and participate in resolving procedural matters.

14.1.11.3 Presiding Officer. The Presiding Officer shall act to ensure that all participants in the hearing have a reasonable opportunity to be heard and to present appropriate oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the Hearing process. The Presiding Officer shall act to ensure that decorum is maintained throughout the Hearing and to prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, abusive, or that causes undue delay. The Presiding Officer shall be entitled to determine the order of procedure during the Hearing,

and shall have the authority and discretion, in accordance with these Bylaws, to make all rulings on all matters of procedure, including the admissibility of evidence. The Presiding Officer may conduct argument by counsel on procedural points and may do so outside the presence of the Hearing Panel.

14.1.11.4 In addition, the Presiding Officer will act in such a way that the Hearing Panel, in formulating its recommendations, considers all information reasonably relevant to the continued appointment or Clinical Privileges of the individual requesting the Hearing. The Presiding Officer may seek legal counsel when he or she feels it is appropriate and may use internal or external Hospital legal counsel for such advice.

14.1.11.5 Hearing Officer. Where a Hearing Officer is employed instead of a Hearing Panel this individual shall have the same authority as a Presiding Officer to determine the manner in which the Hearing will be conducted and rule on all matters of procedure and evidence.

14.1.11.6 Pre-Hearing Conference. The Presiding Officer or Hearing Officer may require a representative (who may be counsel) for the individual and for the MEC and/or Board to participate in a pre-hearing conference. At the pre-hearing conference, the Presiding Officer or Hearing Officer shall resolve all procedural questions, including any objections to exhibits or witnesses and the time to be allotted to each witness's testimony and cross-examination.

14.1.11.7 Record of Hearing. The Hearing Panel shall maintain a complete record of the hearing by having a certified court reporter present to make a record of the hearing. The cost for the certified court reporter shall be borne by the Hospital. The Presiding Officer may, but shall not be required to, order that evidence shall be taken only upon oath or affirmation administered by any person entitled to notarize documents in New Jersey. The record of the hearing may be requested by the Practitioner requesting the hearing and will be forwarded to him/her by the Hospital upon payment of reasonable reproduction costs.

14.1.12 Rights of Parties

14.1.12.1 The Practitioner shall have a limited right, as determined by the Presiding Officer, to inquire as to possible biases of the Hearing Panel. The Presiding Officer has discretion to respond to such inquiries in a manner he/she believes will provide for fair deliberations. Inquiry shall not be allowed into the medical qualifications or expertise of Hearing Panel members.

14.1.12.2 During a hearing, in accordance with procedures established by the Presiding Officer, each of the parties shall have the right to:

(a) Call and examine witnesses;

(b) Introduce exhibits;

(c) Cross-examine any witness on any matter relevant to the issues;

(d) Impeach any witness; and

(e) Rebut any evidence.

14.1.12.3 If the Practitioner who requested the hearing does not testify in his/her own behalf, such Practitioner may be called and examined as if under cross-examination. Either party has the right to submit a written statement at the close of the hearing.

14.1.12.4 Admissibility of Evidence. The hearing shall not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant evidence may be admitted by the Presiding Officer if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law, unless such evidence is deemed by the Presiding Officer be to cumulative. Hearsay is admissible and shall be sufficient to support the decision of the Hearing Panel. The Hearing Panel may question witnesses or call additional witnesses if it deems appropriate.

14.1.12.5 Official Notice. The Presiding Officer shall have the discretion to take official notice of any generally accepted technical or scientific matter relating to the issues under consideration or of any other matter that may be

judicially noticed by the courts of the State of New Jersey. Participants in the hearing shall be informed of the matters to be officially noticed, and such matters shall be noted in the record of the hearing. Any party shall have the opportunity, upon timely request, to ask that a matter be officially noticed or to refute the noticed matters by relevant evidence or by written or oral presentation of authority in a manner determined by the Hearing Panel. Reasonable or additional time shall be granted, if requested, to present written rebuttal of any evidence admitted on official notice.

14.1.13 Burden of Production or Proof

14.1.13.1 Burden of Production. In all cases in which a hearing is conducted, it shall be incumbent on the body whose action or decision prompted the hearing (i.e., the MEC or Board) to come forward initially with evidence in support of its action or decision. Thereafter, the burden shall shift to the Practitioner who requested the hearing to come forward with evidence in his/her support.

14.1.13.2 Burden of Proof. In all cases in which a hearing is conducted, after all the evidence has been submitted by both parties, the Hearing Panel shall rule against the Practitioner who requested the hearing unless it finds that such person has proved, by clear and convincing evidence, that the factual allegations against the Practitioner are untrue in total or in substantial part or unless it concludes, based on its findings of fact that the action of the entity or person which/whose decision prompted the hearing was arbitrary, unreasonable, or appears to be unfounded or unsupported by credible evidence. It is the burden of the Practitioner requesting the hearing to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment, and/or Clinical Privileges, and that he/she complies with all Medical Staff and Hospital policies.

14.1.14 Presence of Panel Members and Vote. A majority of the members of the Hearing Panel must be present throughout the hearings and deliberations; provided; however, that, at the discretion of the Presiding Officer, if a member is absent from part of the hearing, such member may be allowed to read the entire transcript of the

proceedings and, after doing so, may thereafter participate in the deliberations of the Panel.

14.1.15 Recesses and Conclusions. The Presiding Officer may recess the hearing and reconvene the same at any time for the convenience of the participants, without additional notice. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Hearing Panel shall then conduct its deliberations outside the presence of either party to the hearing.

14.1.16 Postponements and Extensions. Postponements and extensions of time beyond the times expressly permitted in these Bylaws may be requested by anyone, but shall be permitted only if the Hearing Panel, or its Presiding Officer acting on its behalf, determines that good cause has been shown.

14.1.17 Hearing Panel Report and Further Action

14.1.17.1 Hearing Panel Report. Within ten (10) days after the conclusion of the hearing, the Hearing Panel shall make a detailed written report signed by each Panel member and setting forth separately each charge against the Practitioner, a summary of the evidence that supports or rebuts such charges, its findings on each fact at issue, and recommendations based on such findings with respect to the matter. The report may recommend confirmation, modification or rejection of the original and any further adverse recommendations of the MEC or the Board. This report, together with the hearing record and all other documentation considered , will then be forwarded to the body whose recommendation or decision prompted the hearing (MEC or Board). All findings and recommendations by the hearing Panel shall be supported by reference to the hearing record and relevant documentation considered by the committee. If the Panel's decision is not unanimous, a minority report or reports may be issued. The Practitioner requesting the hearing has the right to receive the written recommendation(s) of the Panel, including a statement of the basis for the recommendation(s)n.

14.1.17.2 Action on Hearing Panel Report. Within thirty (30) days after receipt of the report of the Hearing Panel, the MEC or Hospital Board, as the case may be, shall consider the same and affirm, modify or reverse its previous recommendation, decision or proposed decision in the

matter. It shall indicate its action in writing, and shall transmit a copy of its written recommendation together with the hearing record, the report of the Hearing Panel, and all other relevant documentation, to the MEC or Board. The Practitioner requesting the hearing has the right to receive the written decision of the MEC or Board, including a statement of the basis for the decision.

14.1.17.3 Notice and Effect of Results. The notice of the action taken shall be given to the President with a copy to the CMO and, by Special Notice, to the affected Practitioner.

14.1.17.4 Effect of Favorable Board Action. If the Board's action is favorable to the Practitioner, such action shall constitute the final decision of the Board and the matter shall be considered finally closed.

14.1.17.5 Adopted by the MEC. If the MEC's action is favorable to the Practitioner, it shall be promptly forwarded, together with all supporting documentation, to the Board for its decision. The Board shall either adopt or reject the MEC's recommendation, in whole or in part, or refer the matter back to the MEC for further reconsideration. Any such referral shall include a statement of the reasons therefore and set a time limit within which a subsequent recommendation to the Board must be made. After receipt of such subsequent recommendation, the Board shall render its decision. The Practitioner will be sent a Special Notice informing him or her of each action taken. A favorable decision shall constitute the final action of the Board, and the matter shall be considered finally closed. If the Board's decision is adverse, the Special Notice shall inform the Practitioner of his or her right to request an appellate review by the Board as provided in these Medical Staff Bylaws.

14.1.17.6 Effect of Adverse Action. If the action of the Board or MEC continues to be adverse to the Practitioner, the Special Notice required shall inform the Practitioner of his or her right to request an appellate review by the Board.

14.2 Appellate Review

14.2.1 Request for Appellate Review. Within ten (10) business days after receipt of the Special Notice given of an adverse recommendation

pursuant to Section 14.1.17.3, the Practitioner who requested the hearing may request in writing, an appellate review by the Board. Such request shall be delivered to the CEO or his/her designee by Special Notice. The written request for an appeal shall also include a brief statement of the reasons for appeal.

14.2.2 Notice of Time and Place. In the event of any appeal to the Hospital Board, the CEO of the Hospital or his/her designee shall, within thirty (30) days after the receipt of such notice of appeal, schedule and arrange for an appellate review. The CEO of the Hospital or his/her designee shall cause the Practitioner to be given written Notice of the time, place and date of the appellate review. The date of the appellate review shall be not less than thirty (30) days or more than sixty (60) days from the date of receipt of the request for appellate review. The Board, for good cause, may extend the time for appellate review.

14.2.3 Appellate Review Body. The Board shall determine whether the appellate review shall be conducted by the Board as a whole or by an Appellate Review Committee of not less than three (3) members of the Board appointed by the Chairman of the Board. The Chairman of the Board or his/her designee shall be the Presiding Officer and shall have the same responsibilities as the Presiding Officer at the initial hearing. If such Committee is appointed, the Board shall delegate to such Committee full authority to render a final decision on behalf of the Board. Members of the Appellate Review Committee may not be direct competitors of the Practitioner under review and should not have participated in any formal Investigation or deliberations leading to the recommendation for Corrective Action under consideration.

14.2.4 Appellate Review Procedure

14.2.4.1 Grounds for Appeal. The grounds for appeal to the Hospital Board shall be limited to the following:

(a) There was substantial failure to comply prior to the hearing with the provisions contained in the Medical Staff Bylaws so as to deny basic fairness or reasonable due process;

(b) The recommendation of the Hearing Panel was made arbitrarily, capriciously, or with prejudice;

(c) The recommendation of the MEC was not supported by substantial evidence based upon the hearing record; and/or

(d) In making this assessment, the Board will consider the record of the hearing before the Hearing Panel and any written statements submitted by parties to the hearing.

14.2.5 Written Statements. Each party shall present a written statement in support of its position on appeal, if such statement is submitted to the Board or the Committee of the Board, at least fifteen (15) days before the date of the appellate review, unless otherwise provided by the Board or the Committee of the Board. A copy shall be provided of each submitted written statement to the opposing party at least seven (7) days before the date of the appellate review.

14.2.6 Submission of Additional Evidence. The Appellate Review Committee may, but is not required to, accept additional oral or written evidence subject to the same cross-examination and admissibility provisions adopted at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence and that any opportunity to admit it at the hearing was denied.

14.2.7 Oral Agreement. The Board or the Committee of the Board may, at its sole discretion, allow the parties and/or their representatives to personally appear and make a time-limited, thirty (30) minute oral argument. Any party or representative so appearing shall be required to answer questions put to him by any member of the Appellate Review Committee. This time restriction may be extended at the sole discretion of the Presiding Officer of the Appellate Review body.

14.2.8 Recesses and Adjournment. At the conclusion of the oral argument, (if allowed), the appellate review shall be closed. The Hospital Board or the Committee of the Board, may thereupon, at a time convenient to itself, conduct deliberations outside the presence of the parties and their representatives. At the conclusion of those deliberations, the appellate review shall be declared finally adjourned.

14.2.9 Action. The Hospital Board or the Committee of the Board, may affirm, modify or reverse the action, which is the subject of the appeal, or refer the matter back to the MEC for further review and recommendation. If the matter is referred back to the MEC for further review and recommendation, the MEC shall promptly conduct its review and make its recommendation(s) to the Hospital Board or the Appellate Review Committee of the Board, in accordance with the instructions given by the Board or the

Appellate Review Committee. This further review process shall in no event exceed sixty (60) days in duration, except as the parties may otherwise stipulate.

14.3 Final Decision of the Board. Within ten (10) days after the conclusion of the proceeding before the Hospital Board or the Appellate Review Committee, the Hospital Board or the Appellate Review Committee shall render a final decision in writing and shall deliver copies thereof to the MEC and, by Special Notice, to the Practitioner. This decision shall be effective immediately and shall not be subject to further review. Notwithstanding the foregoing, if the Board acted as the Appellate Review Committee, instead of appointing a review committee to act as the appellate body, the determination of the Appellate Review Committee shall be the final decision of the Board.

14.4 Effect of Final Board Decision. If the applicant waives his/her right to appeal or the Board denies a Practitioner's initial Medical Staff appointment or reappointment or revokes such Practitioner's Medical Staff membership or one or more Clinical Privileges and the Practitioner has exhausted his/her rights under these Medical Staff Bylaws, such Practitioner may not apply for appointment or reappointment to the Medical Staff, as applicable, or for the affected Clinical Privileges for a period of two (2) years following the waiver or final action or decision of the Board, unless set forth to the contrary by the Board in rendering its final decision in the matter.

14.5 General Provisions.

14.5.1 Exhaustion of Administrative Remedies. By applying for membership on the Medical Staff or for Privileges, each applicant agrees that, in the event of any adverse action or decision with respect to the Medical Staff membership and/or Privileges, the applicant or Medical Staff member shall fully exhaust the administrative remedies afforded by the Medical Staff Bylaws, before resorting to formal legal action.

14.5.2 Limit of One Hearing. No applicant or member of the Medical Staff shall be entitled as a matter of right to more than one hearing and one (1) appellate review on any matter which has been the subject of an action by the MEC, the Hospital Board or a duly authorized committee of either the Medical Staff, Hospital Board or both. For purposes of this provision, the matter shall be defined as the underlying action of the applicant or the Medical Staff member, which was the basis of the corrective action recommended. Solely by means of example, the termination of a member's Clinical Privileges after a precautionary suspension, which has been appealed by the Practitioner and ultimately approved by the Board, shall entitle the Practitioner to an appeal as to the propriety of the termination only

and not the underlying facts that gave rise to the adverse recommendation to suspend precautionarily.

14.5.3 Limit of One Appellate Review. Except as otherwise provided in this Section, no applicant or member shall be entitled as a matter of right to more than one (1) appellate review in total before the Board or the Committee of the Board on any single matter that may be the subject of an appeal, without regard to whether such subject is the result of action by the MEC or the Board, or the Committee of the Board or a combination of actions by such bodies.

14.5.4 Waiver. If at any time after receipt of notice of an adverse recommendation, action or result, a Practitioner fails to make a required request or appearance or otherwise fails to comply with these Bylaws or to proceed with the matter, he shall be deemed to have consented to such adverse recommendation, action, or result and to have voluntarily waived all rights to which he might otherwise have been entitled under the Medical Staff Bylaws then in effect with respect to the matter involved.

14.5.5 Confidential Information and Documentation. All confidential information and documentation is provided to the Practitioner under the express provisions that such documentation and information is confidential, will be maintained as confidential and will not be disclosed or used for any purpose outside of the hearing processes contained herein. The Practitioner shall require his or her counsel and any/all experts to execute the Hospital HIPAA compliant Business Associate Agreement with respect to any patient health information contained in any document, record or information provided, prior to providing access to the same. The Practitioner shall provide a written representation that he/she has obtained such executed Business Associate Agreement and/or a copy of such executed Business Associate Agreement at any time upon request.

14.5.6 Conflict Resolution. Whenever the Board's proposed decision is contrary to the MEC recommendation, the Board shall submit the matter to the Professional Affairs Committee for review and recommendation before making its final decision and giving notice of final decisions as required in these Bylaws. The Board shall give due deference to the recommendation of the MEC and shall reject its recommendation only upon a finding supported by the record, demonstrating that the recommendation of the MEC is contrary to law, or that the recommendation of the MEC must be rejected in order to assure quality of patient care.

SERVICES AND DIVISIONS SCHEDULE

1. Emergency Medicine Service

    a. Employee Health Division

2. Anesthesiology Service

    a. Cardiac Anesthesiology Division
    b. Pain Management Division

3. Dentistry Service

    a. Endodontics Division
    b. Hospital Dentistry Division
    c. Implant Dentistry Division
    d. Oral Surgery Division
    e. Pediatric Dentistry Division
    f. Periodontics Division
    g. Prosthodontics Division
    h. Restorative Dentistry Division

4. Dermatology Service

5. Family Medicine Service

6. Medicine Service

    a. Allergy, Immunology & Infectious Disease Division
    b. Cardiovascular Disease & Hypertension Division
    c. Endocrinology, Metabolism & Nutrition Division
    d. Gastroenterology & Hypertension Division
    e. General Internal Medicine Division
    f. Hematology Division
    g. Medical Oncology Division
    h. Nephrology Division
    i. Pulmonary Disease & Critical Care Division
    j. Rheumatology & Connective Tissue Division

7. Neurology Service

    a. Movement Disorders Division
    b. Neurophysiology Division

8. Obstetrics & Gynecology Service

    a. General Obstetrics & Gynecology Division

b. Gynecologic Oncology Division
c. Maternal-Fetal Medicine Division
d. Reproductive Endocrinology & Infertility

9. Ophthalmology Service

a. Pediatric Ophthalmology Division

10. Orthopedic Surgery Service

a. Pediatric Orthopedic Surgery Division

11. Pathology Service

a. Anatomic Pathology Division
b. Clinical Pathology Division
c. Hematopathology/Hematology Division

12. Pediatrics Service

a. Adolescent Medicine Division
b. Allergy, Immunology & Infectious Disease Division
c. Cardiology Division
d. Critical Care Division
e. Emergency Medicine Division
f. Endocrinology, Diabetes & Metabolism Division
g. Gastroenterology & Hypertension Division
h. General Pediatrics Division
i. Hematology/Oncology Division
j. Medical Genetics Division
k. Neonatology Division
l. Nephrology Division
m. Neurology Division
n. Pulmonary Disease Division
o. Rheumatology Division

13. Psychiatry Service

a. Addiction Psychiatry Division
b. Child & Adolescent Psychiatry Division
c. Consultation Psychiatry Division

14. Radiation Oncology Service

15. Radiology Service

a. Vascular/Interventional Radiology Division
b. Diagnostic Radiology Division
c. Neuroradiology Division
d. Nuclear Medicine Division
e. Interventional Neuroradiology Division

16. Surgery Service

a. Cardio/Thoracic Surgery Division
b. General Surgery Division
c. Neurosurgery Division
d. Surgical Oncology Division
e. Otolaryngology Division
f. Pediatric Surgery Division
g. Plastic Surgery Division
h. Podiatric Surgery Division
i. Trauma & Critical Care Surgery Division
j. Urology Division
k. Vascular Surgery Division