BYLAWS OF THE MEDICAL STAFF

OF

Weisman Children's Rehabilitation Hospital

Preamble

WHEREAS, Weisman Children's Rehabilitation Hospital is a private, for-profit hospital, organized under the laws of the State of New Jersey and;

WHEREAS, it is recognized that the medical staff is responsible for the quality of medical care in the hospital and must accept and discharge this responsibility, subject to the ultimate authority of the hospital's Governing Board, and that the cooperative efforts of the medical staff, the Administrator and the Governing Board are necessary to fulfill the hospital's obligation to its patients; and to comply with any statutory requirements for quality of care programs and;

WHEREAS, the medical staff, the Administrator and the Governing Board have a duty to cooperate in their mutual obligation toward their patients and the community, in which they serve and to assure one level of care and quality of patient care standards for all patients within the hospital, only physicians being able to practice medicine under the laws of the state, and in those areas in which medical judgement and the evaluation of professional competence are involved, the hospital having a duty to rely upon the judgements and recommendations of the medical staff, to cooperate and to provide needed assistance with full understanding that the primary responsibility is that of the medical staff.

THEREFORE, the physicians practicing in this non-departmentalized hospital hereby organize themselves into a medical staff in conformity with these Bylaws.

Definitions

1. "HOSPITAL" or "FACILITY" means Weisman Children's Rehabilitation Hospital.

2. "GOVERNING BOARD" means the Governing Board of Directors of the Hospital.

3. "ADMINISTRATOR" means the person appointed by the Governing Board to serve in an administrative capacity to manage the hospital.

4. "MEDICAL STAFF" or "STAFF" means those licensed practitioners who have been granted recognition as members of the medical staff pursuant to the terms of these Bylaws.

5. "EXECUTIVE COMMITTEE" means the Executive Committee of the Medical Staff, which shall constitute the Governing Board of the medical staff as described in these Bylaws.

6. "PEER" means a professional practitioner within the same area of specialization.

7. "PHYSICIAN" means an individual with a Medical Degree or Doctor of Osteopathy, from a duly accredited school, who is currently licensed to practice medicine in the State of New Jersey.

8. “PRACTITIONER” means any physician, dentist, or limited licensed practitioner who is legally, and without restriction, licensed for the practice of his/her profession within the State of New Jersey, and who is a member of the medical staff.

9. "MEMBER" means, unless otherwise expressly limited, any licensed practitioner holding a current license to practice within the scope of his/her license who is a member of the medical staff.

10. "PRIIVILEGES" or "CLINICAL PRIVILEGES" means the permission granted to the medical staff members to provide patient care and includes unrestricted access to those hospital resources (including equipment, facilities and hospital personnel), which are necessary to effectively exercise those privileges.

11. "MEDICAL STAFF YEAR" means the period from January 1 to December 31.

12. "PRESIDENT" means the President of the medical staff elected by members of the medical staff.

13. "INVESTIGATION" means a process specifically instigated by the Medical Executive Committee to determine the validity, if any, of a concern or complaint raised against a member of the medical staff.

14. “AUTHORIZED REPRESENTATIVE" or "HOSPITAL'S AUTHORIZED REPRESENTATIVE" means the individual designated by the hospital and approved by the Medical Executive Committee to provide information to and request information from the National Practitioner Data Bank according to the terms of these Bylaws.

15. “FAIR HEARING PLAN” means the process set forth in Article 12 of these Bylaws for addressing decisions adverse to any person applying for membership in the medical staff, clinical privileges, or the renewal of either or whose membership in the medical staff or clinical privileges has been reduced, restricted or revoked by means of corrective action as set forth in Article 11 of these Bylaws.

Article 1--Name

1.1 Name

The name of this organization is The Medical Staff of Weisman Children's Rehabilitation Hospital.

Article 2--Purpose

2.1 Purpose

The purpose of this organization is:

a. To assure that all patients admitted to or treated in the hospital shall receive competent care and assure one level of quality care for all patients served;

b. To assure competent and professional performance of all practitioners authorized to practice in the hospital through the appropriate delineation of the clinical privileges that each practitioner may exercise in the hospital and through an ongoing review and evaluation of each practitioner's performance in the hospital;

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

d. To initiate and maintain rules and regulations for self-government of the medical staff as an integral part of the hospital, subject to the ultimate authority of the Governing Board;

e. To provide a means whereby issues concerning the medical staff and the hospital may be discussed by the medical staff with the Governing Board and Administrator.

Article 3--Department

3.1 Department

As the hospital is a specialized hospital to which all patients are admitted for the purpose of rehabilitation, the customary medical departmentalization of a general hospital does not apply as an organizational form. The medical staff as a whole is designated the Department of Pediatrics. Patient beds may be assigned within the hospital by specialty services.

3.2 Delivery of Comprehensive Rehabilitation Services

By reason of the status of the hospital as a licensed and accredited comprehensive rehabilitation hospital, each patient will be the subject of a comprehensive rehabilitation plan which will be formulated under the supervision of a physiatrist or other licensed practitioner who can demonstrate to the Medical Director and the Executive Committee comparable credentials and competence in rehabilitation medicine. This care plan shall be implemented by an interdisciplinary care committee, which may include physicians of other specialties and

other clinical professionals specializing in therapies or other matters relevant to the delivery of comprehensive rehabilitation services.

3.3 Medical Director

The Medical Director shall oversee the clinical organization of the hospital and the quality of care provided by all professional therapeutic departments in coordination with the Executive Committee and the Administrator of the hospital. The Medical Director is the physician appointed by the Governing Board to act on its behalf on clinical matters as set forth in Section 3.3-1. The status of the Medical Director as administrator and manager is unrelated to his/her role as a member of the medical staff. The Medical Director may also be a member of the medical staff with admitting and clinical privileges. The Medical Director's responsibilities shall include all administrative and clinical activities of the department, surveillance of professional performance and recommendation of privileges, staffing and continuing education of department members.

3.3-1 Functions of the Medical Director as they relate to the Medical Staff

The Medical Director shall:

a. Be a member of the Executive Committee giving guidance to the overall medical policies of the hospital and making specific recommendations and suggestions in order to ensure the quality of patient care;

b. Appoint committees in conjunction with the President of the Medical Staff as required by these Bylaws;

c. Act as liaison between the leadership of the hospital and the medical staff;
d. Provide and maintain quality standards of medical services within the hospital;

e. Assist the Executive Committee in recommending new appointments, reappointments, the granting and revision of clinical privileges and the promotion of members of the medical staff when warranted, the granting and revisions of clinical privileges;

f. Assist the Executive Committee in recommending dismissals, suspensions, withholding of reappointments and other disciplinary measures in accordance with these Bylaws;

g. Ascertain that the quality of patient care services and administrative services provided under contract meets the standards established for the hospital;

h. Carry out such other functions as may be provided in these Bylaws.

Article 4--Medical Staff Membership

4.1 Nature of Medical Staff Membership

Membership on the medical staff is a privilege which shall be extended only to professionally competent licensed practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws. All members must have pediatric experience that includes, but is not limited to, pediatric subspecialty board certification in their specialty area or the recommendation of two physicians who are pediatric board certified. No practitioner including those in a medical administrative position by virtue of a contract with the hospital, shall admit or provide medical services to patients in the hospital unless he/she is a member of the medical staff and has been granted privileges in accordance with procedures set forth in these Bylaws.

Appointment to the medical staff shall confer only such clinical privileges and prerogatives as have been granted in accordance with these Bylaws.

4.2 Qualifications for Membership

4.2-1 General Qualifications

a. Only practitioners licensed to practice in the State of New Jersey and who provide the following are qualified for membership in the medical staff:

1. A fully-completed and signed application that includes at least the following information: demographic information, category of staff membership and clinical privileges sought, professional training, experience and accomplishments, continuing medical education documentation, hospital affiliations, teaching activities, status of privileges at other hospitals, professional liability insurance, and reports on all professional liability actions or judgements.

   The application shall also include a request for peer references, authorization to obtain copies of records pertinent to licensure, specific training, experience, current competence, ability to perform the privileges requested, and notification that inquiry will be made of the National Practitioner Data Bank (NPDB) with reports from NPDB being made part of the credentialing process.

2. Copies of current New Jersey Medical Licenses, (and other state of licensure) current DEA and NJ-CDS registrations, Foreign Medical Graduate Certificate (if applicable) and current Curriculum Vitae.

3. Proof of professional liability with a minimum requirement of $1 million per occurrence and $3 million annual aggregate.

4. Proof of graduation from professional school, proof of graduate training, and if applicable, proof of board certification.

5. Letters of reference from at least two (2) peers personally familiar with applicant's professional competence and character. At least one reference must be an individual practicing in a field similar to the applicant and one reference must be an individual working in Pediatrics.

6. Applicant's statement of physical and mental competence and willingness to provide reasonable evidence of current ability to perform privileges requested, including a physical or mental health examination if required by the Medical Executive Committee.

7. Applicant's statement evidencing willingness to be bound by the bylaws and rules and regulations of the hospital.

b. Applicants for membership to the medical staff shall be evaluated to determine his/her professional competence, adhere to the ethics of his/her respective profession, his/her good reputation, ability to work cooperatively with others, with sufficient adequacy to assure the medical staff and the Governing Board that any patient treated by him/her in the hospital will receive a high quality of medical care, and ability to keep confidential as required by law, all information or records in the physician-patient relationship.

4.2-2 Effects of Other Affiliations

No practitioner shall be entitled to membership on the medical staff or to exercise particular clinical privileges in the hospital merely by virtue of the fact that he/she is duly licensed to practice medicine in this or any other state, or that he/she is a member of any professional organization, or that he/she had in the past or present such privileges at another hospital.

4.3 Basic Responsibilities of Medical Staff Membership

a. Providing continuous quality care of patients and meeting the professional standards of the medical staff of this hospital in a cost-effective manner;

b. Refraining from fee splitting or other inducements relating to patients;

c. Refraining from delegating responsibility for diagnosis or care of hospitalized patients to a medical practitioner who is not qualified to undertake this responsibility and who is not adequately supervised;

d. Seeking appropriate consultation whenever necessary;

e. Preparing and completing, in a timely manner medical records for all the patients for whom the member provides care in the hospital;

f. Abide by the Medical Staff Bylaws and Medical Staff Rules and Regulations.

4.4 Facility Assessment of Need

Each practitioner's request for membership on the medical staff regardless of the category, shall be subject to:

a. An assessment of the patient's need for the services proposed. If there is no need exhibited to justify an appointment, the appointment may be denied.

b. An assessment of the hospital's ability to support the applicant with adequate staff and financial resources to maintain a consistent, high level of quality care.

4.5 Non-Discrimination

Neither age, gender, race, creed, national origin or handicap shall be considered in determining medical staff membership or delineation of clinical privileges.

4.6 Conditions and Duration of Appointment

The Governing Board shall act on initial appointments, reappointments or revocation of appointment only after there has been a recommendation from the Executive Committee as provided in these Bylaws. In the event of unwarranted delay on the part of the Executive Committee, the Governing Board may act without such recommendation on the basis of documented evidence of the applicant's or staff member's professional and ethical qualifications obtained from reliable sources other than the Executive Committee.

4.6-1 Reappointments

a. A regular appointment or reappointment shall be for a term of two (2) full medical staff years.

4.6-2 Appointments and Clinical Privileges

a. An appointment (initial or regular) may be revoked whenever deemed necessary according to the regulations set forth in these Bylaws.

b. Appointment to the medical staff shall confer on an appointee only such clinical privileges as have been granted by the Governing Board, in accordance with these Bylaws.

c. Every application for staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgment of the medical staff member's obligation to provide continuous care and supervision of his/her patients, to abide by the Medical Staff Bylaws, Rules and Regulations, to accept committee assignments and to accept consultation assignments.

Article 5--Categories of the Medical Staff

5.1 Categories

The medical staff shall be divided into Attending, Consulting and Specified Healthcare Professionals.

5.2 Attending Medical Staff

The attending staff shall consist of those physicians who, because of their education, experience, skill and achievements, are well qualified in their field of practice and who are actively engaged in the care of patients within the hospital. Each appointee to the active staff shall be required to be located close enough to the hospital to provide continuous care to their patients, and shall assume all the functions and responsibilities of membership on the active staff. All active staff must be certified by the board of their respective specialty within five (5) years of the date of initial eligibility for certifying examination of that specialty. Where a specialty board allows for a longer period of time for completion of board certification, this may be allowed by appeal to the Executive Committee.

A waiver of board certification may be permitted when requirements of the certifying boards do not permit eligibility to the certifying examination because of the requirement of: 1) residency/fellowship in the dual specialty; 2) lack of clinical practice “track” eligibility to the examination; or 3) lack of grandfather clause permitting eligibility by established clinical experience in the specialty.

Attending members of the medical staff agrees to abide by the managed care contract fee for services and cannot bill the payer separately.

Attending staff members shall be required to attend at least 50% of the medical staff meetings each year. Medical staff activities may include medical staff meeting attendance, medical staff committee or committee attendance, performance improvement activity and peer review activity.

Members of the attending staff shall be eligible to vote, to hold office, and to serve on medical staff committees and may be required to pay dues.

5.3 Consulting Medical Staff

The consulting staff shall consist of physicians (MD or DO) qualified for staff membership and recognized as specialists in their field. They shall serve as consultants in the area of their expertise at the request of a member of the active medical staff and shall not admit patients to the hospital.

Consulting staff members shall be eligible to vote and hold office in the medical staff organization. They shall be eligible for committee or committee appointment and may be required to pay dues.

5.4 Specified Healthcare Professionals

Specified healthcare professionals are individuals who exercise independent judgment within the areas of their professional competence and who are qualified to render care on consultations when requested by an active staff member with appropriate privileges. This category includes, but is not limited to; dentists, podiatrists, psychologists, physician assistants, and nurse practitioners practicing independently and not pursuant to a direct or indirect employment contract with the hospital. Applications for clinical privileges are processed through the medical staff procedures set forth in these Bylaws.

Specified healthcare professionals shall be permitted to write orders within the scope of their license and shall record appropriate reports of examinations and treatments.

Members of the specified healthcare professionals shall be eligible to vote, to hold office, to serve on medical staff committees or committees, and may be required to pay staff dues.

5.4-1 Establishment of Categories of Specified Healthcare Professionals

The Governing Board may determine from time to time that a particular category of specified healthcare professionals shall be established in accordance with the needs of the hospital. When such a category has been established, the medical staff at its discretion may recommend to the Governing Board particular qualifications required of members of that category and the recommended scope of the clinical privileges to be exercised by such practitioners.

Article 6--Appointment and Reappointment

6.1 Application for Appointment

A separate record is maintained for each individual requesting medical staff membership. An application for appointment to the medical staff shall be obtained from the Medical Staff Office and shall require information including, but not limited, to that set forth in these Bylaws, and must be signed by the applicant.

6.1-1 Denial of Application

An application for membership or clinical privileges may be denied when:

a. The Governing Board has determined that the hospital does not have the capacity to accommodate the practitioner or the requested clinical privileges by providing adequate facilities and supportive services for the practitioner and his/her patients as determined in conjunction with the hospital□s long-range plans, if any, or

b. The Governing Board has determined that the hospital's patients do not need additional staff members with the practitioner's skills and training.

6.1-2 Pending Inquiry

A practitioner whose application has been denied because of a failure to comply with any requirement set out in Article 6.1.1 of these Bylaws may request that his/her application be held in pending status until he/she can provide the necessary information or otherwise take any necessary action. For good cause, the request for pending status may be granted for a period not to exceed sixty (60) days. At such time as the deficiency is corrected, the application shall be reconsidered.

6.1-3 Applicant's Burden

The applicant shall have the burden of producing adequate information for a proper evaluation of his/her competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications. Applicant shall agree to undergo a physical and/or mental health examination if so required by the Medical Executive Committee to assure physical and/or mental health status. The applicant shall also provide evidence of professional liability insurance in the amount considered adequate by the laws of the State of New Jersey and the Governing Board as well as evidence of completion of the minimum number of continuing Medical Education units required to maintain licensure.

a. Neither the Governing Board, Executive Committee, nor the Administrator shall have any duty or obligation to review any application until the applicant completes it in all respects and submits all required information and supporting material in accordance with the provisions of these Bylaws.

b. The failure of an applicant to complete an application or timely supply requested information shall be deemed a voluntary withdrawal of such application. An application deemed incomplete 120 (one hundred twenty) days after submission, shall be considered to be voluntarily withdrawn by the applicant.

c. An application is complete only when verification as required in 6.2-1 has been completed.

6.1-4 Effect of Application

By applying for appointment to the medical staff, each applicant thereby undertakes the following obligations:

a. Signifies his/her willingness to appear for interviews in regard to his/her application;

b. Authorizes the hospital to consult with members of the medical staff of other hospitals with which the applicant has been associated and with others who may have information bearing on his/her competence, character and ethical qualifications;

c. Consents to the hospital's interview and/or inspection of all individuals' records and documents that may be material to an evaluation of his/her professional qualifications and competence to carry out the clinical privileges he/she requests as well as of his/her moral and ethical qualifications for staff

membership;

d. Release from any liability all representatives of the hospital and its medical staff for their acts performed in good faith and without malice in connection with evaluating the applicant and his/her credentials;

e. Release from any liability, and consents to and directs the production of information by all individuals and organizations who possess and/or provide information to the hospital in good faith and without malice concerning the applicant's competence, ethics, character and other qualifications for staff appointment and clinical privileges, including otherwise privileged or confidential information.

6.1-5 Applicant Adherence to Bylaws and Rules & Regulations

The application form shall include a statement that the applicant has received, read and been oriented to the Bylaws and Rules & Regulations of the medical staff and that he/she agrees to be bound by the terms thereof, if he/she is granted membership and/or clinical privileges, and to act in accordance with the terms thereof without regard to whether or not he/she is granted membership and/or clinical privileges in all matters relating to consideration of the application.

6.2 Appointment Process

An applicant shall submit his/her application to the hospital's Medical Director. The medical staff's authorized representative shall verify information set forth in the application. Action on an individual's application will not take place until the information requested on the application is submitted and verified as outlined in Article 6.2-1 below.

6.2-1 Verification

Within three (3) weeks of receipt of the completed application form, the medical staff's authorized representative shall seek to verify information in the application by contacting original sources for such information.

a. If verification cannot be obtained within ninety (90) days of request, the medical staff's authorized representative shall notify the applicant of his/her obligation to assist in obtaining verification.

b. The medical staff's authorized representative shall verify current licensure, professional liability insurance coverage, medical or professional education, training, experience, current competence and health status.

c. The Medical Director may consider additional information concerning the applicant from other sources including, but not limited to, the National Practitioner Data Bank, the American Medical Association Physician

Masterfile and the Federation of State Medical Boards Physician Disciplinary Data Bank.

d. Completion of verification is necessary for a complete application. An application deemed incomplete within one hundred twenty (120) days after submission shall be considered voluntarily withdrawn by the applicant.

e. In no instance, except pursuant to Article 7.2, will an appointment be made or clinical privileges awarded until information is verified.

6.2-2 Querying the National Practitioner Data Bank

The medical staff's authorized representative shall query the National Practitioner Data Bank for each practitioner who applies for appointment, reappointment, temporary privileges and changes in privileges, to the medical staff.

6.2-3 Submission to Executive Committee

The Medical Director shall notify the applicant within thirty (30) days of deeming an application complete, and shall submit the application and all supporting information to the Executive Committee for review and recommendation.

6.2-4 Executive Committee Review

At the next scheduled meeting after receipt of the complete application, the Executive Committee shall review the application and report its review to the Governing Board. The report shall recommend that the applicant be appointed to the medical staff, that he/she be rejected for medical staff membership, or that his/her application be deferred for future consideration. All recommendations for appointment shall specify the clinical privileges to be granted, which may, as appropriate, be qualified by probationary conditions.

As the basis for its recommendation, the Executive Committee shall examine the evidence of the character, professional competence, qualifications, and ethical standing of the applicant and shall determine, through information contained in references given by the applicant and from other sources available to the Executive Committee, whether the applicant has established and meets all the necessary qualifications for the category of staff membership and clinical privileges requested by him/her as set forth in these bylaws.

6.2-5 Executive Committee Deferral

When the recommendation of the Executive Committee is to defer the application for future consideration, the Executive Committee must, within thirty (30) days, issue a subsequent recommendation for appointment with specified clinical privileges, or for rejection for staff membership. It the burden of the applicant to provide requested additional information in order for the Executive Committee to come to a decision.

6.2-6 Favorable Executive Committee Action

When the recommendation of the Executive Committee is adverse to the applicant, the Executive Committee shall forward the application together with all supporting documentation, within thirty (30) days, to the Governing Board for review at their next regularly scheduled meeting. A favorable recommendation shall be the final Governing Board action required.

6.2-7 Adverse Executive Committee Action

When the recommendation of the Executive Committee is adverse to the applicant either in respect to appointment or clinical privileges, the Medical Director shall notify the applicant of such recommendation by certified mail, return receipt requested, no later than thirty (30) days from the date of such recommendation. No such adverse recommendation need be forwarded to the Governing Board until after the applicant has exercised or has been deemed to have waived, his/her rights to a hearing as provided in the Fair Hearing Plan of these Bylaws. (Articles 11 and 12)

a. If the applicant exercised his/her rights under the Fair Hearing Plan of these Bylaws, the Executive Committee shall review and consider the report and recommendations of the ad hoc committee and the hearing record:

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

c. If such recommendation continues to be adverse, the Medical Director shall so notify the applicant, by certified mail, return receipt requested, within thirty (30) days of such recommendation. The Medical Director shall also forward such recommendation and documentation to the Governing Board, but the Governing Board shall not take any action thereon until the applicant has exercised or has been deemed to have waived his/her rights to an appellate review as provided in the Fair Hearing Plan.

6.2-8 Governing Board Action

The Governing Board shall act upon all final recommendations of the Executive Committee within forty-five (45) days after receipt.

a. If the Governing Board's decision is adverse to the applicant, in respect to either appointment or clinical privileges, the Administrator shall notify him/her of such adverse decision by certified mail, return receipt requested within ten (10) days of such adverse decision. Such adverse decision shall be held in abeyance until the applicant has exercised or has been deemed to waive his/her rights under the Fair Hearing Plan of these Bylaws. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.

b. After the applicant has exhausted or waived his/her rights under the Fair Hearing Plan, the Governing Board shall act in the matter.

c. The Governing Board may defer final determination by referring the matter back to the Executive Committee for further reconsideration. Any such referral back shall state the reasons therefor, set a time limit by which a subsequent recommendation to the Governing Board shall be made, and may include a directive that an additional hearings be conducted to clarify issues which are in doubt.

d. After receipt of such subsequent recommendations, and new evidence in the matter, if any, the Governing Board shall make a decision either to appoint the applicant to the staff or to reject him/her for staff membership. All decisions to appoint shall include a delineation of the clinical privileges which the applicant may exercise.

e. When the Governing Board's decision is final, it shall send a notice of such decision through the Administrator to the Medical Director and by certified mail, return receipt requested, to the applicant.

6.3 Appointment

Appointment to the medical staff shall be for a period of no more than two (2) years. The length of the initial full appointment shall be determined so that the time of the appointee's reappointment shall conform with the next regular reappointment cycle.

6.4 Reappointment Process

Every member of the medical staff shall be subject to reappointment every two (2) years. Reappointment shall be for a period of not more than two (2) years from the date of the previous appointment.

6.4-1 Application for Reappointment

At least ninety (90) days prior to the expiration date of the current appointment, the Medical Staff Office shall provide each reappointment candidate with an application for use in considering reappointment.

a) Each applicant for reappointment shall return the completed interval information form to the Medical Staff Office at least sixty (60) days prior to the expiration date of his/her current appointment.

b) Failure to timely complete and return the application or to provide information requested, shall be deemed a voluntary resignation from staff status and shall result in automatic termination of staff status, together with all clinical privileges, at the expiration of such person□s current term. Such resignation shall not entitle the person resigning to any of the rights in the Fair Hearing Plan.

6.4-2 Information to be submitted

The reappointment application shall require, and when complete, shall contain

information including but not limited to the following:

a) Continuing training, education and experience that qualifies the reappointment applicant for the status and/or privileges sought on reappointment, as well as evidence of continuing Medical Education;

b) Any reasonable evidence of his/her current physical and mental competence and ability to perform the privileges requested (by the Executive Committee), including results of a physical and/or mental health examination if requested by the Medical Executive Committee.

c) Relevant professional activities during the preceding period including clinical activities in any setting, any awards or other professional achievements;

d) Sanctions of any kind, imposed or proposed to be imposed, by any other health care institution, professional health care organization, or licensing or drug control authority or the voluntary relinquishment of licensure or registration;

e) Previously successful or currently-pending challenges to any licensure or resignation including, but not limited to, those by a state or district or the Drug Enforcement Administration or the voluntary or involuntary relinquishment of such licensure or resignation;

f) Voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital;

g) Professional Liability claims experience;

h) Any requests for modification of medical staff status or privileges, which the reappointment applicant may desire to make.

i) When clinical activity is low and insufficient practitioner-specific data exists, two peer recommendations are required.

6.4-3 Reappointment Verification

The medical staff authorized representative shall verify information in the application regarding the applicant's current licensure, current professional liability, professional liability claims history, and other information regarding the applicant's professional activities, performance, and conduct in this or any other hospital.

a) Each member shall be required to assist with verification upon request of the medical staff's authorized representative.

b) A member who does not cooperate with verification shall be deemed to have voluntarily withdrawn his/her application.

c) When verification is complete, the medical staff□s authorized representative

shall transmit the information, application form and related materials to the Executive Committee.

6.4-4 Basis for Reappointment

The reappointment of the medical staff member and granting of clinical privileges shall be based upon such member's demonstrated professional competence, clinical judgment in the treatment of patients, professional peer recommendations, clinical and technical skills as documented by the results of continuous quality improvement activities, ethics and conduct, current physical and mental health and ability to perform the requested privileges documented participation in continuing education activities that relate to his/her current or requested clinical privileges, ability to contribute to the attainment of the hospital's institutional objectives, compliance with the Medical Staff Bylaws, Rules and Regulations, conformity with relevant state and federal regulatory standards, cooperation with hospital personnel, use of the hospital′s facilities, relations with other practitioners, general attitude toward patients, the hospital and the public, and evidenced professional liability insurance in the amount specified in 6.2-1 of these Bylaws.

6.4-5 Reappointment Process

When submitted to the Executive Committee, the application for reappointment shall be reviewed and acted upon as provided for in 6.2 of these Bylaws.

Article 7--Clinical Privileges

7.1 Clinical Privileges

Every practitioner practicing in the hospital shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted to him/her by the Governing Board, except as provided in Sections 7.2 and 7.3 of these Bylaws. All clinical privileges for any practitioner in this hospital shall be specifically delineated. The scope of privileges available in the hospital shall be determined by the Governing Board, taking into consideration the recommendation of the Executive Committee of the Medical Staff.

7.1-1 Basis for Granting Clinical Privileges

Evaluation of all requests for clinical privileges shall be based upon the applicant□s education, training, experience, continued medical education, demonstrated current competence, professional peer references, and other relevant information; and in the case of reappointments, results of continuous quality improvement activities.

a. Applicant's Burden--The applicant shall have the burden of establishing his/her qualifications and ability to perform the clinical privileges he/she requests.

b. Prior Verification--Action on an application for clinical privilege shall be withheld until information providing the basis for granting privileges has been

verified.

7.1-2 Determination of Individual Clinical Privileges

Clinical Privileges--Each initial application for staff appointment by a potential medical staff member, and each application for reappointment shall contain a request for specific privileges.

Revision in Clinical Privileges--Any practitioner with clinical privileges may apply in writing at any time for revisions in his/her clinical privileges by submitting each request to the Medical Director.

7.1-3 Any licensed independent practitioner (LIP) who provides supervision of individuals in graduate medical education programs must apply and be granted the clinical privilege to do so. LIP's with these privileges must supervise residents in order to safeguard patient care and enhance medical education.

7.2 Temporary Privileges

The Administrator, with the recommendation of the Medical Staff President or his/her designee, may grant temporary admitting and clinical privileges to a practitioner who is not a member of the medical staff only in the circumstances and upon the basis set forth herein. Temporary privileges may be granted to a practitioner for the category recognized by the Governing Board, in accordance with this Section and shall not exceed 120 days in all circumstances.

7.2-1 Circumstances Permitting Temporary Privileges

Temporary privileges may be granted in the following situations:

- To fulfill an important patient care need that requires a practitioner's immediate authorization to practice. Temporary privileges shall be granted by the CEO with the recommendation of the Medical Director following verification of current licensure and competence while full credentialing information is verified and approved. The Medical Director shall be responsible for determining if a specific patient care needs warrants granting temporary privileges.
- For a new applicant, after receipt of a completed application, while awaiting review and recommendation of the medical executive committee and approval by the governing body. Temporary privileges may be granted by the CEO with recommendation of the Medical Director following verification of current license, relevant training and experience, current competence and ability to perform requested privileges, and current health status. In addition the results of the National Data Bank query must be obtained and reviewed. The applicant must have no current or previously successful challenge to licensure or registration, must not have been subject to involuntary termination of medical staff membership at another institution, or been subject to involuntary limitation, reduction, denial or lose of clinical privileges.

7.3 Emergency Privileges

In an emergency, any practitioner, to the degree permitted by his/her license and regardless of services or medical staff status, or lack of, shall be permitted as assisted to do everything deemed necessary and appropriate to save the life of a patient, using every facility of the hospital necessary including the calling of consultation(s). The Administrator shall be notified promptly in such case(s).

7.3-1 Conclusion of Emergency

When the emergency no longer exists, such practitioner must request the privileges necessary to continue to treat the patient if he/she desires to continue such treatment. In the event such privileges are denied or he/she does not desire to request privileges, the patient shall be assigned to an appropriate member of the medical staff.

7.3-2 Definition of Emergency

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

7.4 Disaster Privileges

A LIP may be granted Disaster Privileges when the hospital has activated the Emergency Management Plan and the Administrator in charge has determined there are insufficient staff to meet an acute medical need. The Administrator, Medical Staff President or designee may grant Disaster Privileges upon presentation of appropriate identification as per Medical Staff policy. The Coordinator of the Disaster Plan is responsible for directing the services that an LIP performs during a disaster.
Following stabilization of the disaster, the process to grant temporary privileges shall be initiated.

7.5 Voluntary Leave of Absence

A practitioner may obtain a voluntary leave of absence from the medical staff by submitting a written notice to the President of the Medical Staff stating the approximate period of time of the leave, which may not exceed one (1) year, and the reasons for the request. During the period of leave, the staff member's clinical privileges, prerogatives and responsibilities shall be suspended.

7.5-1 Termination of Leave

At least forty-five (45) days prior to the termination of the leave, or at any earlier time, the staff member may request reinstatement of his/her privileges and prerogatives by submitting a written notice to the President of the Medical Staff who shall initiate review by the Executive Committee. The request shall include a written summary of the practitioner's relevant activities during the leave. The Executive Committee shall recommend to the Governing Board action concerning the reinstatement of the member's privileges and prerogatives.

7.5-2 Failure to Request Reinstatement

Failure without good cause to request reinstatement shall be deemed a voluntary resignation from the medical staff and shall result in automatic termination of medical staff membership, privileges and prerogatives. A practitioner whose membership is so terminated shall be entitled to the procedural rights provided in the Fair Hearing Plan for the sole purpose of determining the issue of good cause. A request for medical staff membership subsequently received from a practitioner so terminated shall be submitted and processed in the manner specific for applications for initial appointments.

Article 8-Officers of the Medical Staff

8.1 Officers of the Medical Staff--The officers of the medical staff shall be:

a. President
b. Vice President

8.2 Qualifications of Officers

Officers shall be members of the medical staff at the time of nominations and elections and shall remain members in good standing during their term in office. Failure to maintain such status shall immediately terminate that individual's tenure as an officer and shall create a vacancy in the office involved.

8.3 Election Process:

The officers and members of the Executive Committee shall be elected at the annual meeting of the medical staff. Each member of the medical staff, eligible to vote shall be entitled to one vote, and proxy voting is not permissible.

A slate of nominees of officers for the Executive Committee shall be presented to the President of the Medical Staff by the Nominating Sub-Committee at the Executive Committee meeting prior to the annual meeting

Each voter may cast only one (1) ballot. When the votes are tallied, the nominees shall be arranged in order of the number of votes received. Those with the largest number of votes shall be considered elected.

8.4 Term of Officers

All officers shall serve a two (2) year term beginning on the first day of the medical staff year following their election to office and continuing until their term has expired and a successor has been elected and assumes office. The Medical Staff year is concurrent with the calendar year.

8.5 Vacancies in Office

Vacancies in office during the medical staff year except for the Presidency shall be filled by the Executive Committee of the medical staff. If there is a vacancy in the office of the President, the Vice President shall serve the remaining term.

8.6 Removal of Officers

Officers of the medical staff may be removed from office only upon petition by the Executive Committee signed by at least four (4) members thereof and upon an affirmative removal vote of no less than sixty-six percent (66%) of the medical staff. The removal of such officer shall become effective upon Governing Board approval of such removal. Officers may be removed if they fail to perform the duties as set forth in these Bylaws or if they are no longer members in good standing of the medical staff.

8.7 Duties of Officers

The officers of the medical staff shall perform the duties set forth in these Bylaws and such other functions as may from time to time be assigned by the President of the Medical Staff, or the Executive Committee.

8.7-1 President

The President shall serve as the Chief Administrative Officer of the medical staff for the following purposes:

a. To act in coordination and cooperation with the Administrator with regard to issues of mutual concern within the hospital;

b. To call, preside at, and be responsible for the agenda on all general meetings of the medical staff;

c. To serve on the Executive Committee and act as its Chair; and to serve as an ex-officio member on other medical staff committees without vote;

d. To be responsible for the enforcement of the Medical Staff Bylaws, Rules and Regulations, for the implementation of sanctions where these are imposed, and for the medical staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;

e. To appoint committee members to all standing and special medical staff committees or committees, except the Executive Committee;

f. To represent the views, policies, needs and grievances of the medical staff to the Governing Board and to the Administrator.

g. To receive and interpret the policies of the Governing Board to the medical staff, and report to the Governing Board on the performance and maintenance of quality with respect to the medical staff's delegated responsibility to provide medical care;

h. To be responsible for the educational activities of the medical staff;

i. To be a spokesperson for the medical staff in its external professional and public relations.

8.7-2 Vice President

In the absence of the President the Vice-President, in the absence of the President, shall assume all the duties and have the authority of the President. He/she shall be a member of the Executive Committee and shall automatically succeed the President when the latter fails to serve for any reason.

Article 9--Committees

9.1 Executive Committee

The Executive Committee shall consist of the President, Vice President, at least one Attending Physician and at least two (2) Members-at-Large, all of which must be members of the medical staff. A majority of the members of the committee shall be physician members of the medical staff. The officers of the Medical Staff shall serve as the officers of the Executive Committee.

The Administrator and his/her designee and the Medical Director shall serve on the Executive Committee as ex-officio members with voting privileges. The Administrator shall serve on the Executive Committee as a member without voting privileges.

9.1-1 Duties--The duties of the Executive Committee shall be:

a. To represent and to act on behalf of the medical staff, between medical staff meetings, subject to such limitations as may be imposed by these Bylaws;

b. To receive and act upon all committee reports;

c. To review and approve all policies and procedures related to patient care which are recommended by the services before such rules or regulations are implemented;

d. To provide liaison between the medical staff, the Administrator and the Governing Board;

e. To recommend action to the Administrator on matters of a medical administrative nature;

f. To fulfill the medical staff's accountability to the Governing Board for the medical care rendered to patients in the hospital through the monitoring and evaluation of the quality and appropriateness of patient care;

g. To monitor and evaluate the quality of patient care and the clinical performance of individuals with delineated privileges. To address opportunities to improve

care addressed and important problems in patient care and resolve issues through medical staff performance improvement functions;

h. To ensure one level of quality patient care by all individuals with delineated clinical privileges;

i. To make recommendations relating to revisions to and updating the Bylaws, Rules and Regulations of the medical staff as necessary and to complete a total review of same at least annually;

j. To review, the credentials of all applicants and to make recommendations directly to the Governing Board for staff membership and delineation of privileges;

k. To review all information available regarding the professional performance, judgment and clinical competence of staff members and other practitioners with clinical privileges, and, as a result of such review, to make recommendations directly to the Governing Board for reappointments and renewal or changes in clinical privileges;

l. To make recommendations to the Governing Board concerning:

1. The structure of the medical staff;
2. The mechanisms to review credentials and delineate privileges;
3. Organization of the performance improvement activities of the medical staff;
4. The mechanisms by which medical staff membership may be terminated;
5. The mechanism for fair hearing procedures.

m. To report at each general staff meeting.

9.1-2 Meetings

The Executive Committee shall meet as often as necessary but at least four (4) times per year and shall maintain a permanent record of its proceedings and actions. The presence of sixty percent (60%) of the voting members of the Executive Committee shall constitute a quorum.

9.2 Pharmacy and Therapeutics Committee

The Committee shall serve as the authority for overseeing the pharmaceutical services and nutritional care of the patients of the hospital.

The Committee shall be composed of, but not necessarily be limited to, the following members: Medical Director, Administrator, Director of Nursing, Director of Quality/Risk Management, one Physician member of the Medical Staff, Pharmacy Consultant, dispensing Pharmacy representative and the Nutrition Consultant.

9.3 Infection Control Committee

The Infection Control Committee shall oversee the prevention and control of infections within

the hospital. The committee shall function as an advisory group to the Medical Executive Committee and report its findings through the Hospital-wide Performance Improvement Program.

The committee shall be composed of, but not necessarily limited to, the following personnel: Administrator, Medical Director, Director of Patient Care Services, Infection Control Coordinator, Director of Quality Management and a member of the medical staff.

9.4 Patient Rights and Ethics Committee

Ethical issues arising from patient care will involve the patient and/or his or her representative, the Administrator, the Medical Director, the Risk Manager and the Patient Rights/ Ethics Committee in discussion and recommendations for resolution and to assure full consideration for action necessary is given when reviewing and addressing ethical issues arising in the care of the patient.

The committee shall be composed of, but not necessarily limited to, the following personnel: Medical Director, Representative of Social Services, Administrator, and the attending physician as necessary, President of the Medical Staff, Director of Quality/Risk Management, and a member of the clergy.

9.5 Quality Assessment/Performance Improvement Committee

The Quality Assessment/Performance Improvement Committee shall oversee the hospital-wide program for the assessment and improvement of the quality of care within the hospital. The committee shall function as an advisory group to the Medical Staff and Hospital Administration. Findings and activities of the committee will be reported the Medical Executive Committee and the Governing Body.

The committee shall be composed of, but not limited to, the members: Director of Patient Care Services or his/her designee, Medical Director, Director of Quality/Risk Management, and any one-(1) member of the Medical Staff. Should a vacancy occur on the committee, the Administrator and/or the Medical Director shall appoint a new member to fill the vacancy. Additional staff may be on the committee on an ***ad hoc*** basis and hospital departments will report on their findings and activities on a regular basis.

Article 10--Medical Staff Meetings

10.1 Regular Meetings

The medical staff shall meet once each year. Members of the medical staff are encouraged to attend.

10.1-1 Notice

The Executive Committee shall by standing resolution designate the time and place for the annual meeting. Any deviation from the terms of such resolution shall require notice as for a special meeting of the staff.

10.1-2 Quorum

The presence of twenty-five percent (25%) of the medical staff shall constitute a quorum.

10.2 Special Meetings

The President of the Medical Staff, the Executive Committee, or the Medical Director, may at any time, file a written request for a special meeting within fourteen (14) days of the filing of such request, a special meeting of the medical staff be called. The President of the Medical Staff shall designate the time and place of any such special meeting.

10.2-1 Notice

Written or printed notice stating the place, day and hour of any special meeting of the medical staff shall be delivered, either personally or by mail, to each member of the active staff not less than seven (7) nor more than fourteen (14) days before the date of such meeting, by or at the direction of the President, or other persons authorized to call the meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the United States Mail, addressed to each member of the active staff at his/her address as it appears on the records of the hospital.

a) Notice may also be sent to the members of the consulting staff who have so requested.

b) No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

10.2-2 Waiver of Notice

The attendance of a member of the medical staff at a meeting shall constitute waiver of notice of such meeting.

10.3 Minutes

Minutes shall be taken at medical staff meetings and shall reflect conclusions, recommendations, and actions taken at the meetings.

Article 11--Corrective Action

11.1 As for terms used in Articles 11 and 12 of these Bylaws, these terms shall be the following meanings:

"Adversely affecting" or **"adversely affects"** includes reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges or membership in the medical staff;

"Professional review action" means an action or recommendation of a professional review body which is taken or made in the conduct of a professional review activity, which is based on the competence or professional conduct of an individual practitioner (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges or membership in the medical staff of the practitioner. The term includes a formal decision of a professional review body not to take an action or make a recommendation described in the previous sentences and also includes professional review activities relating to a professional review action.

"Professional review activity" means an activity of Weisman Children's Rehabilitation Hospital with respect to an individual practitioner--

1) to determine whether the practitioner may have clinical privileges with respect to, or membership in, the medical staff;

2) to determine the scope or conditions of such privileges or membership; or

3) to change or modify such privileges or membership.

"Professional review body" means Weisman Children's Rehabilitation Hospital, its Governing Board and the Executive Committee, any committee of the medical staff, any member of the medical staff and any person who participates in or is staff to the body when assisting the Governing Board of Weisman Children's Rehabilitation Hospital in a professional review activity.

"Investigation" shall mean the inquiry performed by the ad hoc committee, as set forth below, to determine whether to recommend that a professional review activity adversely affecting a practitioner be undertaken.

11.2 Professional Review Action

a) Standards-- A professional review action shall only be taken--

1) in the reasonable belief that the action is in the furtherance of quality health care,

2) after a reasonable effort to obtain the facts of the matter,

3) after adequate notice and hearing procedures are afforded to the practitioner involved or after such other procedures as are fair to the practitioner under the circumstances,

4) in the reasonable belief that the action is warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of

subparagraph 3, above.

b) Peer Review Action: The Medical Staff at WCRH work to promote continuous improvement in the quality of care provided by all LIP's with delineated clinical privileges. Members of the medical staff participate in the ongoing assessment of quality of care. Peer review consists of LIP's with clinical privileges in the same professional discipline and equal qualifications. Specific quality of care indicators are defined by the Medical Staff Policy and Procedure. Charts are reviewed by peers and results reported to the Physician-in-Chief. It is the responsibility of the Physician-in-Chief to monitor minor deviations not resulting in adverse patient outcome, notify the LIP involved and follow any lesser plan of correction.
c) When significant departures from established patterns of clinical practice with concerns regarding quality of patient care are identified through peer review, the Physician-in-Chief shall notify the Executive Committee. After reviewing the request and obtaining such additional information as it deems necessary, the Executive Committee shall determine whether there are reasonable grounds to initiate an investigation to determine if a professional review action is warranted. The Executive Committee may take any lesser action if it deems it appropriate as long as such corrective action does not adversely affect the practitioner. When an investigation is appropriate, the Executive Committee shall name a focused peer review panel. This panel shall meet within 30 days of the Executive Committee decision, or within 14 days when a significant deviation in care with adverse patient outcome is identified.
d) The focused peer review panel shall consist of 3 peer members of the medical staff, selected form the active medical staff with privileges and qualifications similar to the identified LIP. The peer review panel will meet and review all information including chart review and interviews as needed. The identified LIP is notified of the concern and invited to participate in the process through a direct interview process or by submitting any information or informing the panel of sources of information that may be helpful. The panel; evaluation shall not constitute a hearing, shall be informal and preliminary in nature and none of the procedural rules provided in these Bylaws with respect to hearings shall apply.
e) The Focused Peer Review Panel shall keep records of the meeting and provide to the Executive Committee a written report of findings and recommendations.
f) An external peer review shall be conducted when:
    a. Peers are considered to have a conflict of interest
    b. There are insufficient numbers of peers to create a panel.
    c. The panel cannot reach consensus.
    d. An external peer review shall be performed when:
    e. The LIP rejects the panel's findings and recommendations.
    f. The Executive Committee rejects the Peer Review Panel decision.

External peer review panels are subject to the same panel requirements and time frames as focused peer review panels. An external peer review panel shall be obtained by querying the state medical society.

The Executive Committee shall consider the recommendations of the Peer Review Panel. If the Executive Committee rejects the findings of the Peer Review Panel by majority vote, an external Peer review is convened. When the recommendation is made for a lesser corrective action that does not adversely affect a practitioner's privileges, the Physician-in-Chief is responsible for monitoring the program to improve an individual ' performance.

When a recommendation is made to limit, suspend, or withdraw privileges, the identified

LIP is notified by certified mail. The affected LIP is entitled to procedural rights provided in Article 12. The notice shall include the proposed action, reasons for the action and LIP right to request a hearing within 30 days of the receipt of the notice or all rights for Due Process will be waived.
The executive Committee shall promptly notify the CEO, Medical Director, and Physician-in-Chief in writing of all requests for a focused peer review panel and shall keep the CEO fully informed.
All activities of the peer review panel and Executive Committee deliberations shall remain confidential.
When deviations in clinical practice are deemed secondary to LIP health, the committee of LIP Health shall operate as the Peer Review Panel.
Following notification of the LIP, the Governing Body is notified of the Executive Committee's recommendations. The Governing Body shall make a final decision regarding corrective action as per Article 12.6. At any time an LIP is subject to summary suspension whenever failure to take such action may result in imminent danger to the health of an individual.

11.3 Summary Suspension

a) The President of the Medical Staff or his/her designee, or the Executive Committee of the Medical Staff or the Governing Board, shall each have the authority to summarily suspend all or any portion of the clinical privileges of a practitioner whenever failure to take such action may result in an imminent danger to the health of any individual, and such summary suspension shall become effective immediately upon imposition.

b) A practitioner whose clinical privileges have been summarily suspended shall be entitled to request a hearing on the matter in accordance with Articles 11 and 12 of these Bylaws.

c) The Executive Committee may recommend modification, continuation or termination of the terms of the summary suspension. If, as a result of such hearing, the Executive Committee does not recommend immediate termination of the summary suspension, the affected practitioner shall, also in accordance with Article 12 be entitled to request an Appellate Review. The terms of the summary suspension as sustained or as modified by the Executive Committee shall remain in effect pending a final decision by the Governing Board.

c) Immediately upon the imposition of a summary suspension, the Chair of the Executive Committee shall have the authority to provide for alternative medical coverage for the patient(s) of the suspended practitioner in Weisman Children's Rehabilitation Hospital at the time of such suspension. The wishes of the patient(s) shall be considered in the selection of an alternative practitioner.

11.4 Suspension Pending an Investigation

a) Clinical privileges of a practitioner may be suspended or restricted for a period of no longer than fourteen (14) days, during which an investigation is being conducted to determine the need for a professional review action.

b) A practitioner whose privileges are suspended or restricted under this section shall not have a right to a hearing or appeal from this suspension or restriction.

11.5 Automatic Suspension

a) A temporary suspension in the form of withdrawal of a practitioner's admitting privileges and consulting privileges shall be imposed automatically fifteen (15) days after a warning of delinquency is issued for failure to complete medical records. Such suspension shall remain in effect until medical records are completed;

b) A temporary suspension in the form of withdrawal of a practitioner's admitting and consulting privileges shall be imposed automatically sixty (60) days after a warning of delinquency is issued for failure to pay medical staff dues. Such suspension shall remain in effect until all dues are paid in full; (not currently applicable)

c) Action by an agency of the State of New Jersey revoking or suspending a practitioners' license, shall automatically suspend all medical staff privileges.

Article 12--Hearing and Appellate Review Procedure

12.1 Request for Hearing Any practitioner who receives notice of a recommendation of the Executive Committee that, if ratified by decision of the Governing Board, will adversely affect his/her appointment to or status as a member of the medical staff or his/her exercise of clinical privileges, shall be entitled to notice of the proposed action and to request a hearing. The request for hearing shall be in writing and delivered to the Medical Director within thirty (30) days of receipt by the practitioner of the notice of proposed action. Any failure to timely request a hearing shall be deemed a waiver of any rights set forth in this Article.

12.2 Appointment of a Hearing Committee Upon receipt of a timely request for hearing, the Medical Director shall confer with the President of the Medical Staff and the Administrator or his/her designee to appoint a committee of five (5) physicians, three (3) of whom shall be past Presidents of the Medical Staff, if possible. None of the members of the panel shall be in direct economic competition with the practitioner and none of them shall have had any involvement in the action of the Executive Committee or any other committee concerning the matter to be heard.

12.3 Notice of Hearing If a hearing is requested on a timely basis, the involved practitioner shall be given notice stating the place, time and date of the hearing which shall not be less than thirty (30) days after the date of the notice and a list of the witnesses, if any, expected to testify at the hearing in support of the proposed action by the medical staff.

12.4 Hearing Procedure

a) The hearing shall be conducted at the time and place indicated and the applicant or staff member shall appear. The President of the Medical Staff, in his/her

judgment, may extend the hearing date at the request of the applicant or staff member, but is not required to do so. If the practitioner fails, without good cause to appear, the hearing committee may decide, within its sole discretion, that the right to a hearing has been forfeited, or it may proceed to hear and decide the matter in the absence of the practitioner, or it may postpone the hearing.

b) The panel shall select one of its members to be the chairperson, who shall preside over the proceedings.

c) At the hearing, a representative of the medical staff shall present the proposed recommendation, the reasons for the recommendation and the evidence in support thereof. The medical staff may be represented by an attorney and may offer such evidence as the chairperson determines to be relevant without regard to its admissibility in court.

d) At the hearing, the involved practitioner shall have the right to be represented by an attorney or person of the practitioner's choice; to have a record made of the proceedings, copies of which may be obtained by the practitioner upon payment of any reasonable charges associated with the preparation thereof; to call, examine and cross-examine witnesses and to present evidence determined to be relevant by the chairman of the panel regardless of its admissibility in a court of law and to submit a written statement at the close of the hearing.

e) The chairman may adjourn the hearing and reconvene the same at the convenience of the parties for the purpose of obtaining new or additional evidence or for consultation without special notice. Upon conclusion of the hearing, the matter shall be closed and the Hearing Committee, at a time convenient for itself, shall conduct its deliberations in Executive Session. Within ten (10) days, unless the interval is extended by the agreement of the parties, the Hearing Committee shall submit its report and recommendations to the Executive Committee. A copy of the written recommendation of the Committee, including a statement of the basis for the recommendation, shall be sent to the practitioner.

f) The Executive Committee shall review the recommendation of the Hearing Committee and may examine the transcript of any of the testimony or any of the evidence presented to the Committee. Thereafter, the Executive Committee shall make its recommendation to the Governing Board, a copy of which shall be sent to the involved practitioner.

12.5 Practitioners' Rights

Throughout the hearing and appellate review, the applicant or practitioner shall be afforded the following rights:

a) After a notice of proposed action has been received, he/ she may be represented by an attorney or any other person of their choice at all stages of the hearing and appellate review process;

b) An official record of the hearing will be made and a copy may be obtained by the

applicant or practitioner upon payment of a reasonable charge associated with the preparation thereof.

c) The applicant or practitioner shall have the right to call, examine and cross-examine witnesses;

d) He/she may present relevant evidence, regardless of its admissibility in court;

e) The applicant or practitioner shall have the right to submit a written statement to the Review Committee at the close of the hearing;

f) He/she shall receive a copy of the written recommendation of the Review Committee and of the Executive Committee, which shall contain an explanation of the basis for the recommendation; and

g) The applicant or practitioner shall receive a written decision of the Governing Board including a statement of the basis for its decision.

12.6 Appeal to the Governing Board

a) If the practitioner is not satisfied with the recommendation of the Executive Committee, the practitioner may request an appeal to the Governing Board by delivering a written request to the Medical Director within fifteen (15) days of the receipt of the recommendation of the Executive Committee.

b) In the event of an appeal to the Governing Board, the Governing Board or its appointed committee shall arrange for a hearing to review the matter. The applicant or practitioner shall be notified by the Administrator of the time, place and date of the hearing. Such hearing shall be held as soon as is practical.

c) No new matters shall be considered by the Governing Board or its appointed committee at the appellate hearing, unless the Governing Board or its appointed committee determines that such was inadvertently omitted or unavailable at the time of the original hearing. Both parties involved in the appeal may be represented by legal counsel.

d) Within ten (10) days after the conclusion of the appellate review, the Governing Board shall make its final decision in the matter. If this decision concurs with the Executive Committee's last recommendation in the matter, it shall be immediately effective and final and it shall not be subject to further hearing or appellate review. A notice shall be sent to the affected practitioner by certified mail, which shall include a statement of the basis for the decision.

e) If the decision is contrary to the Executive Committee's last recommendation, the Governing Board shall refer the matter to an Ad Hoc Committee for further review and recommendation within ten (10) days and shall include a statement that a final decision will not be made until the Ad Hoc Committee's recommendation has been received. The written recommendation of the Ad Hoc Committee shall be forwarded to the Governing Board within thirty (30) days of the date the review is

requested. The Governing Board, at its next regular meeting after receipt of the Ad Hoc Committee's recommendation, must make its final decision in the matter and shall send notice, including a statement of the basis for the decision, to the Executive Committee, the Administrator and the affected practitioner by certified mail.

f) Notwithstanding any other provision of these Bylaws, no practitioner shall be entitled to more than one hearing and one appellate review on any matter by the Executive Committee or by the Governing Board.

12.7 Reporting of Adverse Actions

a) In accordance with the Health Care Quality Improvement Act of 1986, the hospital shall report, within seven (7) days of the reported event, to the Board of Medical Examiners, the Osteopathic Board of Medical Examiners, National Practitioner Data Bank and other boards as they pertain to individual practitioner, the following actions taken against the clinical privileges of a practitioner:

1) Any professional review action that adversely affects the clinical privileges of a practitioner; or

2) Acceptance of the voluntary surrender of clinical privileges or any restrictions of such privileges by a practitioner while he/she is under investigation relating to possible incompetence or improper professional conduct, or in return for not conducting such an investigation or proceeding.

Article 13—Licensed Independent Practitioner (LIP) Program

13.1 A LIP Health Program is hereby established within this hospital which is composed of the Committee on the Physician Health, established by these Bylaws as a peer review organization pursuant to the New Jersey Peer Review Protection Act. This program is entirely independent of any other committee, and entirely separate from any disciplinary or enforcement activities established or authorized by these Bylaws. The Committee on LIP Health is created to receive complaints and referrals, investigate and recommend treatment in any instance of suspected functional and professional impairment because of alcoholism, drug dependency, or mental, physical or aging problems that have or could give rise to injury to a patient.

13.2 Committee of Physician Health. The composition of the Committee on Physician Health shall be composed of the Medical Director, who shall serve as the Chairperson, President of the Medical Staff; and three members of the medical staff appointed yearly or as needed by the Medical Director, with no limitation on the number of terms they may serve. Only appointed members may be removed, and vacancies filled by and at the discretion of the Medical Director. If a complaint involves a member of the committee, that member shall be excused from serving on the committee until resolution of the complaint.

The duties of the Committee of Physician Health include:

- To receive complaints or observations from members of the medical staff, other hospital personnel, relatives of the alleged impaired LIP, patients, and relatives of patients or other interested persons; to receive self-referrals.nvestigation of such complaints or observations including interviews with the complainant or observer and any other individuals who would be likely to contribute meaningful observation.
- Make a determination of impairment.
- Meet with the physician in question to demonstrate that complaints have been received about the physician's professional conduct, that the complaints have been investigated and apparently have substance, and refer the physician to the appropriate professional resource for the diagnosis and treatment of the condition or concern.
- In the event of a determination that a physician is not impaired, notification of this fact to the complainant.
- Recommend to the Executive Committee any limitation of privileges or removal from practice during treatment. This recommendation may be made with the consultation from the individual in charge of the treatment program for the identified physician. Monitor any limitation of privileges.
- Monitor the status of the treatment program and/or any limitations of privileges. Report any change or refusal to undergo treatment to the Medical Executive Committee
- Upon successful completion of a treatment program, prepare and implement a program to reinstate the physician without humiliation or rejection by other members of the medical staff, and to monitor this program.
- Ensure that the investigation proceeds with due diligence to a final conclusion.
- Maintain written records of all matters pertaining to the complaint, investigation, and resolution.
- Provide education to all hospital staff regarding physician illness and impairment, including recognition and referral.

13.3 Confidentiality

The proceedings and the records of the Committee on Physician Health shall be held in strictest confidence except to the extent that findings and action by them must be made known to persons or committees with a valid interest in the proceedings, e.g., Executive Committee. Such persons or committees are also obligated to hold the information in the strictest confidence.

13.5 Report to the Executive Committee

The initial complaint or observation and final results of all investigations, whether confirming or refuting the original complaint or observation, will be reported to the Chairperson of the Executive Committee. This information shall then be reported by the Chairperson of the Executive Committee to the Chairperson of the Governing Board. Any board member with a bona fide valid justification for access to this information may have such access only after discussion with and permission by the Chairperson of the Governing Board.

13.6 Initiation of Action

Should the physician under consideration refuse the recommendations of the Committee on Physician health or fail to follow through on such recommendations, disciplinary action shall be recommended by the Committee on Physician Health under procedures as outlined under Articles 11 and 12.

Article 14--Immunity from Liability

The following shall be expressed conditions to any practitioner's application for exercise of clinical privileges at this hospital;

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

Second, that such privileges shall extend to members of the hospital□s medical staff and of its Governing Board, its other practitioners, its Administrator and his/her representative, and the third parties, who give information to any of the foregoing authorized to receive, release, or act upon the same. For the purpose of this Article the term third party means both individuals and organizations from which information has been requested by an authorized representative of the Governing Board or of the medical staff.

Third, that there shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any act, communication, report, recommendation or disclosure, even where the information involved would otherwise be deemed privileged.

Fourth, that such immunity shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health care institution□s activities related, but not limited to (1) applications for appointment or clinical privileges; (2) periodic reappraisals for reappointment or clinical privileges; (3) corrective action, including summary suspension; (4) hearings and appellate review; (5) continuous quality improvement activities and medical care evaluations; (6) utilization reviews; and (7) other hospital or committee activities related to quality patient care and professional conduct.

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

Sixth, that in furtherance of the foregoing, each practitioner shall upon request of the hospital, execute releases in accordance with the tenor and import of this Article in favor of the individuals and organizations specified in paragraph □Second,□ subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of this state.

Seventh, that the consent, authorizations, releases, rights, privileges and immunities provided by Article 5 of these Bylaws for the protection of this hospital ' s practitioners, other appropriate hospital officials and personnel, and third parties, in connection with applications for initial appointment, shall also be fully applicable to the activities and procedures covered by this Article.

Article 15--Rules and Regulations

15.1 Scope of Rules and Regulations

The medical staff shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found within these Bylaws, and to reflect the hospital's current practices with respect to the medical staff organization and functions, subject to the approval of the Governing Board. These shall relate to the proper conduct of the medical staff organization activities as well as embody the level of practice that is to be required of each practitioner in the hospital.

15.2 Adoption and Amendment

Such Rules and Regulations shall be part of these Bylaws, except that they may be amended or repealed at any meeting 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 of the medical staff. Amendments so made shall be effective when approved by the Governing Board and distributed to the medical staff members. Neither body may unilaterally amend such Rules and Regulations.

Article 16--Bylaws Review and Amendment

16.1 Review

These Bylaws shall be reviewed by the Executive Committee or a committee appointed by them at least annually and more often as needed.

16.2 Amendments

These Bylaws may be amended after submission of the proposed amendment at any regular or special meeting of the Medical Staff. A proposed amendment shall be referred to the Executive Committee which shall report on it at the next regular meeting of the Medical Staff or at a special meeting called for such purpose. To be adopted, an amendment shall require a two-thirds (2/3) vote of the Medical Staff present. Amendments so made shall be effective when approved by the Governing Board and distributed to the Medical Staff members.

16.3 ADOPTION

These Bylaws shall be submitted to a regular or special meeting of the medical staff. They shall be adopted upon an affirmative vote of two-thirds (2/3) of the medical staff present at that or a subsequent regular or special meeting called for such purpose. The Bylaws shall then become effective upon approval of the Governing Board and be distributed to the members of the medical staff.

ADOPTED by the medical staff on April 21, 1998

APPROVED by the Governing Board on April 29, 1998.

Amended by the Medical Staff September 29, 2003

Adopted on September 29, 2003

Approved by the Governing Body on October 3, 2003

Amended by the Medical Staff December 13, 2004

Adopted on December 13, 2004

Approved by the Governing Body on December 13, 2004

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Amended by the Medical Staff December 13, 2004

Adopted on December 13, 2004

Approved by the Governing Body December 13, 2004

Amended by the Medical Staff September 11, 2006

Adopted on December 6, 2006

Approved by the Governing Body December 6, 2006

Amended by the Medical Staff December 11, 2017

Adopted on December 11, 2017

Approved by the Governing Body December 11, 2017

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President, WCRH Medical Staff Date Governing Body Date