MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS OF SARASOTA MEMORIAL HOSPITAL

MEDICAL STAFF ORGANIZATION MANUAL

Adopted by the Medical Staff: April 16, 2009
Approved by the Board: April 20, 2009
Revised by the Medical Staff: 08/24/09
Approved by the Board: 10/19/09
Revised by the Medical Staff: 10/25/2010
Approved by the Board: 11/16/2010
Revised by the Medical Staff: 04/25/11
Approved by the Board: 05/16/11
Revised by the Medical Staff: 04/23/12
Approved by the Board: 05/21/12
Revised by the Medical Staff: 03/27/13
Approved by the Board: 04/15/13
Revised by the Medical Staff: 02/24/14
Approved by the Board: 03/17/14

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ARTICLE 1

GENERAL

1.A: DEFINITIONS

The following definitions shall apply to terms used in this Manual:

(1) "ALLIED HEALTH PROFESSIONALS" ("AHPs") means individuals other than Medical Staff members who are authorized by law and by the Hospital to provide patient care services.

(2) "BOARD" means the Sarasota County Public Hospital Board, which has the overall responsibility for the Hospital, or its designated committee.

(3) "CLINICAL PRIVILEGES" or "PRIVILEGES" means the authorization granted by the Board to a practitioner to render specific patient care services, for which the Medical Staff leaders and Board have developed eligibility and other credentialing criteria and focused and ongoing professional practice evaluation standards.

(4) "CORE PRIVILEGES" means a defined grouping of privileges for a specialty or subspecialty that includes the fundamental patient care services that are routinely taught in residency and/or fellowship training for that specialty or subspecialty and which have been determined by the Medical Staff leaders and Board to require closely related skills and experience.

(5) "DAYS" means calendar days.

(6) "DENTIST" means a doctor of dental surgery ("D.D.S.") or doctor of dental medicine ("D.M.D.").

(7) "HOSPITAL" means Sarasota Memorial Hospital.

(8) "MEDICAL EXECUTIVE COMMITTEE" means the Executive Committee of the Medical Staff.

(9) "MEDICAL STAFF" means all physicians, dentists, oral surgeons, podiatrists, and psychologists who have been appointed to the Medical Staff by the Board.

(10) "MEDICAL STAFF LEADER" means any Medical Staff officer, department chairperson, section chief, or committee chair.

(11) "MEMBER" means any physician, dentist, oral surgeon, podiatrist, or psychologist who has been granted Medical Staff appointment and clinical privileges by the Board to practice at the Hospital.

(12) "NOTICE" means written communication by regular U.S. mail, e-mail, facsimile, Hospital mail, or hand delivery.

(13) "ORGANIZED HEALTH CARE ARRANGEMENT" means the term used by the HIPAA Privacy Rule to describe a clinically-integrated care setting in which patients typically receive health care from more than one provider (such as a hospital and its Medical Staff) and which benefits from regulatory provisions designed to facilitate compliance with the HIPAA Privacy Rule.

(14) "PATIENT CONTACTS" include any admission, consultation, procedure, response to emergency call, evaluation, treatment, or service performed in any facility operated by the Hospital or affiliate, including outpatient facilities. Patient contacts do not include requests for diagnostic services from pathology, radiology, or other departments of the Hospital.

(15) "PHYSICIAN" includes both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s").

(16) "PODIATRIST" means a doctor of podiatric medicine ("D.P.M.").

(17) "PRESIDENT" means the individual appointed by the Board to act on its behalf in the overall management of the Hospital.

(18) "PSYCHOLOGIST" means an individual with a Ph.D. or a Psy.D. in clinical psychology.

(19) "SPECIAL NOTICE" means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.

(20) "SPECIAL PRIVILEGES" means privileges that fall outside of the core privileges for a given specialty, which require additional education, training, and/or experience beyond that required for core privileges in order to demonstrate competence.

(21) "UNASSIGNED PATIENT" means any individual who comes to the Hospital for care and treatment who does not have an attending physician, or whose attending physician or designated alternate is unavailable to attend the patient, or who does not want the prior attending physician to provide him/her care while a patient at the Hospital.

1.B: TIME LIMITS

Time limits referred to in this Manual are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

1.C: DELEGATION OF FUNCTIONS

When a function is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one or more qualified designees.

ARTICLE 2

CLINICAL DEPARTMENTS

2.A: LIST OF DEPARTMENTS AND SECTIONS

The following clinical departments and sections are established:

Department of Anesthesia
- Pain Management Section

Department of Cardiology

Department of Emergency Medicine
- Ambulatory Care Section

Department of Medicine and Family Practice
- Ambulatory Care Section
- Dermatology Section
- Gastroenterology Section
- General Medicine Section
- Infectious Diseases Section
- Nephrology Section
- Neurology Section
- Oncology/Hematology Section
- Palliative Care Section
- Pulmonary and critical Care Medicine Section
- Rehabilitation/Physiatry Section
- Rheumatology Section

Department of Neuroscience

Department of Obstetrics and Gynecology
- Gynecology Section
- Obstetrics Section

Department of Pathology

Department of Pediatrics

Department of Psychiatry
- Psychology Section

Department of Radiology
- Radiation Oncology Section

Department of Surgery
- Cardiothoracic Surgery Section
- Dentistry Section
- General Surgery Section
- Neurosurgery Section
- Ophthalmology Section
- Oral and Maxillofacial Surgery Section
- Orthopedics Section
- Otorhinolaryngology Section
- Plastic Surgery Section
- Podiatric Foot & Ankle Surgery Section
- Urology Section
- Vascular Surgery Section

2.B: FUNCTIONS AND RESPONSIBILITIES OF DEPARTMENTS AND SECTIONS

The functions and responsibilities of departments, department chairpersons, sections, and section chiefs are set forth in Article 4 of the Medical Staff Bylaws.

ARTICLE 3

MEDICAL STAFF COMMITTEES

3.A: MEDICAL STAFF COMMITTEES AND FUNCTIONS

(1) This Article outlines the Medical Staff committees of the Hospital that carry out ongoing and focused professional practice evaluations, peer review, and other performance improvement functions that are delegated to the Medical Staff by the Board.

(2) Procedures for the appointment of committee chairs and members of the committees are set forth in Article 5 of the Medical Staff Bylaws.

3.B: MEETINGS, REPORTS AND RECOMMENDATIONS

Unless otherwise indicated, each committee described in this Manual shall meet as necessary to accomplish its functions, and shall maintain a permanent record of its findings, proceedings, and actions. Each committee shall make a timely written report after each meeting to the Medical Executive Committee and to other committees and individuals as may be indicated in this Manual.

3.C: BLOOD USAGE COMMITTEE

3.C.1. Composition:

The Blood Usage Committee shall consist of at least four members of the Medical Staff. Representatives from Administration and nursing and the Administrator of the Sarasota Community Blood Bank shall also serve on the committee.

3.C.2. Duties:

The Blood Usage Committee shall:

(a) develop, review, and revise policies and procedures pertaining to blood usage and administration in the Hospital;

(b) receive quarterly reports from the Sarasota Community Blood Bank addressing the adequacy of blood product services to meet community needs; and

(c) conduct a regular review of blood usage and physician ordering practices within the Hospital, generating data which shall be analyzed for trends to allow recommendations for improvement in blood usage.

(d) communicate with and counsel physicians individually when patterns of blood utilizations are felt to exceed the norm, determined by evidence based standard of care.

3.D: BYLAWS REVISION COMMITTEE

3.D.1. Composition:

The Bylaws Revision Committee shall consist of at least five members of the Medical Staff, including the Chief of Staff and at least one member of the Medical Executive Committee who shall chair the committee. The Vice President for Medical Affairs shall also serve on the committee.

3.D.2. Duties:

The Bylaws Revision Committee shall:

(a) conduct an annual review of the Medical Staff Bylaws and the Bylaws-related documents to assure their compliance with current guidelines and standards promulgated by the Joint Commission, the Bylaws of Sarasota Memorial Hospital, and applicable federal and state legislation; and

(b) draft amendments to the Medical Staff Bylaws and the Bylaws-related documents and present the proposed amendments to the Medical Executive Committee for discussion and action. In performing this function, the committee may interact with Hospital legal counsel and any special legal counsel that may be appointed by the Board at the request of the Medical Staff.

3.E: CANCER COMMITTEE

3.E.1. Composition:

The Cancer Committee shall consist of members of the Medical Staff. Committee membership shall meet the requirements of the American College of Surgeons Commission on Cancer as defined in its Cancer Program Standards. All members of the committee shall be voting members.

3.E.2. Duties:

The Cancer Committee shall:

(a) develop and evaluate the annual goals and objectives of the clinical, educational, and programmatic activities related to cancer;

(b) promote a coordinated, multidisciplinary approach to patient management;

(c) ensure that educational and consultative cancer conferences cover all major sites and related issues;

(d) ensure that an active support care system is in place for patients, families, and staff;

(e) monitor quality management and improvement through completion of quality management studies that focus on quality, access to care, and outcomes;

(f) promote clinical research;

(g) supervise the cancer registry and ensure accurate and timely abstracting, staging, and follow-up reporting;

(h) perform quality control of registry data;

(i) encourage data usage and regular reporting;

(j) publish by November of each year an annual report which meets the requirements set forth by the American College of Surgeons Commission on Cancer;

(k) uphold medical ethics standards; and

(l) meet as often as necessary to accomplish its functions, at least quarterly.

3.F: CREDENTIALS COMMITTEE

3.F.1. Composition:

The Credentials Committee shall consist of at least eight members of the Active Staff who satisfy the eligibility criteria in Section 3.B of the Medical Staff Bylaws. Particular consideration is to be given to Past Chiefs of Staff and to physicians knowledgeable in the credentialing process. The Vice President for Medical Affairs shall also serve on the committee. Service on this committee shall be considered a primary Medical Staff obligation of each committee member.

3.F.2. Duties:

The Credentials Committee shall:

(a) in accordance with the Credentials Policy, review the credentials of all applicants for Medical Staff appointment, reappointment, and clinical privileges, conduct a thorough review of the applications, interview such applicants as may be necessary, and make written reports of its findings and recommendations;

(b) in accordance with the Policy on Allied Health Professionals, review the credentials of all applicants seeking to practice as Licensed Independent Practitioners or Advanced Dependent Practitioners, conduct a thorough review of the applications, interview such applicants as may be necessary, and make written reports of its findings and recommendations;

(c) review, as may be requested by the Medical Executive Committee, all information available regarding the current clinical competence and behavior of persons currently appointed to the Medical Staff or Allied Health Professionals and, as a result of such review, make a written report of its findings and recommendations; and

(d) review and make recommendations regarding appropriate threshold eligibility criteria for clinical privileges within the Hospital, including specifically as set forth in Section 4.A.2 ("Clinical Privileges for New Procedures") and Section 4.A.3 ("Clinical Privileges That Cross Specialty Lines") of the Credentials Policy.

3.G: INFECTION CONTROL COMMITTEE

3.G.1. Composition:

The Infection Control Committee shall consist of at least five members of the Medical Staff, including at least two representatives from infectious disease and at least one each from surgery and pathology. The Infection Control Officer, the Director of the Sarasota County Public Health Department or his designee, and at least one representative each from Hospital administration, nursing, respiratory therapy, and employee health services shall also serve on the committee.

3.G.2. Duties:

The Infection Control Committee shall:

(a) develop, implement, and maintain the infection control program at the Hospital, including surveillance, prevention, and control of infection;

(b) develop a system for reporting, identifying and analyzing the incidents and cause of all infections, consistent with recommendations by the Centers for Disease Control, the Joint Commission, and the Florida Department of Health;

(c) develop and implement a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, isolation, and sanitation techniques;

(d) develop, evaluate, and review biennially preventive, surveillance, and control policies and procedures relating to all phases of the Hospital's activities,

including: operating rooms, delivery rooms, special care units; central service, housekeeping and laundry; sterilization and disinfection procedures by heat, chemicals, or otherwise; isolation procedures; prevention of cross-infection by anesthesia apparatus or inhalation therapy equipment; testing of Hospital personnel for carrier status; disposal of infectious material; food sanitation and waste management; and other situations as requested;

(e) make periodic recommendations on the utilization of antibiotics within the Hospital, based upon prevalence, susceptibility, and resistance data from the Hospital laboratory;

(f) develop and implement actions to prevent or control infections, based upon an evaluation of surveillance reports and the infection potential among patients and Hospital patient care personnel;

(g) review infection control policies on a biennial basis to maintain optimal standards of care in conformance with current medical knowledge;

(h) recognize, research, and make appropriate recommendations when infection rates exceed endemic (threshold) levels;

(i) make recommendations to Employee Health Service with regard to infection control matters; and

(j) coordinate findings and recommendations with the Pharmacy and Therapeutics Committee regarding antimicrobial therapy.

The committee chair or his/her designee has the authority to initiate any surveillance, prevention, or control measures necessary when there is reason to believe that the health of patients or personnel may be in jeopardy from nosocomial infection.

3.H: INTERDISCIPLINARY CARE COMMITTEE

3.H.1. Composition:

The Interdisciplinary Care Committee shall consist of at least six (6) members of the medical staff from the following specialties, Anesthesia, Emergency Medicine, Medicine, OB/Gyn, Radiology and Surgery. Non-voting members will include the Chief Medical Operations Officer, a Nursing Administration Representative and Allied Health Professional (AHP) representatives to include one each of the following; ARNP, PA, CRNA and CNM.

3.H.2. Duties:

The Interdisciplinary Care Committee shall:

(a) provide one AHP member each medical staff year as a Non-Voting Medical Executive Committee representative to attend monthly MEC meetings;

(b) review and recommend approval of privileging and standard procedures and protocols to the Credentials Committee;

(c) intervene when appropriate to attempt to resolve any issues with credentialing, privileging or supervising physician conflicts which may arise;

(d) develop and recommend policies for AHPs including, but not limited to, the appropriate scope of practice and, granting of expanded role privileges to provide for the assessment, planning and direction of the diagnostic and therapeutic care of patients;

(e) make recommendation regarding appropriate monitoring, supervision, evaluation of AHPs;

(f) identify functions or procedures that require the formulation and adoption of standardized procedures. (Approved 3/24/14)

3.H: MEDICAL EDUCATION/LIBRARY COMMITTEE

3.H.1. Composition:

The Medical Education/Library Committee shall consist of at least ten members of the Medical Staff representing a broad range of disciplines.

3.H.2. Duties:

The Medical Education/Library Committee shall:

(a) develop, plan, and implement a regular program on continuing medical education for the benefit of the Medical Staff, the Allied Health Professionals Staff, Hospital patient care personnel, and the Sarasota medical community at large, of such quality to justify the continued production of Category I American Medical Association Medical Education Programs;

(b) ensure that the program of continuing medical education provides exposure to new medical information, techniques, and skills in a broad variety of disciplines;

(c) interface with the Quality Improvement Committee and other standing committees of the Medical Staff to provide medical education programs tailored to the interests and perceived needs of the Medical Staff and other interested patient care Hospital personnel;

(d) make recommendations to the Hospital with reference to the expenditure of funds for continuing medical education;

(e) supervise and coordinate the maintenance of records of attendance at continuing education functions;

(f) advise the Librarian regarding the purchase of texts and periodicals;

(g) supervise the collections of contributions from the Medical Staff, and review expenditures of such funds; and

(h) make recommendations to improve the operation of the Hospital Library.

3.I: MEDICAL EXECUTIVE COMMITTEE

The composition and duties of the Medical Executive Committee are set forth in Section 5.D of the Medical Staff Bylaws.

3.J: MEDICAL RECORDS COMMITTEE

3.J.1. Composition:

The Medical Records Committee shall consist of at least five members of the Medical Staff. The Director of the Medical Records Department, the Director of Quality Improvement, and at least one representative each from Hospital administration and nursing shall also serve on the committee.

3.J.2. Duties:

The Medical Records Committee shall:

(a) review trends and data related to the individual practitioner's completion of medical records and take action as appropriate;

(b) authorize the permanent filing of a medical record when a practitioner, for whatever reason, is unable to complete documentation;

(c) develop and implement systems to assure that medical records within the Hospital meet such standards of completeness, accuracy, confidentiality, and legibility as may be developed by the committee;

(d) implement a medical records review system to assure that medical records accurately reflect and document medical events occurring during hospitalization;

(e) conduct a regular review of medical records to assure that each represents an accurate description of the patient's condition and progress while hospitalized, the

therapy provided, the results of therapy, including adverse or unexpected occurrences, and identification of responsibility for patient care rendered during hospitalization;

(f) develop, monitor compliance with, and enforce rules and regulations related to the timely completion of medical records such that a complete record is available for patient care and reimbursement procedures;

(g) determine and recommend the medical record format, including approval of forms within the medical record, and educate the Medical Staff concerning new developments in standards of documentation; and

(h) assure that a reliable, confidential, safe, and convenient storage and retrieval system for medical records is operative at all times, such that each patient's record is readily available on an emergent basis.

3.K: PHARMACY AND THERAPEUTICS COMMITTEE

3.K.1. Composition:

The Pharmacy and Therapeutics Committee shall consist of at least five members of the Medical Staff, with a wide representation of medical and surgical specialties. At least one representative each from Hospital administration, nursing, and pharmacy shall also serve on the committee.

3.K.2. Duties:

The Pharmacy and Therapeutics Committee shall:

(a) assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety, and all other matters relating to pharmaceuticals within the Hospital;

(b) advise the Medical Staff and pharmacy professionals on matters related to the choice of available diagnostic and therapeutic agents;

(c) make recommendations concerning medications to be stocked on nursing units, special care units, and any other service or clinical area within the Hospital;

(d) develop and review periodically a Hospital formulary, recommend protocols, policies, and procedures for its use, publish same for distribution to the Medical Staff, and monitor compliance by staff members;

(e) review, study, evaluate, and report unexpected drug reactions or interactions;

(f) evaluate clinical data on new agents, drugs, preparations, or devices requested for use within the Hospital; and

(g) develop a system for continuous surveillance of the utilization of pharmaceuticals within the Hospital in order to assure quality and efficient patient care.

3.L: PLANNING COMMITTEE

3.L.1. Composition:

The Planning Committee shall be an ad hoc committee appointed by the Chief of Staff as needed. Members should not be concurrently serving on the Medical Executive Committee, and membership should be staggered so that members serve for approximately three consecutive years. The President, the Vice President for Medical Affairs, the Director of Hospital Planning, a representative from the Board, and at least one representative each from Hospital administration and nursing shall also serve on the committee.

3.L.2. Duties:

The Planning Committee shall:

(a) participate in evaluating on an annual basis existing programs, services, and facilities of the Hospital and Medical Staff and recommend continuance, expansion, abridgment, or termination of each;

(b) participate in evaluating the financial, personnel, and other resource needs for beginning a new program or service, for constructing new facilities, or for acquiring new or replacement capital equipment, and assess the relative priorities of services and needs and allocation of present and future resources;

(c) encourage and coordinate planning by departments and sections of the Medical Staff such that the Hospital may develop its long-term plans with the input of Medical Staff components;

(d) evaluate plans of individual departments and sections in light of the Hospital Strategic Plan in order to synchronize the plans of Medical Staff components with the Hospital's overall direction;

(e) make recommendations to the Medical Executive Committee, the President, and the Board Strategic Planning Committee which are based upon an analysis of plans submitted by Medical Staff components, and are thought to be in the best interest of patient care, the Hospital, and the Medical Staff;

(f) serve as facilitator and advocate with regard to the education of Medical Staff leaders on the planning process; and

(g) monitor implementation, compliance, and performance of the Hospital Strategic Plan and establish programs designed to educate and inform the Medical Staff of the planning process.

3.M: QUALITY IMPROVEMENT COMMITTEE

3.M.1. Composition:

The Quality Improvement Committee shall consist of at least 13 members of the Medical Staff. The Medical Director of Medical Management, the Director of the Quality Improvement Department, the Vice President for Medical Affairs, the Hospital Risk Manager, and at least one representative each from Hospital administration and nursing shall also serve on the committee. The chair of the committee shall be the Chief of Staff-Elect, with the Immediate Past Chief of Staff functioning as chair in the Chief of Staff-Elect's absence.

3.M.2. Duties:

The Quality Improvement Committee shall:

(a) adopt and implement specific programs and procedures for assessing and improving the quality and efficiency of medical care provided within the Hospital;

(b) formulate recommendations for performance improvement plans to address issues identified by the quality improvement program;

(c) evaluate the effectiveness of any performance improvement plans that may be developed;

(d) coordinate quality improvement activities of the Medical Staff with those of other health care disciplines within the Hospital;

(e) provide written reports to the Medical Executive Committee, the Administration, and the Board on the conduct of the quality improvement program;

(f) reassess the comprehensiveness, effectiveness, integration, and cost effectiveness of the quality improvement program annually, and make recommendations for improvement; and

(g) maintain accurate, confidential records of its proceedings, recommendations, and actions.

3.N: SPECIAL CARE COMMITTEE

3.N.1. Composition:

The Special Care Committee shall consist of at least eight members of the Medical Staff representing specialties which frequently utilize the Intensive Care Unit, including, but not limited to, surgery, pediatrics, and pulmonary medicine. At least one representative each from Hospital administration, nursing, and respiratory therapy shall also serve on the committee.

3.N.2. Duties:

The Special Care Committee shall:

(a) establish written policies which define the circumstances under which consultation by a qualified specialist is required, and promote compliance with such policies;

(b) develop and implement relevant educational programs on critical care medicine when indicated;

(c) develop written policies and procedures concerning the scope and provision of care in the Intensive Care Unit in cooperation with the departments of nursing and respiratory therapy;

(d) review requests for equipment to be used in the Intensive Care Unit; and

(e) be responsible for monitoring and evaluating the quality and appropriateness of patient care, through routine collection of information about important aspects of care, assessment of collected information, actions taken based upon this assessment, and reevaluation to determine the effectiveness of the actions taken.

The committee chair, or his/her designee, shall be responsible for making decisions in consultation with the admitting physician for the disposition of patients when patient load exceeds optimal operating capacity.

3.P: UTILIZATION REVIEW COMMITTEE

3.P1. Composition

The Utilization Review Committee shall consist of at least seven (7) members of the Active Medical Staff, who satisfy the eligibility criteria in Section 3.B of the Medical Staff Bylaws. Non-voting representatives will include the Chief Medical Operations Officer, Chief Financial Officer or designee, the Medical Director of Medical Management and the Director of Case Management.

3.P.2 Duties:

The Utilization Review Committee shall:

(a) develop and review the utilization management plan;

(b) continuously evaluate patient care issues and determine which activities related to patient care and services are high priority and to recommend appropriate actions and follow-up;

(c) review actions and follow-up documentation of all Hospital and Medical Staff utilization review activities as appropriate and any additional review as assigned by the Medical Executive Committee;

(d) conduct an ongoing program of utilization review that is applicable to all patients regardless of payment source and to coordinate the results of these reviews with fiscal intermediaries;

(e) under prospective payment, review cases reasonably assumed to be outliers as determined by high costs and utilization of institutional resources, extended length of stay and/or extraordinarily high costs for professional services;

(f) consider and make recommendations on all matters related to the utilization of Hospital resources;

(g) continuously evaluate utilization review activities. If inappropriate utilization of the Hospital's resources is identified, corrective action will be taken and follow-up studies conducted to demonstrate improvement.

ARTICLE 4

AMENDMENTS

(a) An amendment to this Manual may be made by a majority vote of the members of the Medical Executive Committee present and voting at any meeting of that committee where a quorum exists.

(b) Notice of all proposed amendments shall be provided to each voting member of the Medical Staff at least 14 days prior to the Medical Executive Committee meeting when the vote is to take place, and any voting member may submit written comments on the amendments to the Medical Executive Committee.

(c) No amendment shall be effective unless and until it has been approved by the Board.

ARTICLE 5

ADOPTION

This Medical Staff Organization Manual is adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff Bylaws and policies pertaining to the subject matter herein.

Adopted by the Medical Staff: April 16, 2009

Approved by the Board: April 20, 2009

Revised MEC 08/24/09, Approved Bd 10/19/09 pg. 4

Revised MEC 10/25/10, Approved Bd 11/16/10 pg. 4

Revised MEC 04/25/11, Approved Bd 05/16/11 pg. 4

Revised MEC 04/23/12, Approved Bd 05/21/12 pg. 7

Revised MEC 03/27/13, Approved Bd 04/15/13 pg. 4

Revised MEC 02/24/14, Approved Bd 03/17/14 pg. 10

Revised MEC 02/24/14, Approved Bd 03/17/14 pg. 16