

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

**ALLIED HEALTH
PROFESSIONALS POLICY**

*Adopted by the Medical Staff: April 16, 2009
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ARTICLE 1

GENERAL

1.A. DEFINITIONS

The following definitions apply to terms used in this Policy:

- (1) "ADVANCED DEPENDENT PRACTITIONER" (hereinafter referred to as a "Category II practitioner") means an Allied Health Professional who provides a medical level of care or performs surgical tasks (i.e., Advanced Practice Registered Nurse ("APRN"), Physician Assistant ("PA")) consistent with the clinical privileges granted, but is permitted by law or the Hospital to only exercise those clinical privileges under the direction of, or in collaboration with, a Supervising Physician pursuant to a written supervision or collaborative agreement.
- (2) "ALLIED HEALTH PROFESSIONALS" means a licensed or certified health care practitioner other than a physician, dentist, oral surgeon, podiatrist or psychologist who is authorized by the Hospital to provide patient care services with the Hospital.
- (3) "BOARD" means the Sarasota County Public Hospital Board, which has the overall responsibility for the Hospital, or its designated committee.
- (4) "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.
- (5) "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.
- (6) "CREDENTIALS POLICY" means the Hospital's Medical Staff Credentials Policy.
- (7) "DAYS" means calendar days.
- (8) "DENTIST" means a doctor of dental surgery ("D.D.S.") or doctor of dental medicine ("D.M.D.").

- (9) "DEPENDENT PRACTITIONER" (hereinafter referred to as a "Category III practitioner") means an Allied Health Professional who is permitted by law or the Hospital to function only under the direction of or in collaboration with a Supervising Physician pursuant to a written supervision agreement and consistent with the scope of practice granted.
- (10) "HOSPITAL" means Sarasota Memorial Hospital.
- (11) "LICENSED INDEPENDENT PRACTITIONER" (hereinafter referred to as a "Category I practitioner") means an Allied Health Professional who is permitted by law and by the Hospital to provide patient care services without direction or supervision, within the scope of his or her license and consistent with the clinical privileges granted. Category I practitioners also include those physicians not appointed to the Medical Staff who seek to exercise certain limited clinical privileges at the Hospital under the conditions set forth in this Policy (e.g., moonlighting residents).
- (12) "MEDICAL EXECUTIVE COMMITTEE" means the Executive Committee of the Medical Staff.
- (13) "MEDICAL STAFF" means all physician, dentist, oral surgeon, podiatrist, and psychologist who have been appointed to the Medical Staff by the Board.
- (14) "MEMBER" means any physician, dentist, oral surgeon, podiatrist, and psychologist who has been granted Medical Staff appointment and clinical privileges to practice at the Hospital.
- (15) "PERMISSION TO PRACTICE" means the authorization granted by the Board or President, as applicable, to exercise a scope of practice and/or clinical privileges.
- (16) "PHYSICIAN" includes both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s").
- (17) "PODIATRIST" means a doctor of podiatric medicine ("D.P.M.").
- (18) "PRESIDENT" means the individual appointed by the Board to act on its behalf in the overall management of the Hospital.
- (19) "PSYCHOLOGIST" means an individual with a Ph.D. or a Psy.D. in clinical psychology.
- (20) "SCOPE OF PRACTICE" means the authorization granted by the Board or President, as applicable, to perform certain clinical activities and functions under the supervision of or in collaboration with, a Supervising Physician.

- (21) "SPECIAL NOTICE" means hand delivery, certified mail, return receipt requested, or overnight delivery service providing receipt.
- (22) "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.
- (23) "SUPERVISING PHYSICIAN" means a member of the Medical Staff with clinical privileges, who has agreed in writing to supervise a Category II or Category III practitioner and to accept full responsibility for the actions of the Category II or Category III practitioner while he or she is practicing in the Hospital.
- (24) "SUPERVISION" means the supervision of (or collaboration with) a Category II or Category III practitioner by a Supervising Physician, that may or may not require the actual presence of the Supervising Physician, but that does require, at a minimum, that the Supervising Physician be readily available for consultation. The requisite level of supervision (general, direct, or personal) shall be determined at the time each Category II or Category III practitioner is credentialed and shall be consistent with any applicable written supervision or collaboration agreement that may exist.

1.B. TIME LIMITS

Time limits referred to in this Policy 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 person in a particular office or by a committee, the person, or the committee through its chair, may delegate performance of the function to one or more qualified designees.

ARTICLE 2

SCOPE AND OVERVIEW OF POLICY

2.A. SCOPE OF POLICY

- (1) This Policy addresses those Allied Health Professionals who are permitted to provide patient care services in the Hospital and are listed in the Appendices to this Policy. It also addresses those physicians who are not appointed to the Medical Staff, but who are permitted to exercise certain limited clinical privileges, granted under the conditions set forth in this Policy (e.g., moonlighting residents).
- (2) This Policy sets forth the credentialing process and the general practice parameters for these individuals, as well as guidelines for determining the need for additional categories of Allied Health Professionals at the Hospital.

2.B. CATEGORIES OF ALLIED HEALTH PROFESSIONALS

- (1) Only those specific categories of Allied Health Professionals that have been approved by the Board of Directors shall be permitted to practice at the Hospital. All Allied Health Professionals who are addressed in this Policy shall be classified as either Category I, Category II, or Category III practitioners.
- (2) Current listings of the specific categories of Allied Health Professionals functioning in the Hospital as Category I, Category II, and Category III practitioners are attached to this Policy as Appendices A, B and C, respectively. The Appendices may be modified or supplemented by action of the Board, after receiving the recommendation of the Medical Executive Committee, without the necessity of further amendment of this Policy.

2.C. PROCESS FOR DETERMINING NEED FOR A NEW CATEGORY OF ALLIED HEALTH PROFESSIONALS

2.C.1. Review of Need:

- (a) Whenever an Allied Health Professional requests to practice at the Hospital, and the Board has not already approved the category of practitioner for practice at the Hospital, the President shall appoint an ad hoc committee to evaluate the need for that category of Allied Health Professional. The ad hoc committee shall report to the Medical Executive Committee, which shall make a recommendation to the Board for final action.
- (b) As part of the process of determining need, the Allied Health Professional shall be invited to submit information about the nature of the proposed practice, the reason

access to the Hospital is sought, and the potential benefits to the community of having such services available at the Hospital.

- (c) The ad hoc committee may consider the following factors when making a recommendation as to the need for the services of a specific category of Allied Health Professional:
- (1) the nature of the services that would be offered;
 - (2) any state license or regulation which outlines the specific patient care services and/or activities that the Allied Health Professional is authorized by law to perform;
 - (3) any state "nondiscrimination" or "any willing provider" laws that would apply to the Allied Health Professional;
 - (4) the patient care objectives of the Hospital, including patient convenience;
 - (5) the community's needs and whether those needs are currently being met or could be better met if the services offered by the Allied Health Professional were provided at the Hospital;
 - (6) the type of training that is necessary to perform the services that would be offered and whether there are individuals with more training currently providing those services;
 - (7) the availability of supplies, equipment, and other necessary Hospital resources;
 - (8) the need for, and availability of, trained staff to support the services that would be offered; and
 - (9) the ability to appropriately supervise performance and monitor quality of care.

2.C.2. Additional Recommendations:

- (a) If the ad hoc committee makes a recommendation that there is a need for the particular category of Allied Health Professional at the Hospital, it shall also recommend:
- (1) any specific qualifications and/or training that must be possessed beyond those set forth in this Policy;
 - (2) a detailed description of a scope of practice or clinical privileges;

- (3) any specific conditions that apply to practice within the Hospital; and
 - (4) any supervision requirements, if applicable.
- (b) In developing such recommendations, the ad hoc committee shall consult the appropriate department chairperson(s) and consider relevant state law and may contact professional societies or associations. The ad hoc committee may also recommend the number of Allied Health Professionals that are needed.

ARTICLE 3

QUALIFICATIONS, CONDITIONS AND RESPONSIBILITIES

3.A. QUALIFICATIONS

3.A.1. Eligibility Criteria:

To be eligible to apply for initial and continued permission to practice, Allied Health Professionals must, where applicable:

- (a) have a current, unrestricted license, certification, or registration to practice in Florida and have never had a license, certification, or registration to practice revoked or suspended in any state;
- (b) have a current, unrestricted DEA registration and state controlled substance license;
- (c) be located (office and residence) within the geographic service area of the Hospital, as defined by the Board, close enough to fulfill responsibilities and provide timely and continuous care for patients in the Hospital;
- (d) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital;
- (e) have never been convicted of, or entered a plea of guilty or no contest to, Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse or have been required to pay civil monetary penalties for the same;
- (f) have never been and are not currently excluded or precluded from participation in Medicare, Medicaid or other federal or state governmental health care program;
- (g) have never had a scope of practice or clinical privileges denied, revoked, resigned, relinquished, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct;
- (h) have never been convicted of, or entered a plea of guilty or no contest to, any felony, or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, or violence (federal or in any state);
- (i) be able to read and understand the English language, to communicate in writing, electronically, and verbally in the English language in an understandable, intelligible manner, and to prepare medical record entries and other required

documentation in an understandable, intelligible manner, all of which serves as essential elements of safe patient care;

- (j) participate in, and comply with, computerized physician order entry systems;
- (k) satisfy all additional eligibility qualifications relating to their specific area of practice that may be established by the Hospital; and
- (l) if seeking to practice as a Category II or Category III practitioner, have a written agreement with a Supervising Physician, which agreement must meet all applicable requirements of state law and Hospital policy.

3.A.2. Waiver of Criteria:

- (a) Any individual who does not satisfy an eligibility criterion may request that it be waived. The individual requesting the waiver bears the burden of demonstrating that his or her qualifications are equivalent to, or exceed, the criterion in question.
- (b) The Board may grant waivers in exceptional cases after considering the findings of the Credentials Committee, the Medical Executive Committee, or other committee designated by the Board, the specific qualifications of the individual in question, and the best interests of the Hospital and the community it serves. The granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals.
- (c) No individual is entitled to a waiver or to a hearing if the Board determines not to grant a waiver.
- (d) A determination that an individual is not entitled to a waiver is not a "denial" of scope of practice or clinical privileges.

3.A.3. Factors for Evaluation:

The following factors will be evaluated as applicable, as part of a request for permission to practice:

- (a) relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment, and an understanding of the contexts and systems within which care is provided;
- (b) adherence to the ethics of their profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients and their profession;
- (c) ability to safely and competently perform the clinical privileges or scope of practice requested;

- (d) good reputation and character;
- (e) ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families and other members of health care teams; and
- (f) recognition of the importance of, and willingness to support, the Hospital's commitment to quality care and a recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

3.A.4. No Entitlement to Medical Staff Appointment:

Allied Health Professionals shall not be appointed to the Medical Staff or entitled to the rights, privileges, and/or prerogatives of Medical Staff appointment unless otherwise provided for under this Policy.

3.A.5. Nondiscrimination Policy:

No individual shall be denied a scope of practice or clinical privileges at the Hospital on the basis of gender, race, creed or national origin.

3.B. GENERAL CONDITIONS OF PRACTICE

3.B.1. Assumption of Duties and Responsibilities:

As a condition of being granted permission to practice and as a condition for continued permission to practice, Allied Health Professionals specifically agree to the following:

- (a) to provide continuous and timely care to all patients for whom the individual has responsibility;
- (b) to abide by all bylaws, policies and rules and regulations of the Hospital and Medical Staff;
- (c) to accept committee assignments, participation in quality improvement and peer review activities, and such other reasonable duties and responsibilities as assigned;
- (d) to constructively participate in the development, review, and revision of clinical protocols and pathways pertinent to his or her specialty, including those related to national patient safety initiatives and core measures;
- (e) to comply with adopted protocols and pathways or document reasons for variance;

- (f) to provide, with or without request, new or updated information to the President as it occurs, pertinent to any question on the application form;
- (g) to immediately submit to a blood and/or urine test, or to a complete physical and/or mental evaluation, if at least two Medical Staff leaders (or one Medical Staff leader and one member of the Administrative team) are concerned with the individual's ability to safely and competently care for patients. The health care professional(s) to perform the testing and/or evaluations shall be determined by the Medical Staff leadership;
- (h) to acknowledge that the individual has had an opportunity to read a copy of this Policy and any other applicable bylaws, policies, rules and regulations and agrees to be bound by them;
- (i) to appear for personal interviews as may be requested;
- (j) to refrain from illegal fee splitting or other illegal inducements relating to patient referral;
- (k) to refrain from assuming responsibility for diagnosis or care of hospitalized patients for which he or she is not qualified or without adequate supervision;
- (l) to refrain from deceiving patients as to his or her status as an Allied Health Professional;
- (m) to seek consultation when appropriate;
- (n) to participate in monitoring and evaluation activities;
- (o) to complete, in a timely manner, all medical and other required records containing all information required by the Hospital;
- (p) to perform all services and conduct himself or herself at all times in a cooperative and professional manner;
- (q) to satisfy applicable continuing education requirements;
- (r) to promptly pay any applicable dues and assessments;
- (s) to maintain a current e-mail address with Medical Staff Services and acknowledge that all notices, with the exception of any special notice as defined in Section 1.A(20), will be provided via e-mail; and
- (t) that any misstatement in, or omission from, the application form is grounds for the Hospital to stop processing the application. If permission to practice has been

granted prior to the discovery of a misstatement or omission, clinical privileges or scope of practice may be deemed to be automatically relinquished. In either situation, there shall be no entitlement to the procedural rights in Article 7 of this Policy.

3.B.2. Burden of Providing Information:

- (a) Allied Health Professionals seeking permission to practice shall have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications.
- (b) Allied Health Professionals seeking permission to practice at the Hospital have the burden of providing evidence that all the statements made and information given on the application are accurate.
- (c) It is the responsibility of the individual seeking permission to practice at the Hospital to provide a complete application, including adequate responses from references. An incomplete application shall not be processed.

3.C. APPLICATION

3.C.1. Information:

- (a) The applications for Allied Health Professionals shall be approved by the Medical Executive Committee and the Board. The applications existing now, and as may be revised, are incorporated by reference and made a part of this Policy.
- (b) The applications shall require detailed information concerning the applicant's professional qualifications. In addition to other information, the applications shall seek the following:
 - (1) information as to whether the applicant's scope of practice or clinical privileges and/or affiliation has ever been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subject to probationary or other conditions, reduced, limited, terminated, or not renewed at any hospital or health care facility or is currently being investigated or challenged;
 - (2) information as to whether the applicant's license or certification to practice any profession in any state or DEA registration or any state controlled substance license is, or has ever been, voluntarily or involuntarily relinquished, suspended, modified, terminated, or restricted or is currently being investigated or challenged;

- (3) information concerning the applicant's professional liability litigation experience, including past and pending claims, final judgments or settlements, and the substance of the allegations, as well as the findings and the ultimate disposition;
 - (4) current information regarding the applicant's ability to safely and competently exercise the scope of practice or clinical privileges he or she has requested; and
 - (5) the results of a current criminal background check or written authorization for the Hospital to obtain the same.
- (c) The applicant shall sign the application and certify that he or she is able to perform the scope of practice or clinical privileges requested and the responsibilities of Allied Health Professionals.

3.C.2. Grant of Immunity and Authorization to Obtain/Release Information:

By requesting an application and/or applying for permission to practice, the individual expressly accepts the following conditions:

- (i) whether or not permission to practice and clinical privileges or scope of practice are granted;
 - (ii) throughout the term of any affiliation with the Hospital and thereafter;
 - (iii) should permission to practice or clinical privileges or scope of practice be denied, revoked, reduced, restricted, suspended, and/or otherwise affected as part of the Hospital's professional review activities; and
 - (iv) to any third-party inquiries received after the individual leaves the Hospital about his/her tenure at the Hospital.
- (a) Immunity:

To the fullest extent permitted by law, the individual releases from any and all liability, extends absolute immunity to, and agrees not to sue the Hospital, any member of the Board, any member of the Medical Staff, their authorized representatives, and third parties who provide information for any matter relating to permission to practice, clinical privileges, or scope of practice, or the individual's qualifications for the same. This immunity covers any actions, recommendations, reports, statements, communications, and/or disclosures involving the individual that are made, taken, or received by the Hospital, its authorized agents, or third parties in the course of credentialing and peer review activities.

(b) Authorization to Obtain Information from Third Parties:

The individual specifically authorizes the Hospital, Medical Staff leaders, and their authorized representatives (1) to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on his or her qualifications for initial and continued authorization to practice at the Hospital, and (2) to obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of third parties that may be relevant to such questions. The individual also specifically authorizes third parties to release this information to the Hospital and its authorized representatives upon request and agrees to sign necessary consent forms to permit a consumer reporting agency to conduct a criminal background check on the individual and report the results to the Hospital.

(c) Authorization to Release Information to Third Parties:

The individual also authorizes Hospital representatives to release information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their agents when information is requested in order to evaluate his or her professional qualifications for permission to practice, clinical privileges or scope of practice, and/or participation at the requesting organization/facility, and any licensure or regulatory matter. The specific process for the release of information shall be coordinated by Medical Staff Services.

(d) Procedural Rights:

The Allied Health Professional agrees that the procedural rights set forth in this Policy shall be the sole and exclusive remedy with respect to any professional review action taken by the Hospital.

(e) Legal Actions:

If, notwithstanding the provisions in this Section, an individual institutes legal action and does not prevail, he or she shall reimburse the Hospital, any members of the Medical Staff or Board, and any other agent named in the action for all costs incurred in defending such legal action, including reasonable attorney's fees.

ARTICLE 4

CREDENTIALING PROCEDURE

4.A. CREDENTIALING PROCESS FOR CATEGORY III PRACTITIONERS

The application, credentialing, and recredentialing process for all Category III practitioners shall be handled by the Human Resources Department in accordance with the Policy on Physician Sponsored Staff Members or Employed Personnel and Contract Personnel.

4.B. PROCESSING OF INITIAL APPLICATION TO PRACTICE FOR CATEGORY I AND CATEGORY II PRACTITIONERS

4.B.1. Request for Application:

- (a) Any individual requesting an application for permission to practice as a Category I or Category II practitioner shall be sent a letter that outlines the eligibility criteria for permission to practice and the application form.
- (b) A Category I or Category II practitioner who is in a category of practitioners that has not been approved by the Board to practice at the Hospital shall be ineligible to receive an application. A determination of ineligibility does not entitle an individual to the procedural rights outlined in Article 7 of this Policy.

4.B.2. Submission of Application:

- (a) A completed application, with copies of all required documents, must be returned to Medical Staff Services within 30 days after receipt of the application if the Category I or Category II practitioner desires further consideration. The application must be accompanied by the application processing fee, if one is required.
- (b) An application shall be deemed to be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified. An application shall become incomplete if the need arises for new, additional or clarifying information any time during the evaluation.
- (c) Any application that continues to be incomplete 30 days after the applicant has been notified of the additional information required shall be deemed to be withdrawn. It is the responsibility of the applicant to provide a complete application, including adequate responses from references. An incomplete application shall not be processed.

4.B.3. Initial Review of Application:

- (a) As a preliminary step, Medical Staff Services shall review the application to determine that the individual satisfies all threshold criteria. An individual who fails to meet the eligibility criteria set forth in Section 3.A.1 of this Policy shall be notified that his or her application shall not be processed.
- (b) Medical Staff Services shall also review the application to determine if all questions have been answered, all references and other information or materials have been received, and pertinent information provided on the application has been verified with primary sources. If an application is complete, it shall be transmitted, along with all supporting documentation, to the applicable department chairperson.

4.B.4. Review by Department Chairperson:

- (a) Medical Staff Services shall transmit the complete application and all supporting materials to the appropriate department chairperson. Each chairperson shall prepare a written report regarding whether the applicant has satisfied all of the qualifications for the clinical privileges requested.
- (b) In preparing this report, the department chairperson has the right to meet with the applicant, and the Supervising Physician (if applicable), to discuss any aspect of the application, qualifications, and requested clinical privileges. The department chairperson may also confer with experts within the department and outside of the department in preparing the report (e.g., other physicians, appropriate supervisor within the department, nurse managers).
- (c) The department chairperson shall be available to answer any questions that may be raised with respect to that chair's report and findings.

4.B.5. Credentials Committee Procedure:

- (a) The Credentials Committee shall review and consider the report prepared by the department chairperson and may interview the applicant. Thereafter, the Credentials Committee shall make a recommendation.
- (b) After determining that an applicant is otherwise qualified for permission to practice, the Credentials Committee shall review the applicant's Health Status Confirmation Form to determine if there is any question about the applicant's ability to practice. If so, the Credentials Committee may require the applicant to undergo a physical and/or mental health examination by a physician(s) satisfactory to the Committee. The results of this examination shall be made available to the Credentials Committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall be considered a

voluntary withdrawal of the application and all processing of the application shall cease.

- (c) The Credentials Committee's recommendation shall be forwarded to the Medical Executive Committee or the Chief of Staff, as applicable.

4.B.6. Medical Executive Committee Procedure:

- (a) For each applicant seeking to practice as a Category I or Category II practitioner, at its next regular meeting, after receipt of the written findings and recommendations of the Credentials Committee, the Medical Executive Committee shall:
 - (1) adopt the findings and recommendations of the Credentials Committee; or
 - (2) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the Medical Executive Committee prior to its final recommendation; or
 - (3) state its reasons in its report and recommendation, along with supporting information, for its disagreement with the Credentials Committee's recommendation.
- (b) The recommendation of the Medical Executive Committee shall be forwarded to the Board.
- (c) If the recommendation of the Medical Executive Committee would entitle the applicant to the procedural rights set forth in Article 7, the President shall send the applicant special notice. The President shall then hold the application until after the applicant has completed or waived the procedural process outlined in this Policy.

4.B.7. Board Action:

- (a) The Board may delegate to a committee, consisting of at least two Board members, action on the clinical privileges requested if there has been a favorable recommendation from the Credentials Committee and the Medical Executive Committee and there is no evidence of any of the following:
 - (1) a current or previously successful challenge to any license or registration;
 - (2) an involuntary termination, limitation, reduction, denial, or loss of appointment or privileges at any other hospital or other entity; or
 - (3) an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

Any decision reached by the Board Committee to grant the clinical privileges requested shall be effective immediately and shall be forwarded to the Board for ratification at its next meeting.

- (b) When there has been no delegation to the Board Committee, upon receipt of a recommendation that the applicant be granted clinical privileges requested, the Board may:
 - (1) grant the applicant the clinical privileges as recommended; or
 - (2) refer the matter back to the Credentials Committee or Medical Executive Committee or to another source inside or outside the Hospital for additional research or information; or
 - (3) reject or modify the recommendation.
- (c) If the Board determines to reject a favorable recommendation, it should first discuss the matter with the Chair of the Credentials Committee and the Chair of the Medical Executive Committee. If the Board's determination remains unfavorable to the applicant, the President shall promptly send special notice to the applicant that the applicant is entitled to request a hearing.

4.C. CLINICAL PRIVILEGES

4.C.1. General:

The clinical privileges recommended to the Board will be based upon consideration of the following:

- (a) education, relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal and communication skills, and professionalism with patients, families and other members of the health care team and peer evaluations relating to these criteria;
- (b) ability to perform the privileges requested competently and safely;
- (c) information resulting from ongoing and focused professional practice evaluation, performance improvement and other peer review activities, if applicable;
- (d) adequate professional liability insurance coverage for the clinical privileges requested;
- (e) the Hospital's available resources and personnel;

- (f) any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;
- (g) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital;
- (h) practitioner-specific data as compared to aggregate data, when available;
- (i) morbidity and mortality data, when available; and
- (j) professional liability actions, especially any such actions that reflect an unusual pattern or excessive number of actions.

4.C.2. Provisional Clinical Privileges:

- (a) All initial clinical privileges, regardless of when granted, will be provisional for a period of 12 months or longer, up to a maximum of 24 months, if recommended by the Credentials Committee.
- (b) During the provisional period, the individual's exercise of the provisional clinical privileges will be evaluated by the chairperson of the department in which the individual has clinical privileges and/or by a physician(s) designated by the Credentials Committee. The evaluation may include chart review, monitoring of the individual's practice patterns, proctoring, external review, and information obtained from other practitioners and Hospital employees.
- (c) During the provisional period, the individual must participate in the care of a sufficient number of patients so as to permit the Credentials Committee to evaluate the individual's competence to exercise the newly granted privilege(s), or those clinical privileges will be automatically relinquished.

4.D. TEMPORARY CLINICAL PRIVILEGES

4.D.1. Request for Temporary Clinical Privileges:

- (a) Temporary privileges may be granted by the President, upon recommendation of the Chief of Staff, when a Category I or Category II practitioner has submitted a completed application and the application is pending review by the Medical Executive Committee and the Board, following a favorable recommendation of the Credentials Committee (or its Chair). Prior to temporary privileges being granted in this situation, the credentialing process must be complete, including, where applicable, verification of current licensure, relevant training or experience, current competence, ability to exercise the privileges requested, and compliance with criteria, and consideration of information from the Data Bank. In order to be

eligible for temporary privileges, an individual must demonstrate that there are no current or previously successful challenges to his or her licensure or registration and that he or she has not been subject to involuntary termination of membership, or involuntary limitation, reduction, denial, or loss of clinical privileges at another health care facility.

- (b) Prior to temporary privileges being granted, the individual must agree in writing to be bound by all applicable bylaws, rules and regulations, policies, procedures and protocols.
- (c) Temporary privileges shall be granted for a specific period of time, not to exceed 120 days, and shall expire at the end of the time period for which they are granted.

4.D.2. Termination of Temporary Clinical Privileges:

- (a) The President may, at any time after consulting with the Chief of Staff, or the Chair of the Credentials Committee or the department chairperson, terminate temporary privileges for any reason.
- (b) The granting of temporary privileges is a courtesy. Neither the denial nor termination of temporary privileges shall entitle the individual to the procedural rights set forth in Article 7.

4.E. PROCESSING APPLICATIONS FOR RENEWAL OF CLINICAL PRIVILEGES

4.E.1. Submission of Application:

- (a) The grant of clinical privileges is a courtesy and, if granted, shall be for a period not to exceed two years. A request to renew clinical privileges shall be considered only upon submission of a completed renewal application.
- (b) At least three months prior to the date of expiration of a Category I or Category II practitioner's clinical privileges, Medical Staff Services shall notify the individual of the date of expiration and provide the individual with a renewal application.
- (c) Failure to return a completed application at least two months prior to the expiration of the individual's clinical privileges shall result in automatic expiration of such clinical privileges at the end of the then current term.
- (d) Once an application for renewal of clinical privileges has been completed and submitted to Medical Staff Services, it shall be evaluated following the same procedures outlined in this Policy regarding initial applications.

4.E.2. Renewal Process for Category I and Category II Practitioners:

- (a) The procedures pertaining to an initial request for clinical privileges, including eligibility criteria and factors for evaluation, shall be applicable in processing requests for renewal.
- (b) As part of the process for renewal of clinical privileges, the following factors shall be considered:
 - (1) an assessment prepared by the applicable department chairperson;
 - (2) an assessment prepared by a peer;
 - (3) results of the Hospital's performance improvement and peer review activities, taking into consideration, when applicable, practitioner-specific information concerning other individuals in the same or similar specialty (provided that, other practitioners shall not be identified);
 - (4) resolution of any verified complaints received from patients or staff; and
 - (5) any focused professional practice evaluations.
- (c) In addition to the above, for Category II Practitioners, the following information shall be considered:
 - (1) an assessment prepared by the Supervising Physician(s); and
 - (2) an assessment prepared by the applicable Hospital supervisor (i.e., OR Supervisor, Nursing Supervisor).

ARTICLE 5

CONDITIONS OF PRACTICE APPLICABLE TO CATEGORY II AND CATEGORY III PRACTITIONERS

5.A. OVERSIGHT BY SUPERVISING PHYSICIAN

- (1) Category II and Category III practitioners may function in the Hospital only so long as they have a Supervising Physician.
- (2) Any activities permitted to be performed at the Hospital by a Category II and Category III practitioner shall be performed only under the supervision or direction of the Supervising Physician.
- (3) It shall be the responsibility of the Supervising Physician to countersign all medical record entries made by his or her Category II and Category III practitioner in accordance with applicable policies and rules and regulations.
- (4) If the Medical Staff appointment or clinical privileges of a Supervising Physician are resigned, revoked or terminated, the Category III practitioner's scope of practice or Category II practitioner's clinical privileges shall automatically terminate. The Credentials Committee may, however, recommend that the Category II or Category III practitioner be permitted to arrange for another Supervising Physician.
- (5) As a condition of a scope of practice or clinical privileges, a Category II or Category III practitioner and the Supervising Physician must provide the Hospital with notice of any revisions or modifications that are made to the supervision agreement. This notice must be provided to the President within three days of any such change.

5.B. QUESTIONS REGARDING THE AUTHORITY OF CATEGORY II AND CATEGORY III PRACTITIONERS

- (1) Should any member of the Medical Staff, or any employee of the Hospital who is licensed or certified by the state, have a reasonable question regarding the clinical competence or authority of a Category II or Category III practitioner to act or issue instructions outside the presence of the Supervising Physician, such individual shall have the right to request that the Supervising Physician validate, either at the time or later, the instructions of the Category II or Category III practitioner. Any act or instruction of the Category II or Category III practitioner shall be delayed until such time as the individual with the question has ascertained that the act is clearly within the scope of practice granted to the individual.

- (2) Any question regarding the conduct of a Category II and Category III practitioner shall be reported to the Chief of Staff, the Chair of the Credentials Committee, the relevant department chairperson, or the President for appropriate action. The individual to whom the concern has been reported shall also discuss the matter with the Supervising Physician.

5.C. RESPONSIBILITIES OF SUPERVISING PHYSICIAN

- (1) The Supervising Physician shall remain responsible for all care provided by the Category II and Category III practitioner in the Hospital.
- (2) The number of Category II and/or Category III practitioners acting under the supervision of one Medical Staff member, as well as the care they may provide, shall be consistent with applicable state statutes and regulations and any other policies adopted by the Hospital. The Supervising Physician shall make all appropriate filings with the State Board of Medicine regarding the supervision and responsibilities of the Category II or Category III practitioner, to the extent that such filings are required.
- (3) It shall be the responsibility of the Supervising Physician to provide, or to arrange for, professional liability insurance coverage for the Category II or Category III practitioner in amounts required by the Board. The insurance must cover any and all activities of the Category II or Category III practitioner in the Hospital. The Supervising Physician shall furnish evidence of such coverage to the Hospital. The Category II or Category III practitioner shall act in the Hospital only while such coverage is in effect.

ARTICLE 6

PEER REVIEW PROCEDURES FOR QUESTIONS INVOLVING ALLIED HEALTH PROFESSIONALS

6.A. COLLEGIAL INTERVENTION

- (1) As part of the Hospital's performance improvement and professional and peer review activities, this Policy encourages the use of progressive steps by Medical Staff leaders and administration to arrive at voluntary, responsive actions by individuals to resolve questions that have been raised. Collegial intervention efforts are not mandatory and shall be within the discretion of the appropriate Medical Staff leaders.
- (2) Collegial efforts may include, but are not limited to, counseling, sharing of comparative data, monitoring, and additional training or education.
- (3) Collegial intervention is a part of ongoing and focused professional practice evaluation, performance improvement and peer review activities.
- (4) The Chief of Staff, in conjunction with the President, shall determine whether to direct that a matter be handled in accordance with another policy (e.g., policy on practitioner health or code of conduct policy) or to direct the matter to the Credentials Committee or the Medical Executive Committee for further review and/or investigation.

6.B. INVESTIGATIONS

6.B.1. Initiation of Investigation:

- (a) When a question involving clinical competence or professional conduct of an Allied Health Professional is referred to, or raised by, the Medical Executive Committee, the Medical Executive Committee will review the matter and determine whether to conduct an investigation or to direct the matter to be handled pursuant to another policy, or to proceed in another manner.
- (b) The Chief of Staff will keep the President fully informed of all action taken in connection with an investigation.

6.B.2. Investigative Procedure:

- (a) The Medical Executive Committee shall either investigate the matter itself or request that it be conducted by the Credentials Committee or appoint an individual or ad hoc committee to conduct the investigation ("investigating committee"). The investigating committee will not include relatives or financial

partners of the Allied Health Professional or the Allied Health Professional's Supervising Physician (where applicable).

- (b) The investigating committee will have the authority to review relevant documents and interview individuals. It will also have available to it the full resources of the Medical Staff and the Hospital.
- (c) The investigating committee will also have the authority to use outside consultants, if needed.
- (d) The investigating committee may require a physical and/or mental examination of the individual by a health care professional(s) acceptable to it.
- (e) The individual will have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual will be informed of the general questions being investigated. At the meeting, the individual will be invited to discuss, explain, or refute the questions that gave rise to the investigation. A summary of the interview will be prepared. This meeting is not a hearing, and none of the procedural rules for hearings will apply.
- (f) The investigating committee will make a reasonable effort to complete the investigation and issue its report within 45 days of the commencement of the investigation, provided that an outside review is not necessary. When an outside review is necessary, the investigating committee will make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the outside review. These time frames are intended to serve only as guidelines.
- (g) At the conclusion of the investigation, the investigating committee will prepare a report with its findings, conclusions, and recommendations.

6.B.3. Recommendation:

- (a) The Medical Executive Committee may accept, modify, or reject any recommendation it receives from an investigating committee. Specifically, the Medical Executive Committee may:
 - (1) determine that no action is justified;
 - (2) issue a letter of guidance, counsel, warning, or reprimand;
 - (3) impose a requirement for monitoring or consultation;
 - (4) recommend additional training or education;
 - (5) recommend reduction of clinical privileges or scope of practice;

- (6) recommend suspension of clinical privileges or scope of practice for a term;
 - (7) recommend revocation of clinical privileges or scope of practice; or
 - (8) make any other recommendation that it deems necessary or appropriate.
- (b) A recommendation by the Medical Executive Committee or Board that would entitle the individual to request a hearing will be forwarded to the President, who will promptly inform the individual by special notice. The President will hold the recommendation until after the individual has completed or waived a hearing and appeal.
 - (c) If the Medical Executive Committee makes a recommendation that does not entitle the individual to request a hearing, it will take effect immediately and will remain in effect unless modified by the Board.
 - (d) When applicable, any recommendations or actions that are the result of an investigation or hearing and appeal will be monitored by Medical Staff leaders on an ongoing basis through the Hospital's performance improvement activities or pursuant to the applicable policies regarding conduct, as appropriate.

6.C. ADMINISTRATIVE SUSPENSION

- (1) The President, the Chief of Staff, and/or the appropriate department chairperson shall each have the authority to impose an administrative suspension of all or any portion of the scope of practice or clinical privileges of any Allied Health Professional whenever a question has been raised about such individual's clinical care or professional conduct.
- (2) An administrative suspension shall become effective immediately upon imposition, shall immediately be reported in writing to the President and the Chair of the Medical Executive Committee, and shall remain in effect unless or until modified by the President or Medical Executive Committee. The imposition of an administrative suspension does not entitle an Allied Health Professional to the procedural rights set forth in Article 7 of this Policy.
- (3) Upon receipt of notice of the imposition of an administrative suspension, the President and Chief of Staff shall forward the matter to the Medical Executive Committee which shall review and consider the question(s) raised and thereafter make a recommendation to the Board.

6.D. AUTOMATIC RELINQUISHMENT OF SCOPE OF PRACTICE
OR CLINICAL PRIVILEGES

- (1) The scope of practice or clinical privileges of an Allied Health Professional shall be automatically relinquished, without entitlement to the procedural rights outlined in this Policy, in the following circumstances:
 - (a) the Allied Health Professional no longer satisfies any of the threshold eligibility criteria set forth in Section 3.A.1 or any additional threshold credentialing qualifications set forth in the specific Hospital policy relating to his or her discipline;
 - (b) the Allied Health Professional is indicted, convicted, or pleads guilty or no contest pertaining to any felony, or to any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; or (iv) violence against another (federal or in any state);
 - (c) the Allied Health Professional fails to provide information pertaining to his or her qualifications for the scope of practice or clinical privileges, in response to a written request from the Credentials Committee, the Medical Executive Committee, the President, or any other committee authorized to request such information;
 - (d) a determination is made that there is no longer a need for the services of a particular discipline or category of Allied Health Professional; or
 - (e) the Category II or Category III practitioner fails, for any reason, to maintain an appropriate supervision relationship with a Supervising Physician as defined in this Policy.
- (2) Requests for reinstatement shall be reviewed by the relevant department chairperson, the Chair of the Credentials Committee, the Chief of Staff, and the President. If all these individuals make a favorable recommendation on reinstatement, the Allied Health Professional may immediately resume clinical practice at the Hospital. This determination shall then be forwarded to the Credentials Committee, Medical Executive Committee, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee, Medical Executive Committee, and Board for review, recommendation, and final action.

ARTICLE 7

PROCEDURAL RIGHTS OF ALLIED HEALTH PROFESSIONALS

Allied Health Professionals shall not be entitled to the hearing and appeals procedures set forth in the Medical Staff Credentials Policy. Any and all rights to which Allied Health Professionals are entitled are set forth in this Policy.

7.A. PROCEDURAL RIGHTS FOR CATEGORY III PRACTITIONERS

- (1) In the event a recommendation is made by the Medical Executive Committee, the Chief of Staff, or the President that a Category III practitioner not be granted a scope of practice or that a scope of practice previously granted be restricted for a period of more than 30 days, terminated, or not renewed, the individual shall receive special notice of the recommendation. The notice shall include a general statement of the reasons for the recommendation and shall advise the individual that he or she may request a meeting with the Chief Medical Officer and the Chief Nursing Officer.
- (2) If a meeting is requested, the meeting shall be scheduled to take place within a reasonable time frame. The meeting shall be informal and shall not be considered a hearing. The Supervising Physician and the Category III practitioner shall both be permitted to attend this meeting. However, no counsel for either party shall be present.
- (3) Following this meeting, the Chief Medical Officer and the Chief Nursing Officer shall make a final recommendation to the President who shall make a final decision.

7.B. PROCEDURAL RIGHTS FOR CATEGORY I AND CATEGORY II PRACTITIONERS

7.B.1. Notice of Recommendation and Hearing Rights:

- (a) In the event a recommendation is made by the Medical Executive Committee that a Category I or Category II practitioner not be granted clinical privileges or that the privileges previously granted be restricted for a period of more than 30 days, terminated or not renewed, the individual shall receive special notice of the recommendation. The special notice shall include a general statement of the reasons for the recommendation and shall advise the individual that he or she may request a hearing.
- (b) The rights and procedures in this Section shall also apply if the Board, without a prior adverse recommendation from the Medical Executive Committee, makes a recommendation not to grant clinical privileges or that the privileges previously granted be restricted, terminated or not renewed. In this instance, all references in

this Article to the Medical Executive Committee shall be interpreted as a reference to the Board.

- (c) If the Category I or Category II practitioner wants to request a hearing, the request must be in writing, directed to the President, within 30 days after receipt of written notice of the adverse recommendation.
- (d) The hearing shall be convened as soon as is practical, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to by the parties.

7.B.2. Hearing Committee:

- (a) If a request for a hearing is timely made, the President, in consultation with the Chief of Staff, shall appoint a Hearing Committee composed of up to three individuals (including, but not limited to, members of the Medical Staff, Allied Health Professionals, Hospital management, individuals not connected with the Hospital, or any combination of these individuals). The Hearing Committee shall not include anyone who previously participated in the recommendation, any relatives or practice partners of the Category I or Category II practitioner, or any competitors of the affected individual.
- (b) The President, in consultation with the Chief of Staff, shall appoint a Presiding Officer ("Presiding Officer"), who may be legal counsel to the Hospital. The role of the Presiding Officer shall be to allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination. The Presiding Officer shall maintain decorum throughout the hearing.
- (c) As an alternative to a Hearing Committee, the President, in consultation with the Chief of Staff, may appoint a Hearing Officer to perform the functions that would otherwise be carried out by the Hearing Committee. The Hearing Officer shall preferably be an attorney at law. The Hearing Officer may not be in direct economic competition with the individual requesting the hearing and shall not act as a prosecuting officer or as an advocate to either side at the hearing. In the event a Hearing Officer is appointed instead of a Hearing Committee, all references in this Article to the Hearing Committee or Presiding Officer shall be deemed to refer instead to the Hearing Officer, unless the context would clearly otherwise require.

7.B.3. Hearing Process:

- (a) A record of the hearing shall be maintained by a stenographic reporter or by a recording of the proceedings. Copies of the transcript shall be available at the individual's expense.

- (b) The hearing shall last no more than six hours, with each side being afforded up to three hours to present its case, in terms of both direct and cross-examination of witnesses.
- (c) At the hearing, a representative of the Medical Executive Committee shall first present the reasons for the recommendation. The Category I or Category II practitioner shall be invited to present information to refute the reasons for the recommendation.
- (d) Both parties shall have the right to present witnesses. The Presiding Officer shall permit reasonable questioning of such witnesses.
- (e) The Category I or Category II practitioner and the Medical Executive Committee may be represented at the hearing by legal counsel. However, while counsel may be present at the hearing, counsel shall not call, examine, or cross-examine witnesses or present the case.
- (f) The Category I or Category II practitioner shall have the burden of demonstrating, by clear and convincing evidence, that the recommendation of the Medical Executive Committee was arbitrary, capricious or not supported by substantial evidence. The quality of care provided to patients and the smooth operation of the Hospital shall be the paramount considerations.
- (g) The Category I or Category II practitioner and the Medical Executive Committee shall have the right to prepare a post-hearing memorandum for consideration by the Hearing Committee. The Presiding Officer shall establish a reasonable schedule for the submission of such memoranda.

7.B.4. Hearing Committee Report:

- (a) Within 20 days after the conclusion of the proceeding or submission of the post-hearing memoranda, whichever date is later, the Hearing Committee shall prepare a written report and recommendation. The Hearing Committee shall forward the report and recommendation, along with all supporting information, to the President. The President shall send a copy of the written report and recommendation by special notice to the Category I or Category II practitioner and the Medical Executive Committee for information.
- (b) Within ten days after notice of such recommendation, the Category I or Category II practitioner and/or the Medical Executive Committee may make a written request for an appeal. The request must include a statement of the reasons, including specific facts, which justify an appeal.
- (c) The grounds for appeal shall be limited to an assertion that there was substantial failure to comply with this Policy and/or other applicable bylaws or policies of the

Hospital and/or that the recommendation was arbitrary, capricious or not supported by substantial evidence.

- (d) The request for an appeal shall be delivered to the President by special notice.
- (e) If a written request for appeal is not timely submitted, the appeal is deemed to be waived and the recommendation and supporting information shall be forwarded to the Board for final action. If a timely request for appeal is submitted, the President shall forward the report and recommendation, the supporting information and the request for appeal to the Board. The Chair of the Board shall arrange for an appeal.

7.B.5. Appellate Review:

- (a) An Appellate Review Committee appointed by the Chairperson of the Board shall consider the record upon which the adverse recommendation was made. New or additional written information that is relevant and could not have been made available to the Hearing Committee may be considered at the discretion of the Appellate Review Committee. This review shall be conducted within 30 days after receiving the request for appeal.
- (b) The Category I or Category II practitioner and the Medical Executive Committee shall each have the right to present a written statement on appeal.
- (c) At the sole discretion of the Appellate Review Committee, the Category I or Category II practitioner and a representative of the Medical Executive Committee may also appear personally to discuss their position.
- (d) Upon completion of the review, the Appellate Review Committee shall provide a report and recommendation to the full Board for action. The Board shall then make its final decision based upon the Board's ultimate legal responsibility to grant privileges and to authorize the performance of clinical activities at the Hospital.
- (e) The Category I or Category II practitioner shall receive special notice of the Board's action. A copy of the Board's final action shall also be sent to the Medical Executive Committee for information.

ARTICLE 8

HOSPITAL EMPLOYEES

- A. Except as provided below, the employment of an Allied Health Professional by the Hospital shall be governed by the Hospital's employment policies and manuals and the terms of the individual's employment relationship and/or written contract. To the extent that the Hospital's employment policies or manuals, or the terms of any applicable employment contract, conflict with this Policy, the employment policies, manuals and descriptions, and terms of the individual's employment relationship and/or written contract shall apply.
- B. A request for clinical privileges, on an initial basis or for renewal, submitted by a Category I or Category II practitioner who is seeking employment or who is employed by the Hospital, shall be processed in accordance with the terms of this Policy. A report regarding each practitioner's qualifications shall be made to Administration or Human Resources (as appropriate) to assist the Hospital in making employment decisions.
- C. A request for a scope of practice on an initial basis or for renewal from a Category III practitioner who is seeking employment or is employed by the Hospital shall be evaluated by Human Resources through the Human Resources policies and procedures.
- D. If a concern about an employed Allied Health Professional's clinical conduct or competence originates with the Medical Staff, the concern will be reviewed and addressed in accordance with Articles 6 and 7 of this Policy, after which a report will be provided to Human Resources.

ARTICLE 9

AMENDMENTS

- A. This Policy may be amended 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, provided that the written recommendations of the Credentials Committee concerning the proposed amendments shall have first been received and reviewed by the Medical Executive Committee.
- B. Notice of all proposed amendments shall also be provided to all voting members of the Medical Staff at least 14 days prior to the Medical Executive Committee meeting, and any voting member of the Medical Staff shall have the right to submit written comments to the Medical Executive Committee pertaining to a proposed amendment to this Policy.
- C. No amendment shall be effective unless and until it has been approved by the Board.

ADOPTION

This Allied Health Professionals Policy is adopted and made effective upon approval of the Board, superseding and replacing any and all other bylaws, rules, regulations, policies, or manuals pertaining to the subject matter thereof.

Adopted by the Medical Staff: April 16, 2009

Approved by the Board: April 20, 2009

APPENDIX A

Those Allied Health Professionals currently practicing as Category I Practitioners at Sarasota Memorial Hospital are as follows:

Certified Addiction Professionals

Licensed Clinical Social Workers

Marriage and Family Therapists

Mental Health Counselors

Physicians with Limited Privileges (as referenced in Section 2.A.1)

APPENDIX B

Those Allied Health Professionals currently practicing as Category II Practitioners at Sarasota Memorial Hospital are as follows:

Advanced Registered Nurse Practitioners

Certified Nurse Midwives

Certified Registered Nurse Anesthetists

Physician Assistants

Psychiatric Mental Health Nurses

APPENDIX C

Those Allied Health Professionals currently practicing as Category III Practitioners at Sarasota Memorial Hospital are as follows:

Angiography Technologist

Autotransfusion Technician

Certified Clinical Perfusionist (CCP)

Certified Surgical Technologist (CST)

Certified Surgical Technologist First Assistant (CSTFA)

Eye Tech

Licensed Occupational Therapist

Licensed Physical Therapist

Licensed Practical Nurse (LPN)

Magnetic Resonance Technologist

Radiation Therapy Technician

Registered Electroencephalographic Technologist (REEGT)

Registered Nuclear Medical Technologist

Registered Nurse (RN)

Registered Nurse First Assistant (RNFA/CRNFA)

Registered Radiologic Technologist RT(R)

Registered Respiratory Therapist (RRT)

Sonographer