

**PUBLIC HEALTH TRUST
BYLAWS
AND
RULES AND REGULATIONS
OF THE MEDICAL STAFF**

As Last Amended May 26, 2015

**BYLAWS OF THE MEDICAL STAFF
OF THE PUBLIC HEALTH TRUST**

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BYLAWS OF THE MEDICAL STAFF OF THE PUBLIC HEALTH TRUST**PREAMBLE**

BECAUSE the Public Health Trust (PHT) governs and operates Jackson Health System (JHS) which includes Jackson Memorial Hospital (JMH), Jackson South Community Hospital (JSCH), and Jackson North Medical Center (JNMC) and has authority to govern and operate other designated facilities where healthcare is rendered by practitioners with privileges under the supervision of the Medical Staff of the Public Health Trust; and

BECAUSE Jackson Memorial Hospital serves as a general hospital providing patient care, residency teaching and training, and, through its affiliations also provides education, teaching, and research; and

BECAUSE Jackson South Community Hospital and Jackson North Medical Center serve as community hospitals primarily providing patient care; and

BECAUSE it is recognized that a single organized self-governing staff has overall responsibility to ensure a uniform standard of quality patient care, treatment and services to be provided by qualified individuals with clinical privileges; and

BECAUSE all facilities are subject to the ultimate authority of the Public Health Trust, and as a clinically integrated entity, the cooperative efforts of the Medical Staff, the Chief Executive Officer, and the PHT are necessary to fulfill the PHT's mission and obligation to its patients; and

THEREFORE, the allopathic and osteopathic physicians, dentists, oral surgeons, podiatrists, psychologists and optometrists serving the patients of the PHT hereby organize themselves into a Medical Staff in conformity with these Bylaws.

IT IS FURTHER THE INTENT of the organized PHT self-governing Medical Staff that together with the PHT, they hereby establish and form an Organized Health Care Arrangement (OHCA), pursuant to the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R., Parts 160, et seq., as an integrated clinical setting which needs to share protected health information for patient care and the joint management of PHT healthcare facilities.

DEFINITIONS

1. “Adverse Action” shall have the meaning established in Article IX of these Bylaws.
2. “Allied Health Professional (AHP)” means an individual other than a licensed physician, dentist, oral surgeon, psychologist, podiatrist or optometrist who provides direct patient care services in a PHT facility under a defined degree of supervision, exercises judgment within areas of documented professional competence and consistent with applicable law and is granted clinical privileges to perform specified patient care activities through the credentialing process established in these Bylaws and shall include but not be limited to Physician Assistants, Certified Nurse Anesthetists, Nurse Midwives, Advanced Registered Nurse Practitioners, Registered Nurse First Assistants, Physicists, Anesthesia Assistants, and Radiology Assistants. The Medical Staff shall, through its Medical Executive Committee, identify other professions to be considered Allied Health Professionals.

3. “Ambulatory Care Services” means services provided in facilities other than Jackson Memorial Hospital, Jackson South Community Hospital, Jackson North Medical Center, other hospitals, or the hospital-based ambulatory care centers.
4. “Attending Physician” means a medical staff member who admits the patient and/or is responsible for the continuing care of the patient.
5. “Board Committee” shall mean any Governing Board committee with jurisdiction over matters related to the Medical Staff. This shall include a committee of the Financial Recovery Board or may mean the Governing Board itself.
6. “Chief Executive Officer” means the individual appointed by the Governing Board to act on its behalf in the overall management of the PHT’s designated facilities or his/her designee.
7. “Clinical privileges” means the authorization granted by the Governing Board to provide specific diagnostic, therapeutic, medical, dental or surgical services for specific patient care services in the hospitals or other PHT facilities within defined limits, based on an individual’s license, education, training, experience, competence, judgment and health status. Such health status relates to the ability to perform requested privileges.
8. “Days” mean calendar days.
9. “Dentist” means a doctor of dentistry licensed by the State of Florida under Chapter 466 of the Florida Statutes.
10. “Governing Board” shall mean the governing board of the Public Health Trust which may be the Governing Board, the Board of Trustees, the Financial

- Recovery Board or any other governing board; or the governing board of any other legal entity which operates the Jackson Health System.
11. “Hospital” means all hospital facilities governed by the PHT.
 12. “Jackson Health System (JHS)” shall consist of the PHT facilities.
 13. “Licensed Independent Practitioner” (LIP) shall mean an individual permitted by law and by the organization to provide care, treatment and services without direction or supervision within the scope of the individual’s license and consistent with individually granted privileges and shall include Physicians (M.D.; D.O.), Dentists (D.D.S.), Oral Surgeons (D.M.D.), Psychologists (Ph.D.; Psy.D.), Podiatrists (D.P.M.) and Optometrists (O.D.).
 14. “Medical Executive Committee” means the Medical Executive Committee of the Medical Staff.
 15. “Medical Staff of the PHT” means licensed medical and osteopathic physicians, dentists, oral surgeons, podiatrists, psychologists and optometrists who have clinical privileges in accordance with the Bylaws, and shall be made up of Active Academic, Active Community, Courtesy, Associate, and Honorary Medical Staff members and shall serve as the Medical Staff for PHT.
 16. “Medical Staff Year” means the period from July 1 through June 30.
 17. “Member” shall mean a member of the Medical Staff.
 18. “Organized Medical Staff” shall mean the single organized self-governing body consisting of the members described in paragraph 15 above.

19. “PHT” means the Public Health Trust, which as set forth in Chapter 25A of the Code of Miami-Dade County, is an agency and instrumentality of Miami-Dade County and operates Jackson Health System.
20. “PHT Facilities” means Jackson Memorial Hospital, Jackson South Community Hospital, Jackson North Medical Center, Primary Care Centers, Long-Term Care Facilities, Corrections Health Services Clinics and all other designated or other healthcare facilities operated by PHT.
21. “PHT Policies and Procedures” shall mean all policies and procedures of the PHT including but not limited to medical staff policies and procedures, departmental policies and procedures, and service policies and procedures.
22. “Physician” means a doctor of medicine, doctor of osteopathy, a doctor of dental surgery or medical dentistry who is licensed to practice medicine, surgery or dentistry by the State of Florida.
23. “Podiatrist” means a doctor of podiatric medicine licensed by the State of Florida under Chapter 461 of the Florida Statutes.
24. “Practitioner” means an individual who is licensed or otherwise authorized by the State of Florida to provide health care services.
25. “Psychologist” means an individual who has been awarded a degree in psychology or a doctoral degree with a major in psychology and is licensed under Chapter 490 of the Florida Statutes.
26. “Optometrist” means an individual who has been awarded a degree in optometry and is licensed to practice optometry by the State of Florida.

27. “Telemedicine” means the use of medical information exchanged from one site to another via electronic communications for the health and education of the patient or health care provider and for the purpose of improving patient care, treatment, and services.

ARTICLE I: NAME

The name of this organization shall be the Medical Staff of the Public Health Trust.

ARTICLE II: PURPOSES

The purposes of this organization shall be to:

- A. Ensure that all patients admitted or treated in any PHT facility and all patients who receive health care services from the PHT are treated with the same standard of care;
- B. Provide the highest level of professional performance by all members of the Medical Staff authorized to practice in PHT facilities through the appropriate delineation of clinical privileges and through an ongoing review and evaluation of each member’s clinical, professional and ethical performance;
- C. Provide an appropriate educational and teaching setting that will maintain scientific standards and lead to the continuous advancement in professional knowledge and skill;
- D. Initiate and maintain Bylaws, Rules and Regulations, as well as policies and procedures for self-governance of the Medical Staff;
- E. Provide a mechanism for communication between the Medical Staff and the PHT through its Governing Board and Chief Executive Officer regarding medical

staff issues, facilities issues, training program issues, policy development which impacts patient care services, and any other matter;

- F.** Provide research opportunities under proper institutional control;
- G.** Provide for a single organized Medical Staff that has overall responsibility to ensure a uniform standard of quality patient care provided by qualified individuals with clinical privileges, accountable to the Governing Board;
- H.** Provide for a mechanism to assure that individuals with clinical privileges provide services within the scope of the respective clinical privileges granted;
- I.** Create a framework within which medical staff members can act with a reasonable degree of freedom and confidence;
- J.** Assure that the Medical Staff is organized to accomplish its required functions;
- K.** Promote, support and participate in medical programs designed and conducted to improve the general health of the community served by the PHT;
- L.** Promote and support the appropriate utilization of resources;
- M.** Review and participate in risk management and quality improvement activities; and
- N.** Participate in medical staff activities that serve to promote and maintain accreditation of all facilities by the Joint Commission on Accreditation of Healthcare Organizations and all other relevant accreditation or regulatory agencies.

ARTICLE III: MEDICAL STAFF MEMBERSHIP**Section 3.1 Nature of Medical Staff Membership**

Medical staff membership is a privilege entitling members to attend to patients within PHT facilities. Admitting privileges and the right to provide care within PHT facilities shall be pursuant to these Bylaws. All medical staff members have delineated clinical privileges that define the scope of the care that they can independently provide. All members of the Medical Staff are subject to: the PHT Medical Staff Bylaws; all duly adopted Medical Staff Rules and PHT policies and procedures; and all PHT risk management and continuous quality improvement activities.

Section 3.2 Qualifications for Medical Staff Membership

- A. General Qualifications.** To be qualified for medical staff membership and to ensure that any patient treated will be given the same standard of care:
1. Applicants and members shall be licensed to practice in the State of Florida.
 2. Applicants seeking medical staff membership after January 1, 2013 shall also be board certified, certified by an appropriate specialty board or affirmatively establish comparable competence through the credentials process. The requirements of this section shall apply prospectively. Practitioners who are current medical staff members on January 1, 2013 shall not be subject to this requirement.
 - a. To satisfy the requirements of this section, the applicant must be currently board certified or become board certified following the completion of formal training within the timeframes as defined by the appropriate specialty board of the American Board of Medical Specialties, American

Osteopathic Association, American Dental Association, the Council on Podiatric Medical Education or the National Board of Examiners in Optometry. If no time limits for certification are specified by a given board, then the applicant will be required to become board certified within seven (7) years of completing formal training as defined by the appropriate specialty board of the American Board of Medical Specialties, American Osteopathic Association, American Dental Association or the Council on Podiatric Medical Education. If an applicant is beyond seven (7) years of completing formal training, current board certification will be required for consideration of membership and privileges.

- b. In the alternative, applicants who do not meet the requirements of subsection (a) of this section shall provide proof of comparable competence. Such proof shall include a letter from the appropriate Chief of Service that specifically describes the applicant's qualifications and competence and that recommends the applicant for medical staff membership and specific clinical privileges, despite the applicant's lack of board certification or compliance with subsection (a) of this section, or approval of the application by a two-thirds vote of the voting members of the Medical Executive Committee members present.
3. All applicants must provide information with regard to the following: relevant education; relevant training and experience; demonstrated current competence, medical and clinical knowledge; treatment and clinical skills; clinical judgment; health status; professional conduct; adherence to the ethics of his/her profession;

good reputation; availability for and thoroughness in patient care; interpersonal skills; communication skills; professionalism and the ability to cooperate and work with others; and other elements as set forth in these Bylaws or as may be reasonably determined by the PHT.

B. Geographical Qualifications. An application to the PHT Medical Staff will be accepted from:

1. An applicant who:
 - a. May be expected to admit or provide on-going care to patients in one or more of the PHT facilities; and
 - b. Is in sufficient proximity to the PHT facility or facilities so as to provide continuity of care in a timely manner; or
2. An applicant who, pursuant to recommendation by the Chief of Service, Associate Chief of Service, Chief Nursing Executive or designee, or PHT administration applies for an available position with the PHT, or one of the PHT's agents or contractors for physician services. If at any time after submission of the application for medical staff membership and clinical privileges, the position does not remain available, the application will be deemed to have been voluntarily withdrawn by the applicant.

C. Non-Discrimination. Professional criteria uniformly applied to all applicants constitute the basis for granting medical staff membership and clinical privileges. The PHT shall not discriminate on the basis of gender, race, color, religion, age, handicap, disability, national origin, ethnicity, familial status, pregnancy or sexual

orientation when making decisions regarding the granting or denying of medical staff membership or clinical privileges.

D. Ethical Requirements. Acceptance of membership on the Medical Staff constitutes the member's certification that he/she has in the past, and will in the future, strictly abide by the Code of Ethics of his/her profession. The JHS Code of Ethics as adopted or amended from time to time, shall govern the professional and ethical conduct of the medical staff members. Specifically, each applicant and member of the PHT Medical Staff pledges and agrees to:

1. Authorize the PHT and/or designee to request, procure and review any information regarding the applicant's background (including criminal background), education, training, licensure, general qualifications as described in Section 3.2(A), and medical practice from any institution, individual, organization, governmental entity, or any other reference or source in relation to the application submitted by the applicant; and
2. Abide by the Medical Staff Bylaws, Medical Staff Rules and Regulations, PHT Policies and Procedures, and continuous quality improvement activities, as they may be amended or modified from time to time.

E. Financial Responsibility Requirement. Applicants for and members of the Medical Staff shall provide and maintain proof of compliance with the financial responsibility laws of the State of Florida.

F. Volume Considerations. The matter of patient/case volume shall be evaluated pursuant to medical staff policy on low volume and no volume practitioners, as adopted or amended. However, at a minimum, active medical staff members shall have a

record of at least ten (10) clinical encounters during one two-year appointment to the Medical Staff; associate medical staff members shall have a records of at least fifty (50) patient encounters during one two-year appointment to the Medical Staff.

Section 3.3 Conditions and Duration of Appointment

The PHT shall appoint and reappoint members to the Medical Staff. The PHT shall act on appointments, reappointments, modifications, or revocation of appointments upon a recommendation from the Medical Staff as provided in these Bylaws. Appointments and reappointments shall be for a period of not more than two years.

Section 3.4 Employed, Contracted or Faculty Physicians/Allied Health Professionals.

A. Employed. Physicians or allied health professionals who are employed by the PHT shall obtain and maintain appropriate medical staff appointment and clinical privileges in good standing. Separation from employment with the PHT shall have the effect of an automatic resignation from the Medical Staff and automatic relinquishment of clinical privileges.

B. Contracted.

1. The PHT may enter into contracts with physicians or physician groups for the performance of clinical and/or administrative services at PHT facilities. All physicians and allied health professionals functioning pursuant to such contracts shall obtain and maintain appropriate medical staff appointment and clinical privileges in good standing.

2. To the extent that any such contracts confers the exclusive right to perform specified services at the PHT facilities, applications for initial appointment or for clinical privileges related to those services specified in such contract(s) will not be

accepted for processing unless submitted with documentation that the applicant will be providing those services pursuant to the existing or proposed exclusive contract with the PHT.

3. If a physician ceases to provide services pursuant to an existing contract with the PHT for exclusive services, the physician will be considered to have automatically resigned from the Medical Staff and automatically relinquished clinical privileges.

4. If any such exclusive contract would have the effect of preventing an existing medical staff member from exercising clinical privileges that had previously been granted, the affected member shall be given notice of the exclusive contract and have the right to meet with the Governing Board or designated Board Committee to discuss the matter prior to the contract in question being signed by the PHT. At the meeting, the affected member shall be entitled to present any information relevant to the decision to enter into the exclusive contract. That individual shall not be entitled to any other procedural rights with respect to the decision or the effect of the contract on his or her clinical privileges, notwithstanding any other provision in this Section 3.4(B). The inability of a physician to exercise clinical privileges because of an exclusive contract is not a matter that entitles the member to a hearing pursuant to Article IX and is not a matter reportable to the state licensure board or the National Practitioner Databank.

5. In the event of any conflict between this Section 3.4(B) of the Medical Staff Bylaws and the terms of any contract, the terms of the contract shall prevail.

C. Faculty. The Trust has at least two basic affiliation agreements with medical schools with faculty serving as members of the Medical Staff. Faculty who separate from employment with the medical school that has an affiliation agreement with the Trust shall be considered to have automatically resigned from the Medical Staff and automatically relinquish clinical privileges from the Trust. Following separation, affected faculty members may reapply pursuant to Section 5.8(B) of these Bylaws.

D. Allied Health Professional. If the medical staff member with whom an allied health professional is affiliated ceases to be a member of the Medical Staff, then the allied health professional shall cease to have clinical privileges at PHT facilities unless the allied health professional becomes affiliated with another medical staff member.

ARTICLE IV: CATEGORIES OF THE MEDICAL STAFF

Section 4.1 Composition of the Medical Staff

The Medical Staff of the Public Health Trust shall include members of all PHT facilities. The Medical Staff shall be comprised of the Active Academic, Active Community, Associate, Courtesy, and Honorary medical staff members. At the time of appointment, the member's staff category shall be determined.

Section 4.2 The Active Academic and Active Community Medical Staff

A. Criteria. Active Academic and Active Community medical staff members shall meet the qualifications in Section 3.2 and regularly treat patients in a PHT facility.

1. Active Academic. Active Academic medical staff members shall demonstrate clear evidence of a commitment to assume all the functions and

responsibilities of membership on the Active Medical Staff, including, where appropriate, supervision of residents/fellows and/or the teaching of medical students, emergency service care, consultation assignments, and participation in medical staff and other committees.

2. Active Community. Active Community medical staff members shall demonstrate clear evidence of a commitment to assume all functions and responsibilities of membership on the Active Medical Staff, including, where appropriate, emergency service care, consultation assignments, and participation on medical staff and other committees. Active Community Medical Staff are also eligible to provide supervision of residents/fellows, if desired and so approved by the appropriate chief of service and the relevant graduate medical education program directors, and the teaching of medical students, if desired and so approved by the Dean of the relevant medical school or his/her designee.

B. Privileges. Active Academic and Active Community medical staff members shall be appointed to the specific clinical service(s) in which they will primarily exercise active privileges. Privileges granted will be based upon: services, personnel, equipment and other resources available at the various facilities to support the privileges requested in conformance with a Governing Board approved medical staff master plan, if applicable; the documented clinical competency submitted by the applicant; and patient/case volume pursuant to the medical staff policy on low volume and no volume practitioner policy. Active Academic and Active Community medical staff members shall be individually privileged to admit patients to PHT facilities pursuant to core privileging processes and if applicable, specialty privileging processes.

C. Participation in Medical Staff Activities. Members of the Active Academic and Active Community Medical Staff shall be appointed to a specific clinical service and shall be eligible to vote at meetings of the Medical Staff, to hold office on the Medical Staff, and to serve as a voting member on medical staff committees and other committees.

Section 4.3 The Associate Medical Staff

Associate medical staff members shall meet the qualifications in Section 3.2. and shall be individually privileged to manage primary ambulatory conditions including appropriate procedures and initial emergency care in an outpatient setting. Members of the Associate Medical Staff may have hospital admitting privileges and may render care within the hospital setting. Associate medical staff members shall be appointed to a specific clinical service. S/he shall be eligible to vote at meetings of the Medical Staff shall be eligible to hold office on the Medical Staff, and may serve as non-voting members on medical staff committees or other committees.

Section 4.4 The Courtesy Medical Staff

A. Criteria. Courtesy medical staff members shall meet the qualifications in Section 3.2. and shall be appointed to a specific clinical service in the PHT facility where they will primarily exercise privileges. Courtesy medical staff members shall be individually privileged to consult on patients according to their privileges, but shall not have admitting privileges.

B. Participation in Medical Staff Activities. All Courtesy medical staff members shall be appointed to a specific clinical service but shall not be eligible to vote

at meetings of the Medical Staff, shall not be eligible to hold office on the Medical Staff, but may serve as non-voting members of medical staff committees or other committees.

Section 4.5 The Honorary Medical Staff

Honorary medical staff members do not actively practice in PHT facilities and are honored by emeritus status. These members may have retired from active hospital practice, may be of outstanding reputation, and may not necessarily reside in this community. The criteria outlined in Section 3.2. regarding geographic proximity and Article V regarding reappointment process shall not apply to Honorary Medical Staff. The Governing Board upon recommendation of the Medical Executive Committee and showing of good cause may waive any requirement of these Bylaws for an honorary medical staff member. Honorary medical staff members shall not be granted clinical privileges, shall not be eligible to vote at meetings of the Medical Staff, shall not hold office on the Medical Staff but may serve as an ex-officio, non-voting member on medical staff or other committees at the pleasure of the Chief Medical Officer and President of the Medical Staff.

ARTICLE V: PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT TO THE MEDICAL STAFF

Section 5.1 General Requirements of Applicant

A. Complete Application. The applicant for appointment, reappointment and/or clinical privileges has the burden of providing a complete application as well as all information required by these Bylaws in order for the PHT to properly evaluate his/her competence to exercise the privileges sought, character, ethics, and other qualifications. The applicant shall provide accurate, up-to-date information on the application, and shall be responsible for ensuring that all supporting information and verifications are

provided, as requested, and are continuously and voluntarily updated even in the absence of additional requests for information. It shall be the responsibility of the applicant to ensure that any required information from his/her training programs, peer references, or other facilities is submitted directly to the Medical Staff Office by such sources. The applicant shall be responsible for resolving any doubts regarding the application.

B. Incomplete Information. The Medical Staff Office shall notify the applicant of any problem in collecting such information, and it shall be the applicant's responsibility to obtain and/or facilitate the collection of the requested information. If the review cannot be completed due to the applicant's failure to provide the requested information, the applicant shall be notified in writing, by certified mail or other delivery method, including electronic delivery, which provides for confirmation of receipt, that failure to provide the requested information within ten (10) business days will be deemed a voluntary withdrawal of the application for appointment/reappointment and if applicable, and an automatic relinquishment of the medical staff membership and clinical privileges at the end of the current term. If the review is not completed due to circumstances within the control of the PHT, the applicant's application shall be referred to the Credentials Committee.

C. No Obligation to Review. The Medical Staff, PHT administration and the Governing Board shall have no obligation to review or consider any application until it is complete and verified.

D. Request for Additional Information or Interview. If during the processing of the application, the Medical Staff Office or any committee or

representative thereof, determines that additional information or verification, or an interview with the applicant is needed, the application shall not be considered complete until such additional information or verification is received, or the interview is conducted. The Credentials Committee, Medical Executive Committee, Board Committee, or the Governing Board may request that the applicant appear for an interview with regard to the application. The Medical Staff Office shall notify the applicant of the specific information being requested, the timeframe within which a response is required, and the effect on the application if the information is not received timely.

E. Voluntary Withdrawal. Failure to provide a complete and verified application after being provided with an application for appointment, reappointment or clinical privileges, or failure to appear for any requested interview, shall be deemed a voluntary withdrawal from the application process. An initial appointment application shall be considered to be withdrawn if not complete within 180 days from date of signature. (Must be re-attested by the applicant no later than 120 days from initial signature of release and attestation). The Practitioner may reapply in accordance with these Bylaws. Voluntary withdrawal from the application process shall not be considered an Adverse Action, and shall not entitle the applicant to procedural rights outlined in Article IX of these Bylaws. The Medical Staff Office shall provide notice to an individual regarding his/her withdrawal from the application process due to lack of requested information or failure to appear for an interview.

F. Electronic Mail and Facsimile. A valid electronic mail (email) address must be provided and updated immediately during the application process as well as

when the applicant becomes a member of the Medical Staff or Allied Health Professional Staff.

G. Availability of Medical Staff Bylaws. Upon application for appointment to the Medical Staff, each applicant will be notified that the PHT Medical Staff Bylaws and Medical Staff Rules and Regulations are available online through the Jackson Health System website. Printed copies of the Bylaws, Rules and Regulations, and PHT Policies and Procedures will be provided upon request by the Medical Staff Office. It is the responsibility of the applicant to become familiar with the contents of the PHT Medical Staff Bylaws.

H. Policies. Matters not specifically addressed in the Bylaws regarding appointment and reappointment to the Medical Staff are addressed through the medical staff policies on appointment and reappointment.

Section 5.2 Application

A. Applicants for initial appointment and reappointment to the PHT Medical Staff shall file a written and signed application as prescribed by the PHT. The application must be received within thirty (30) business days of being signed and attested to by applicant. The application shall include detailed information regarding the applicant's character, professional qualifications and physical and mental status.

B. Initial Appointment. The PHT's decision to approve or deny an application will be based upon the content of the application and the following information that shall be provided by the applicant:

1. Post-graduate training, including the name of each institution, degree(s) granted, programs completed, and dates attended;

2. All current valid medical, dental, and other professional licenses.
3. All current specialty or subspecialty board certification or recertification;
4. Drug Enforcement Administration registration, if applicable, with the date and number of each registration.
5. Medicaid Provider number and Medicare Provider number, if applicable;
6. National Provider Identification (NPI) number;
7. A valid electronic mail (email) address;
8. Health status, any and all continuing health concerns, including chemical dependencies, if any, that may affect the applicant's ability to perform privileges requested;
9. The nature and specifics for any past, pending or completed action or challenge whether voluntary or involuntary, involving denial, revocation, suspension, reduction, limitation, probation, non-renewal, relinquishment (by resignation or expiration) of: licenses or certificates to practice any profession in any state or country; Drug Enforcement Administration or other controlled substances registration; faculty membership in any medical or other professional school; staff membership status; or clinical privileges at any other hospital, clinic or health care institution;
10. Staff category, service, and specific clinical privileges requested;
11. Any current felony or misdemeanor charges pending against the applicant and any felony or misdemeanor convictions;

12. Names of all hospitals with which applicant has a current or previous association, including medical staff status and dates;

13. An uninterrupted chronology of past and present medical practice as well as an explanation of any gaps or lapses in the chronology;

14. Proof of compliance with the financial responsibility laws of the State of Florida and information on malpractice claims, notices of intent to initiate litigation, reported complaints against applicant, and all suits and settlements made, concluded and pending during the past five (5) years. The physician shall provide information regarding any final judgments or settlements in excess of \$10,000 against the physician, individually, in a professional liability action;

15. Any additional information as may be required by the various regulatory agencies;

16. The names of three practitioners who have had sufficient recent experience in observing and working with the applicant to enable them to render an opinion as to the applicant's professional competence, character, and professional ethics, which should include an assessment of the following areas: medical/clinical knowledge, technical and clinical skills, clinical judgment, availability for and thoroughness in patient care, interpersonal skills, communication skills, professionalism and ability to cooperate and work with others. At least one of the three practitioners must have no current or currently-contemplated medical practice affiliation and no current or currently-contemplated referral pattern with the applicant.

17. Proof of compliance with continued medical education (CME) requirements. Proof of CME compliance shall be considered adequate if it includes

evidence or attestation of completion of all mandatory CME components and completion of all the required hours as defined by applicable laws and regulations. Upon request, as outlined in the CME Attestation Form, the medical staff member must be able to provide copies of continuing medical education documentation; and

18. Certification that the applicant has not been excluded, debarred, terminated, cancelled, or found ineligible to participate in any state or federal healthcare programs, has not withdrawn from participation while under investigation by any state or federal health care program, and is currently not under investigation by any state or federal health care program.

C. Reappointment.

1. Term. Reappointment shall be required of every member of the Medical Staff at regular intervals not to exceed two (2) years. No member shall be automatically entitled to or have a vested right of renewal of medical staff membership and privileges.

2. Submission of Application. Ninety (90) days prior to expiration of a member's medical staff membership and clinical privileges, the Medical Staff Office will provide the member with a reappointment packet. The member desiring reappointment shall complete the reappointment application and submit it to the Medical Staff Office sixty (60) days prior to expiration of his/her membership. Failure, without good cause, to submit a timely completed application for reappointment shall result in automatic relinquishment of membership and clinical privileges at the end of the current term. The Medical Staff Office shall collect and verify the information regarding the member's professional activities, performance and conduct in PHT facilities. When the

information has been collected and verified, the Medical Staff Office shall transmit the application and supporting documents to the Chief of Service of each clinical service in which the staff member has requested privileges.

3. Except as otherwise provided in these Bylaws, no member of the Medical Staff shall be reappointed until his/her performance and qualifications have been reviewed and evaluated including but not limited to:

4. Clinical privileges requested with any basis for change;

5. Documentation of recommended corrective or disciplinary action, if any, by medical staff review committees, including quality care committees;

6. Professional performance, current competence and ability, judgment, technical skills, and mental and physical health, including evaluation of initial proctoring, focused professional practice evaluation, and ongoing professional practice evaluation;

7. Professional ethics and conduct;

8. Fulfillment of continuing medical education requirements;

9. Conscientious maintenance of timely, accurate and legible medical records;

10. Compliance with the Medical Staff Bylaws, Rules and Regulations, and PHT Policies and Procedures;

11. Cooperation with facility or hospital personnel and collegial and professional relations with other staff members;

12. Cost efficient and appropriate utilization of facility or hospital services;

13. General attitude and behavior toward patients, facility/hospital and staff;
14. Provision of information on voluntary or involuntary loss of or reduction in clinical privileges and/or medical staff membership and whether he/she has voluntarily or involuntarily relinquished privileges and/or medical staff membership to any hospital within the United States;
15. Challenges, either previously successful or currently pending, to any licensure or registration or the voluntary relinquishment of such licensure or registration;
16. Involvement in a professional liability action, final or non final judgments or settlements;
17. Query of National Practitioner Data Bank;
18. Utilization of membership and clinical privileges during previous appointment;
19. Health status, any and all continuing health concerns, including chemical dependencies, that may affect the member's ability to perform privileges requested;
20. Any current felony or misdemeanor charges pending against the member and any felony or misdemeanor convictions; and
21. Any exclusion, debarment, termination, cancellation or ineligibility to participate in any state or federal health care program, withdrawal from participation while under investigation by any state or federal health care program or current investigation by any state or federal health care program.

D. Conditions of Application. Each applicant agrees as follows:

1. To be bound by the PHT Medical Staff Bylaws, Rules and Regulations, and PHT Policies and Procedures and PHT continuous quality improvement activities including but not limited to initial proctoring, focused professional practice evaluation (FPPE), and ongoing professional practice evaluation (OPPE), as may be amended or modified from time to time;
2. To appear for credentials interviews, if requested;
3. To authorize the PHT to consult with members of other hospital medical staffs with which the applicant has been associated and with other persons as deemed appropriate, concerning the applicant's professional and ethical qualifications, current competence, character, and other factors, that may be considered in evaluating his/her application, and authorizes such persons to release such information, and to consent to the inspection and copying of any and all records in the possession of any such hospitals, persons or other entities which would be material in any evaluation of his/her qualifications, and authorize anyone in possession of such records to release them;
4. To authorize the PHT to conduct a criminal background screening, and to cooperate with such screening.
5. To release all representatives of the PHT and its Medical Staff from any liability for their acts performed in good faith and without malice in connection with evaluating the applicant and agrees to release from any liability all individuals and organizations who provide information to the PHT in good faith and without malice concerning the applicant's competence, ethics, character and other qualifications for staff appointment and privileges, including otherwise privileged or confidential information;

6. To acknowledge that, to the fullest extent permitted by law, there shall be absolute immunity extended to the members of the Medical Staff, the Governing Board, administrators, or representatives, agents, employees and servants of the PHT, from any and all civil liability arising from any such act, communication, report, recommendation, or disclosure involving the applicant even where the information involved would otherwise be deemed privileged;

7. To acknowledge that such immunity shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with PHT activities related but not limited to: (1) the application for staff appointment or clinical privileges, (2) periodic reappraisals for appointment or for increase or decrease in clinical privileges including but not limited to initial proctoring, focused professional practice evaluation (FPPE), and ongoing professional practice evaluation (OPPE), (3) proceedings for suspension of clinical privileges or revocation of staff membership, (4) precautionary suspension, (5) hearings and appellate reviews, (6) medical care evaluations, (7) utilization reviews, and (8) other hospital, departmental, service, or committee activities related to the quality of care and applicant's professional conduct.

8. To execute releases in accordance with the tenor and import of this statement in favor of the individuals and organizations specified in paragraph six (6) above, subject to such requirements, including those of good faith, absence of malice, and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under Florida law.

9. To acknowledge that the consents, authorizations, releases, rights, privileges, and immunities pursuant to the Medical Staff Bylaws for the protection of the individuals and entities described in paragraph five (5), in connection with applications for initial appointment, shall also be fully applicable to the activities and procedures covered by the application.

10. To notify the PHT at any time during the initial appointment or reappointment process or, any time during his/her medical staff membership of any change to any information provided on the application or in any of the documents submitted in support of such application.

11. To immediately notify the PHT at any time during the initial appointment or reappointment process or any time during his/her medical staff membership, of any change in any qualifications for medical staff membership or clinical privileges, including but not limited to: debarment, exclusion, ineligibility, termination, cancellation or withdrawal from participation in any state or federal health care program or any investigation by any state or federal health care program; designation as an ineligible person or any exclusion or other sanctions imposed or recommended by the federal Department of Health and Human Services or related federal agencies, state regulatory boards or other regulatory bodies or agencies required by law; the receipt of a peer review organization (PRO) citation; a quality denial letter from another facility or organization regarding alleged quality concerns in patient care; current pending changes to current licensure; change in Drug Enforcement Administration registration; change in financial responsibility requirement; change in specialty board certification, if applicable; the submission of any report made to the National Practitioner Databank or the

Federation of State Medical Boards; continued eligibility to participate in any state or federal health care programs; involvement in any current professional liability action; final or non-final judgments or settlements; current pending felony or misdemeanor charges or felony or misdemeanor convictions; and any other significant change to the qualifications for medical staff membership or clinical privileges.

12. That failure to continuously maintain the necessary credentials to be a member of the Medical Staff during the entire term of appointment shall be reported to the Credentials Committee and action shall be taken as provided in these Bylaws.

13. To submit to ongoing verification of credentials.

14. To sign the attestation statement as required by Medicare.

15. That it may be deemed an automatic relinquishment of membership or clinical privileges, at the time of reappointment, if the applicant cannot demonstrate active participation and functioning in the Jackson Health System, under the member's designated medical staff category and within the member's approved clinical privileges, unless the Chief of Service recommends otherwise.

16. To adhere to any applicable medical staff, Public Health Trust/Jackson Health System or County conflict of interest policy.

17. To participate in electronic records training and other reasonable orientation activities prior to exercising privileges.

Section 5.3 Process for Appointment/Reappointment.

A. Application Verification.

1. Application. Applicant shall submit a complete application to the Medical Staff Office as prescribed by the Medical Executive Committee.

2. Primary Source Verification. Upon receipt of a complete application and in accordance with the medical staff policy on credentialing of initial appointment and reappointment applications, the Medical Staff Office shall seek to collect or verify information provided by the applicant in the application including but not limited to references, primary verification of licensure, education, training and other evidence submitted. Primary source verification shall be completed at the time of appointment, reappointment, renewal or modification of clinical privileges and at time of licensure expiration.

3. Reports, Recommendations and Other Forms. All reports and recommendations made during the review process shall be submitted in writing as prescribed by the Medical Executive Committee along with the application and all other documentation under consideration. Each report and recommendation for initial appointment shall specify whether membership is recommended or not and, if so, the service where the privileges are to be granted, and any conditions to be attached to the individual's appointment. Each report and recommendation for reappointment shall state whether reappointment is recommended or not and, if so, the staff category to be assigned, and delineated clinical privileges to be granted. If the recommendation is to: (1) deny appointment/reappointment; (2) reduce clinical privileges; (3) deny a requested increase in privileges; or (4) deny change of staff category, the reasons must be stated in the report and recommendation.

B. Review by Chief of Service. Once the Medical Staff Office has deemed the application complete and has verified all information, the Chief of Service will review the application and make a recommendation to the Credentials Committee. If the

application is for reappointment, the Chief of Service shall also review the member's quality of care record, including initial proctoring, focused professional practice evaluation and ongoing professional practice evaluation and the member's utilization of membership and privileges during the previous appointment and then the Chief of Service shall make a recommendation to the Credentials Committee. The Chief of Service may delegate this review to the appropriate Associate Chief of Service or other designee, and may withdraw such delegation at his/her discretion. If the Chief's recommendation to the Credentials Committee is unfavorable, the Chief must provide an explanation of the recommendation to the Credentials Committee.

C. Credentials Committee Member or Subcommittee Review. Once the Chief of Service has made a recommendation, the application will be reviewed by a member of the Credentials Committee or a Subcommittee. The recommendation of the Credentials Committee member or the Subcommittee will be submitted to the Credentials Committee.

D. Credentials Committee Review and Recommendation. The Credentials Committee shall review the complete and verified application, the supporting documentation, the recommendation of the Chief or Hospital-Based Associate Chief of Service, the recommendation of the Credentials Committee member or Subcommittee, and such other relevant information as may be available. The Credentials Committee may interview the applicant or request other information necessary for its review and recommendation. The application may be deferred for no more than three consecutive meetings to allow for the receipt and review of the requested information. The

Credentials Committee shall furnish its recommendations to the Medical Executive Committee.

E. Medical Executive Committee and Recommendation. After receipt of the Credentials Committee recommendations, the Medical Executive Committee shall consider the recommendations and such other relevant information available to it and shall forward its recommendation to the appropriate Board Committee. The Medical Executive Committee may also defer action on the application for further consideration of the application, but not for more than one meeting cycle, except for good cause shown, after which time the Medical Executive Committee must forward a recommendation to the appropriate Board Committee to accept or reject the applicant. Any member of the Medical Staff may offer information about the applicant to the Chairperson of the Medical Executive Committee.

F. Board Committee Report and Recommendation. The Board Committee, following receipt of the Medical Executive Committee's recommendation, shall consider such recommendation and accept, reject, or modify the recommendations. The Board Committee may refer the recommendations back to the Medical Executive Committee, stating the reasons for such referral, and setting a time limit within which an additional report shall be made to the Board Committee. At its next regular meeting after its receipt of the additional report, the Board Committee shall vote on the recommendations submitted. Any member of the Medical Staff may offer information about the applicant to the Chair of the Board Committee. This section shall apply only if the Governing Board has a committee with jurisdiction over medical staff matters. If

there is no Board Committee with jurisdiction over medical staff matters, the Governing Board shall have all the rights and responsibilities delineated in this section.

G. Adverse Action Recommendation and Right to Hearing and Appeal.

If the Medical Executive Committee recommends an Adverse Action as to the applicant's application, the Chief Executive Officer shall notify the applicant of the recommended Adverse Action and his/her right to a hearing and appeal pursuant to Article IX of the Bylaws. If the Medical Executive Committee provides a favorable recommendation to the Board Committee, but the Board Committee rejects such recommendation and instead recommends Adverse Action with regard to the applicant's application, the Chief Executive Officer shall notify the applicant of the recommended Adverse Action and his/her right to hearing and appeal pursuant to Article IX of these Bylaws. An Adverse Action is one that results in the denial of medical staff membership, reduction of medical staff membership category, denial of reappointment to medical staff membership, denial of advancement in medical staff membership or category, demotion to a lower staff membership category, suspension, denial, modification, reduction or revocation of some or all clinical privileges.

H. Governing Board. The Governing Board, following receipt of the recommendation from the Board Committee, shall consider such recommendation and accept, reject or modify the recommendation. The Governing Board shall act on the recommendation of the Board Committee or Medical Executive Committee only after all hearings and appeals have been exhausted, if applicable. The action of the Governing Board shall be the final action of the Public Health Trust.

I. Notification. When the Governing Board has taken final action on any application for appointment to the Medical Staff, it shall, acting through its Chief Executive Officer, notify the Chairperson of the Medical Executive Committee and the applicant of the action taken.

Section 5.4 Terms and Conditions of Appointment

A. Appointment to the Medical Staff shall confer on the applicant only such admitting and clinical privileges as have been granted by the Governing Board. Any member of the Medical Staff must be able to render continuous and appropriate care and supervision to his/her patients, abide by the PHT and Medical Staff Bylaws, Rules and Regulations, JHS/PHT policies and procedures, abide by the terms of his/her delineation of privileges and medical staff category, and abide by the medical staff member job description policy.

B. To assure that all members of the Medical Staff are functioning within their delineated privileges as granted, a list of delineated privileges will be maintained by the Medical Staff Office so that the staff may have access to verify privileges. In addition, a copy of each member's DEA certification will be maintained by the Medical Staff Office and made available upon request.

C. General Proctoring Requirements.

1. Except as otherwise determined by the Medical Executive Committee and Governing Body, the following shall be subject to proctoring:

a. All initial appointees to the Medical Staff, Allied Health Professional Staff, and all practitioners granted new privileges in accordance with

standards and procedures defined by each clinical service and documented on delineations of clinical privileges;

b. Medical Staff, Allied Health Professional Staff and other practitioners granted privileges as a condition of renewal of privileges, if deemed appropriate;

c. Any member of the Medical Staff or Allied Health Professional Staff when the Medical Executive Committee determines that additional information is needed to assess a practitioner's performance.

2. The purpose of proctoring is for the practitioner to demonstrate that s/he is qualified to exercise the privileges that were granted. Proctoring should be imposed only for such period of time or number of cases reasonably necessary to evaluate whether or not the practitioner is qualified to exercise the privileges granted, but shall be for no fewer than three (3) cases. The proctoring described in this section is not a form of discipline and therefore, the procedural rights provided in Article IX of these Bylaws do not apply.

3. Completion of Proctoring. Proctoring shall be deemed successfully completed when the practitioner completes the required number of proctored cases within the timeframe established or as required by the Chief of Service or Associate Chief of Service and the Practitioner's professional performance in the cases meets the standard of care.

4. Effect of Failure to Complete Proctoring

a. Failure to Complete Necessary Volume. Any practitioner who fails to complete the required number of proctored cases within the timeframe

established when privileges were granted shall be deemed to have voluntarily withdrawn his or her request for membership (or relevant privileges), and he or she shall not be afforded the procedural rights provided in the Right to Hearing section within this Bylaws. However, the clinical service has the discretion to extend the time for completion of proctoring in appropriate cases subject to ratification by the Medical Executive Committee. The inability to obtain such an extension shall not give rise to procedural rights described in the Right to Hearing section in within these Bylaws.

b. Failure to Satisfactorily Complete Proctoring. If a Practitioner completes the necessary volume of proctored cases but fails to perform satisfactorily during proctoring, he or she may be terminated (or the relevant privileges may be modified or revoked) and he or she shall be afforded the procedural rights as provided in the Right to Hearing section.

c. The failure to complete proctoring for any specific privilege shall not, by itself, affect the member's category of medical staff membership. The specific privileges may be voluntarily relinquished or terminated if proctoring is not completed thereafter within a reasonable time.

5. The proctoring process may be further defined in medical staff policy and procedures.

D. Focused Professional Practice Evaluation (FPPE)

1. The purpose of FPPE is to evaluate the privilege-specific competence of a practitioner who does not have documented evidence of competently performing the requested privilege(s) within a PHT facility and to address concerns

identified through ongoing professional practice evaluation (OPPE), peer review or other sources.

2. Within the first six (6) months of appointment to the Medical Staff, each new medical staff member shall receive a focused case review by the appropriate Chief of Service, Hospital-Based Associate Chief of Service or designee with regard to initial clinical privileges.

3. Focused case review may include, but is not limited to, chart review, direct observation, clinical practice patterns review, simulation, monitoring/proctoring, peer review including external peer review, data collection, sentinel event data and discussion with other staff involved in the care of each patient (e.g., consulting physicians, assistants at surgery, nursing or administrative personnel).

4. The focused professional practice evaluation process may be further outlined in medical staff policy and procedure.

E. Ongoing Professional Practice Evaluation (OPPE).

1. The purpose of ongoing professional practice evaluation is to identify any potential areas for performance improvement and to support an efficient, evidence-based privilege renewal process. The ongoing professional practice evaluation will be factored into recommendations regarding continuation of existing privileges, revision of existing privileges or revocation of existing privileges prior to or at the time of renewal.

2. Each member of the Medical Staff shall receive, at least every eight (8) months, an evaluation of his/her professional performance. Each clinical service will monitor and review trends and outliers through periodic chart review; direct

observation; quality and safety dashboards; monitoring of diagnostic and treatment techniques; departmental quality review processes; and discussion with other individuals involved in the care of each patient including consulting physicians, assistants at surgery, nursing, and administrative personnel.

3. Relevant information obtained from the ongoing professional practice evaluation shall be integrated into performance improvement activities.

4. If there is uncertainty regarding the practitioner's professional performance, the Medical Staff shall follow the course of action defined in these Bylaws such as peer review, credentialing, collegial intervention, health and welfare committee or disciplinary action.

5. The ongoing professional practice evaluation process may be further outlined in medical staff policy and procedure.

Section 5.5 Acceptance to Staff Membership

No applicant shall be deemed to have been accepted for medical staff membership except upon application made and fully acted upon according to these Bylaws. Temporary privileges granted pursuant to these Bylaws shall not be deemed to confer upon the applicant any form of staff membership or any right or privilege of membership associated with the Medical Staff of the Public Health Trust.

Section 5.6 Leave of Absence

A. A member may request, for medical, academic, military or exceptional reasons, a voluntary leave of absence from the Medical Staff by submitting a written request to the Medical Staff Office which shall forward such request to the Chief of Service of the clinical service where the member has clinical privileges. The written

notice shall state the reason for the requested leave of absence and a specific period of time for the leave of absence, which may not exceed one (1) year except for military leave or other reason approved by the Chief of Service, which may be longer.

B. Upon receiving a member's request for a leave of absence, the Chief of Service shall review the member's request and submit a recommendation to the Credentials Committee. The Credentials Committee shall forward its recommendation to the Medical Executive Committee, which in turn shall forward its recommendation to the Board Committee. The Board Committee shall forward its recommendation to the Governing Board for final action.

C. During the period of leave, the staff member's clinical privileges shall be considered voluntarily suspended. The member requesting a leave of absence shall complete all delinquent medical records prior to the beginning of the leave, except in emergency circumstances.

D. Upon return from the leave of absence, the staff member shall return to the same clinical service, in the same staff category, and with the same clinical privileges that existed upon his/her departure. However, a leave of absence due to any physical, medical, psychological or other impairment that interferes with his/her ability to practice medicine necessitates review by the appropriate Chief of Service before prior clinical privileges are restored.

E. At least thirty (30) days prior to the end of the leave period, or at any earlier time, the member may request reinstatement of his/her privileges by submitting written notice to that effect to the Chief of Service. The member shall submit a written summary, detailing his/her educational, professional, and patient care activities during the

leave period. The consideration for reinstatement will follow the steps outlined in Section 5.3 above.

F. If the reinstatement process is not completed due to the individuals' failure, without good cause, to provide the requested information, the individual will be notified in writing, by certified mail or other delivery method, including electronic delivery, which provides for confirmation of receipt that failure to provide the information within ten (10) days will be deemed an automatic relinquishment of medical staff membership and clinical privileges. The Medical Executive Committee shall, in its sole discretion and after giving such member the opportunity to address the Committee, determine whether or not good cause existed. A member who is deemed to have automatically relinquished his/her medical staff membership and clinical privileges as set forth in this section shall not be entitled to the procedural rights provided in Article IX. A request for staff membership subsequently received from the staff member shall be treated and processed as an application for initial appointment.

G. Reinstatement may be made subject to a proctoring or monitoring requirement as determined by the Credentials Committee and Medical Executive Committee in consultation with the appropriate Chief of Service for a period of time during which the individual's clinical performance is observed by one or more designated medical staff members to determine the individual's continued qualification for membership and clinical privileges. The proctoring or monitoring may be voluntary or mandatory.

H. If the term of his/her membership to the Medical Staff is due to expire during the leave period or within ninety (90) days of reinstatement, the individual shall

submit a reappointment application as part of the reinstatement process. However, if his/her medical staff membership has already expired during the leave period, the individual must submit an application for initial appointment.

Section 5.7 Resignation from the Medical Staff; Automatic Relinquishment

A. Any member who desires to resign from the Medical Staff must submit a letter of resignation, through his/her Chief of Service, to the Credentials Committee. The Credentials Committee shall forward its recommendation to the Medical Executive Committee, which in turn shall forward its recommendation to the Board Committee. The Board Committee shall forward its recommendation to the Governing Board for final action.

B. A request for resignation shall not be considered until all obligations at all PHT facilities have been satisfactorily met by the member, including, but not limited to completion of all medical records, satisfaction of financial obligations to the PHT, compliance with reasonable requests of the PHT regarding outstanding accounts receivable, and other arrangements satisfactory to the PHT.

C. A member, including a member who automatically relinquishes his/her membership and clinical privileges, will be considered to have resigned not in good standing if:

1. The member has not met the obligations described in this section;
2. The member resigns while under investigation or in lieu of an investigation;
3. The member leaves employment of the PHT due to disciplinary action.

Section 5.8 Reapplication to the Medical Staff

A. A practitioner who is denied membership or reappointment to the Medical Staff or whose membership is revoked may not reapply to the Medical Staff for at least one (1) year after such action is considered final. An exception may be granted upon written request of the member within fifteen (15) days from the date of denial or revocation for extenuating circumstances with approval by the Chief of Service, the Credentials Committee, the Medical Executive Committee, the Board Committee and the Governing Board.

B. An applicant whose application was automatically withdrawn or a member who had his/her membership automatically resigned may reapply at any time. An exception may be granted upon written request of the applicant to reinstate the application or of the member to reinstate membership within fifteen (15) days from the date of the automatic withdrawal or automatic resignation for extenuating circumstances with approval of the Chief of Service, the Credentials Committee, the Medical Executive Committee, the Board Committee and the Governing Board.

C. A member who voluntarily resigns may reapply at any time. An exception may be granted upon written request of the member to reinstate membership within fifteen (15) days from the date of the voluntary resignation for extenuating circumstances with approval of the Chief of Service, the Credentials Committee, the Medical Executive Committee, the Board Committee and the Governing Board.

ARTICLE VI: ALLIED HEALTH PROFESSIONAL MEMBERSHIP**Section 6.1 Qualification for Allied Health Professional Membership**

Applicants for allied health professional membership shall meet all the criteria and comply with all the requirements delineated in Section 3.2, 3.3 and 3.4 of these Bylaws.

Section 6.2 Nature and Scope of Practice

A. Allied health professionals who are trained, qualified and licensed in allied health professional disciplines may be permitted to perform specified patient care activities within the scope of their recognized professional qualification and skills in PHT Facilities. The patient care activities that can be performed by allied health professionals shall be defined by appropriate law, protocols, and/or job description.

B. Allied health professionals who are employed or sponsored by members of the Medical Staff shall limit their practice to patients of that particular medical staff member (hereinafter “supervising physician”). Allied health professionals shall be assigned to the appropriate clinical service of the Medical Staff by the Medical Executive Committee and shall be responsible to the Chief of Service through their supervising physician, as applicable. The PHT or supervising physician may solicit evaluations of the allied health professional at any time from the appropriate Chief of Service.

C. Allied health professionals shall be subject to the provisions of these Bylaws pertaining to hospital privileges, duties, and the ethical practice of their profession.

D. Allied health professionals shall not be considered members of the Medical Staff.

E. When requested by a patient's attending physician, the allied health professional may attend the patient in the hospital within the scope of his/her privileges as well as these Medical Staff Bylaws, Medical Staff Rules and Regulations, and the PHT policies and procedures.

F. Applications for privileges for allied health professionals will be reviewed and recommended for approval by the supervising physician, the appropriate Chief of Service, and the Chief Nursing Executive or designee.

Section 6.3 Procedure for Appointment and Reappointment to Allied Health Professional Membership

An allied health professional shall apply for appointment or reappointment through the procedures established in Article V of these Bylaws. In addition, in the application for privileges, the allied health professional shall agree:

A. To retain appropriate responsibility within his/her area of professional competence for the care and supervision of each patient in the PHT Facility for whom he/she is providing services;

B. That his/her services shall be limited to those specified on the application and subsequently approved;

C. That privileges will be granted consistent with roles, job description, clinical privileges, protocols, and as defined by the PHT in consultation with the appropriate Chief of Services;

D. To participate when requested in patient care evaluation studies and other quality review, evaluations, and monitoring activities;

E. To comply with any requests of the Medical Staff and/or administration for attendance at meetings;

F. To adhere strictly to the ethics of his/her respective profession and work in cooperation with others;

G. That the allied health professional has in the past and will in the future, strictly abide by the Code of Ethics of the practitioner's profession. The Code of Ethics as adopted or amended by the appropriate professional association shall govern the professional and ethical conduct of the members of the Allied Health Professional Staff;

H. To have his/her performance reviewed, and to participate in reappointment in the same manner as the Medical Staff; and

I. To certify that the applicant has not been excluded, debarred, terminated, cancelled or found ineligible to participate in a state or federal health care program, has not withdrawn from participation in a state or federal health care program while under investigation or is not currently under investigation by a state or federal health care program.

J. To submit to a criminal background screening.

K. To provide a National Provider Identification (NPI) number.

Section 6.4 Hearing and Appellate Review

A. If disciplinary action or Adverse Action is initiated against an allied health professional who is also a member of a collective bargaining unit, the disciplinary action or Adverse Action shall be pursued through the procedures established in the collective bargaining agreement. The allied health professional will be provided with all the procedural protections in the collective bargaining agreement.

B. If an allied health professional is a PHT employee but not a member of a PHT collective bargaining unit, the disciplinary action or Adverse Action shall be

pursued through the procedures established in the PHT Personnel Policies, Rules and Procedures. The allied health professional will be provided with all procedural protections in the PHT Personnel Policies, Rules and Procedures.

C. If an allied health professional is not a PHT employee, disciplinary action or Adverse Action shall be pursued through Article VIII of these Bylaws. The allied health professional may avail himself/herself of the hearing and appeal rights in Article IX of these Bylaws only for Adverse Actions as defined in Article 9.1(A) of these Bylaws.

Section 6.5 Protection from Liability

In matters relating to clinical privileges for allied health professionals, all medical staff members and other practitioners, and all PHT officers, trustees, employees, and agents, shall be acting pursuant to the same rights, privileges, immunities, and authority as are provided for in Article V, Section 5.2(D) of these Bylaws and as provided by law.

ARTICLE VII: CLINICAL PRIVILEGES

Section 7.1 Medical Staff Clinical Privileges

PHT medical staff members shall be entitled to exercise only those clinical privileges specifically granted by the Governing Board, except as otherwise provided in these Bylaws. The privileges shall be within the scope of the medical staff member or practitioner's licensure and certification or other legal limitations placed upon the medical staff member or practitioner's practice, and only for those services and current capabilities of the medical staff member or a practitioner's designated PHT Facility. Matters not specifically addressed in these Bylaws regarding privileges may be addressed through a medical staff policy or procedure on privileges. The medical staff member

shall participate in and complete electronic records training and other orientation activities prior to exercising privileges

Section 7.2 Application for Privileges

Applications for staff appointment or reappointment must: contain a request for the specific clinical privileges requested by the applicant; be supported by the documentation of the applicant's relevant recent training and/or experience; and be submitted in writing as prescribed by the PHT. Requests for privileges and for modification of privileges will be processed as provided for in these Bylaws, the Medical Staff Rules and Regulations and applicable policies and procedures.

An individual holding clinical privileges or applying for clinical privileges provided in more than one service or clinical specialty area must have the privileges reviewed by the Chief of Service from each service involved, as well as the Credentials Committee, Medical Executive Committee, the Board Committee, if applicable, and the Governing Board.

Section 7.3 Delineation of Privileges

Requests for clinical privileges shall be evaluated based upon the applicant's education, training, experience, references, current health status, demonstrated current clinical competence, ability and judgment, licensure, and recommendation by the Chief of Service in which privileges are requested. When delineated privileges are based primarily on experience, the individual's supporting documentation must reflect the specific experience that forms the basis for granting those privileges. The applicant shall have the burden of establishing his/her qualifications and current competence to exercise the clinical privileges requested.

Section 7.4 Dental and Oral Surgery Privileges

Requests for dental/oral surgery privileges shall be evaluated on the same basis as other privileges. The scope and extent of surgical procedures that each dentist/oral surgeon may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by dentists/oral surgeons shall be under the overall supervision of the Chief of Surgery. A dental/oral surgeon may admit to a PHT facility. All dental/oral surgery patients shall receive the same medical appraisal as patients admitted to other surgical services. A physician member of the Medical Staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization and shall be responsible for the history and physical examination pertinent to the patient's general health, which shall be on the patient's chart, prior to induction of anesthesia and start of surgery. The designated responsible physician shall be documented in the patient's record at the time of admission. The dentist/oral surgeon is responsible for that part of the history and physical examination related to dentistry/oral surgery.

Section 7.5 Podiatry Privileges

Requests for podiatry privileges shall be evaluated on the same basis as other privileges. The scope and extent of surgical procedures and treatments that each podiatrist may perform shall be specifically delineated and granted in the same manner as all other surgical procedures. Surgical procedures performed by podiatrists shall receive the same medical appraisal as patients admitted to other surgical services. A podiatrist may admit to a PHT facility. The evaluation, history and examination may be performed by the podiatrist if the podiatrist has been granted the clinical privileges to do so (based

upon a determination of the Medical Staff that s/he is currently competent to perform such services pursuant to section 7.3). A physician member of the Medical Staff shall be consulted and shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization and shall be responsible for the medical history and physical examination pertinent to the patient's general health, which shall be on the patient's chart, prior to induction of anesthesia and start of surgery. The designated responsible physician shall be documented in the patient's record at the time of admission.

Section 7.6 Psychology Privileges

Requests for psychology privileges shall be evaluated on the same basis as other privileges. The scope and extent of psychological treatment that each psychologist may perform shall be specifically delineated and granted in the same manner as any other treatment. Therapy and other clinical protocol procedures performed by psychologists shall be under the supervision of the Chief of Psychiatry. All psychology patients shall receive the same medical appraisal as other patients admitted to psychiatric services. A physician member of the Medical Staff shall be the admitting physician of record and shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization and shall be responsible for the medical history and physical examination pertinent to the patient's general health, which shall be on the patient's chart, prior to induction of anesthesia and start of surgery.

Section 7.7 Optometry Privileges

Requests for optometry privileges shall be evaluated on the same basis as other privileges. The scope and extent of optometry treatment that each optometrist may

perform shall be specifically delineated and granted in the same manner as any other treatment. Therapy and other clinical protocol procedures performed by optometrists shall be under the supervision of the Chief of Ophthalmology. All optometry patients shall receive the same medical appraisal as other patients admitted to other services. A physician member of the Medical Staff shall be the admitting physician of record and shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization and shall be responsible for the medical history and physical examination pertinent to the patient's general health, which shall be on the patient's chart, prior to induction of anesthesia and start of surgery. The designated responsible physician shall be documented in the patient's record at the time of admission.

Section 7.8 Temporary Privileges

A. Granting Temporary Privileges. Temporary clinical privileges are not a matter of right and will be granted by the Chief Medical Officer or designee to fulfill an urgent patient care need only if there is a completed and verified application awaiting review by the Credentials Committee. Temporary privileges shall be granted on a case by case basis.

B. Urgent Patient Care Need. The granting of temporary privileges for an urgent patient-care need shall be based upon: (1) the recommendation of the Chief Medical Officer, the appropriate Chief of Service, the President of the Medical Staff, or such other persons as deemed appropriate by the Chief Executive Officer; (2) the submission of a completed and verified application; (3) the verification of current

licensure; (4) the verification of current competence; (5) and a finding of an urgent care need.

C. Length of Temporary Services. Temporary privileges may be granted for a limited period of time not to exceed ninety (90) days.

D. Termination of Temporary Privileges. The Chief Executive Officer or in his/her absence, the Chief Medical Officer, may at any time upon the recommendation of the appropriate Chief or Associate Chief of Service or the President of the Medical Staff, terminate temporary privileges. The Chief Medical Officer or Chief or Associate Chief of Service shall assume responsibility for appointing a member of the Medical Staff to assume the care of such terminated applicant's patient(s) until they are discharged from the hospital or have chosen another medical staff member with appropriate clinical privileges in the hospital.

E. Restrictions and Limitations.

1. Physicians with temporary privileges are eligible to admit patients according to their admitting priority. Special requirements of supervision and admissions may be imposed on or voluntarily agreed to by the physician to whom temporary privileges are granted.

2. Physicians with temporary privileges are not members of the Medical Staff, and do not have any of the rights or privileges granted to medical staff members.

Section 7.9 One-Case Privilege

A. Granting One-Case Privilege. A one-case privilege will only be granted by the Chief Executive Officer: (1) in urgent care or life-threatening circumstances where

there is no medical staff member in good standing available to render the necessary treatment or consultation; or (2) a patient requests a consultation or care from an outside physician who is on staff and in good standing at a facility accredited by The Joint Commission. The one-case privilege shall not be granted more than three (3) times to the same applicant in a twelve-month period.

The applicant must present a copy of his/her current unrestricted Florida license, current unrestricted DEA license with Florida address, evidence of compliance with current Florida Statutes on financial responsibility, and proof of current competence in the privileges requested. The National Practitioner Databank will be queried in response to a request for one-case privileges.

B. Termination of One-Case Privileges. The Chief Executive Officer, or in his/her absence the Chief Medical Officer, may at any time upon the recommendation of the appropriate Chief or Associate Chief of Service or President of the Medical Staff, immediately terminate the applicant's one-case clinical privileges. The Chief Medical Officer or Chief or Associate Chief of Service shall assume responsibility for appointing a member of the Medical Staff to assume the care of such terminated applicant's patient until the patient is discharged from the hospital or has chosen another medical staff member with appropriate clinical privileges in the hospital.

C. Restrictions and Limitations. In connection with the granting of a one-case clinical privilege, special requirements of supervision and reporting may be imposed on or voluntarily agreed to by the applicant. Failure to comply with such conditions shall be cause for immediate termination of such applicant's one-case privilege by the Chief Executive Officer or, in his/her absence, the Chief Medical Officer.

Applicants who have been granted a one-case privilege are not members of the Medical Staff and do not have any of the rights or privileges granted to Medical staff.

Section 7.10 Emergency Privileges; Disaster Privileges

A. Emergency Privileges. For purposes of this section, an “emergency” is defined as a condition which could result in serious or permanent harm to a patient(s) and in which any delay in administering treatment would add to that harm. In the case of a medical emergency, any practitioner is authorized to do everything possible to save the patient’s life or to prevent serious harm, to the degree permitted by the practitioner’s license, regardless of department affiliation, staff category, or level of privileges. A practitioner exercising emergency privileges is obligated to summon all consultative assistance deemed necessary and to arrange appropriate follow-up.

B. Disaster Privileges. Disaster privileges shall be granted pursuant to the “Policy for Credentialing Licensed Independent Practitioners and/or Allied Health Professionals in the Event of Disaster,” As amended from time to time. Licensed Independent Practitioners and/or allied health professionals granted emergency/disaster privileges are not members of the Medical Staff and do not have any rights or privileges granted to Medical Staff.

Section 7.11 Locum Tenens

A. Granting Locum Tenens. Any member of the Active Medical Staff in good standing may have an appointment granted to a locum tenens when the member is temporarily absent from his/her practice because of vacation, illness, or military service. The privileges of the locum tenens shall depend on his/her training and experience as presented in a complete and verified application of appointment endorsed by the member,

evaluated by the appropriate Chief of Service, and approved pursuant to these Bylaws. The privileges of the locum tenens shall not exceed those of the member who is temporarily replaced. The opportunity afforded to members to have a locum tenens shall not extend longer than the temporary absence from their practice and, regardless of the circumstance, shall not extend longer than 120 days.

B. Termination. The Chief Executive Officer, or in his/her absence the Chief Medical Officer, may at any time upon the recommendation of the appropriate Chief or Associate Chief of Service or President of the Medical Staff, immediately terminate the clinical privileges of the locum tenens. The Chief Medical Officer or Chief or Associate Chief of Service shall assume responsibility for appointing a member of the Medical Staff to assume the care of such terminated applicant's patient until the patient is discharged from the hospital or has chosen another medical staff member with appropriate clinical privileges in the hospital.

C. Responsibilities. A locum tenens is eligible to admit and/or attend patients and may be required to take mandatory emergency room call where applicable. The locum tenens is eligible to take voluntary emergency room call if the physician he/she is covering for is eligible for voluntary emergency room call.

D. Limitations. A locum tenens is not a member of the Medical Staff and does not have any rights or privileges granted to medical staff members. A locum tenens shall have no right to vote on matters relating to the Medical Staff.

Section 7.12 Telemedicine Privileges

Licensed independent practitioners who are responsible for either the total or shared care, treatment, and services of patients via telemedicine link will be credentialed

and granted privileges in the same manner as other members of the Medical Staff or if applicable as established by policies approved by the Medical Executive Committee and the Governing Board.

Section 7.13 Allied Health Professionals Privileges

Allied health professionals shall be entitled to exercise only those clinical privileges specifically granted by the Governing Board, except as otherwise provided in these Bylaws. The privileges shall be within the scope of the allied health professional's licensure and certification or other legal limitations placed upon the allied health professional's practice, and only for those services and current capabilities of the allied health professional's designated PHT facility.

Section 7.14 Not Entitled to Hearing or Appeal

Applicants for temporary, one-case, emergency/disaster, or locum tenens privileges shall not be entitled to a hearing or appeal as described in these Bylaws.

Section 7.15 Protection from Liability

In matters relating to clinical privileges, all medical staff members and other practitioners, and all PHT officers, trustee, employees and agents, shall be acting pursuant to the same rights, privileges, immunities and authority as are provided for in Article V of these Bylaws and as provided by law.

Section 7.16 History and Physicals.

A. A medical history and physical examination shall be completed and documented for each patient pursuant to the regulatory requirements (42 CFR 482.22(c)(5)(i)) of the Centers for Medicare and Medicaid Services (CMS) and as amended. Unless and until CMS amends its regulation, a medical history and physical

examination shall be completed and documented for each patient no more than thirty (30) days before or twenty four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, or as amended by the Centers for Medicare and Medicaid Services (CMS). The medical history and physical examination must be completed and documented by a medical physician, osteopathic physician, podiatrist, oromaxillofacial surgeon, or other qualified licensed individual authorized to perform a history and physical under the Medical Staff Rules and Regulations or policies and procedures. If CMS amends its regulation with regard to history and physicals, then the PHT Medical Staff shall comply with the amended regulation.

B. An updated examination shall be completed and documented for each patient pursuant to the regulatory requirements (42 CFR 482.22(c)(5)(i)) of the Centers for Medicare and Medicaid Services and as amended. Unless and until CMS amends its regulation, an updated examination of the patient, including any changes in the patient's condition, shall be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within 30 days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a medical physician, osteopathic physician, podiatrist, an oromaxillofacial surgeon, or other qualified licensed individual authorized to perform a history and physical under the Medical Staff Rules and Regulations and/or policies and procedures. If CMS amends its regulation with regard to history and physicals, then the PHT Medical Staff shall comply with the amended regulation.

ARTICLE VIII: PROCEDURES FOR MATTERS CONCERNING MEMBERS

Section 8.1 Collegial Intervention

A. Progressive steps are encouraged to address questions relating to an individual's clinical practice and/or professional conduct, beginning with collegial and educational efforts. The goal of these efforts is to arrive at voluntary, responsive actions by the medical staff member to resolve questions that have been raised.

B. Collegial intervention is a part of ongoing and focused professional practice evaluation, performance improvement, and peer review, in accordance with applicable policies, as amended from time to time.

C. Collegial intervention efforts involve reviewing and following up on questions raised about the clinical practice and/or conduct of staff members and pursuing counseling, education, and related steps, such as the following:

1. Advising colleagues of all applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;
2. Proctoring, monitoring, consultation, and letters of guidance; and
3. Sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist individuals to conform their practices to appropriate norms.

D. The relevant Chief of Service shall determine whether it is appropriate to include documentation of collegial intervention efforts in a member's confidential file. If documentation of collegial efforts is included in a member's file, the individual shall have

an opportunity to review it and respond in writing. The response shall be maintained in that individual's file along with the original documentation.

E. Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Chief of Service and PHT administration.

F. The relevant Chief of Service, in conjunction with the Chief Medical Officer, shall determine whether to direct that a matter be handled in accordance with another policy (e.g., code of conduct policy; impaired practitioner policy; peer review policy, disruptive behavior policy). Medical staff leaders may also direct these matters to the Medical Executive Committee for further action.

Section 8.2 Disruptive Practitioners.

While within PHT facilities, all people will be treated with courtesy, respect and dignity. To that end, the Medical Staff requires that all medical staff members conduct themselves in a professional and cooperative manner while in PHT facilities and when acting as a representative of the Medical Staff, whether in the course of delivering health care services or otherwise.

If a medical staff member fails to conduct himself or herself appropriately, the matter shall be addressed in accordance with the appropriate JHS and medical staff policies and procedures. It is the intention of the Medical Staff and of the PHT that this policy be enforced in a firm, fair and equitable manner.

Disruptive behavior by medical staff members will be addressed by the relevant Chief of Service, the President of the Medical Staff, and/or the Executive Vice President and Chief Medical Officer, as described in JHS Policy 279, entitled Medical Staff Peer Review.

Section 8.3 Automatic Relinquishment; Automatic Resignation.

A. The following shall result in automatic relinquishment of clinical privileges and/or automatic resignation of medical staff membership:

1. Medical Records. Members are responsible for completion of their medical records. Failure to complete medical records as outlined in the Rules and Regulations of the Medical staff and PHT Policies and Procedures shall result in an automatic relinquishment of all clinical privileges if not completed within the timeframe established by policy. If the medical records are completed within the time specified, the member shall have his/her clinical privileges reinstated. If the medical records are not completed within the time specified, the member shall be deemed to have automatically resigned his/her membership except for good cause shown.

2. Licensure. If the State Board which regulates the practitioner revokes or suspends a member's license or the member fails to renew his/her license, the member's clinical privileges shall be automatically relinquished. If the member's license is reinstated in good standing within six (6) months of the automatic relinquishment, then the member shall have his/her privileges reinstated. If the member's license is not reinstated in good standing within six (6) months of the automatic relinquishment, the member shall be deemed to have automatically resigned membership.

3. Professional Liability (malpractice coverage). Any member who ceases to meet the financial responsibility requirements of state or federal law shall have his/her clinical privileges automatically relinquished. If the member meets the financial responsibility requirements within thirty (30) days of the automatic relinquishment, the member shall have his/her privileges reinstated. If the member does not meet the

financial responsibility requirements within thirty (30) days of the automatic relinquishment, the member will be deemed to have automatically resigned his/her membership.

4. Felony. A member who has been indicted or charged with a felony shall have his/her clinical privileges automatically relinquished until a final decision (including exhaustion of all appeals) is rendered. If the charges are dropped or there is an acquittal, the member shall have his/her privilege reinstated but may be subject to disciplinary action. If there is a conviction or the member pleads guilty or no contest to the felony charges, the member shall be deemed to have automatically resigned membership.

5. Misdemeanor. A member who has been indicted or charged with a misdemeanor involving (a) controlled substances; (b) illegal drugs; (c) Medicare, Medicaid or insurance or health care fraud or abuse; or (d) violence against another, shall have his/her clinical privileges automatically relinquished until a final decision (including exhaustion of all appeals) is rendered. If the charges are dropped or there is an acquittal, the member shall have his/her privileges reinstated but may be subject to disciplinary action. If the conviction is upheld or the member pleads guilty or no contest to the misdemeanor charges, the member shall be deemed to have automatically resigned membership.

6. Failure to Maintain Current Credentials File. Failure to maintain a current credentials file, including a current electronic mail (email) address, shall result in automatic relinquishment of clinical privileges. If the member provides the information necessary to update the credentials file within fifteen (15) days of receipt of notification

to do so, in writing, by certified mail or other delivery method, including electronic delivery, which provides for confirmation of receipt, the member shall have his/her privileges reinstated. If the member does not provide the information necessary to update the credentials file within fifteen (15) days of receipt of said written notification to do so, the member will be deemed to have automatically resigned his/her medical staff membership.

7. Failure to Provide Requested Information. Failure to provide information pertaining to an individual's qualifications for appointment/reappointment or clinical privileges, in response to a written request or request for an interview from the Credentials Subcommittee, Credentials Committee, the Medical Executive Committee, the Chief Medical Officer, the Chief Executive Officer or any other committee authorized to request such information or interview, shall result in automatic relinquishment of clinical privileges. If the member provides the information or interview requested within fifteen (15) days of receipt of the request to do so, the member's privileges shall be reinstated. If the member does not provide the information requested within fifteen (15) days of receipt of the request to do so, the member will be deemed to have automatically withdrawn the application for appointment or reappointment or clinical privileges.

8. Controlled Substance. Upon revocation, suspension or restriction of a member's DEA certificate, the member's right to prescribe medications covered by the certificate or number shall be modified immediately for the duration of such suspension, restriction, or revocation.

9. Participation in state or federal health care program. Upon revocation, suspension, restriction, termination, exclusion, debarment or withdrawal from

participation in a state or federal health program, the member's right to care for or treat patients who are in enrolled in or are eligible to be enrolled in the state or federal health care program shall be restricted, for the duration of the revocation, suspension, restriction, termination, exclusion, debarment or withdrawal.

B. An automatic relinquishment of clinical privileges or automatic resignation of medical staff membership is self-executing and shall be enforced by the President of the Medical Staff in cooperation with the Chief Medical Officer and Chief Executive Officer. The member shall be notified of the automatic relinquishment or automatic resignation by the Medical Staff Office.

C. If an individual engages in any patient contact at any of the PHT facilities after being notified of an automatic relinquishment of privileges, the relinquishment shall be permanent and the member will be deemed to have automatically resigned.

A member whose clinical privileges are automatically relinquished or membership is automatically resigned under this section is not entitled to a hearing or appellate review as provided in these Bylaws.

D. A member who has his/her medical staff membership and clinical privileges automatically relinquished must satisfy the requirements of resignation in Section 5.7. Requests for reinstatement shall be considered pursuant to Section 5.7 and/or 5.8.

Section 8.4 Precautionary Suspension

A. Precautionary Suspension. To protect any individual(s) in a PHT facility from imminent danger, it may be necessary to suspend or restrict a member's clinical privileges while more information is gathered and the matter is more fully

evaluated. When necessary to prevent an imminent threat to the life, health, or safety of any individual(s) or to prevent imminent disruption to the operations of any PHT facility, the President of the Medical Staff, any Chief of Service or in his/her absence any Associate Chief of Service, the Chief Medical Officer or Associate Chief Medical Officer, the Chief Executive Officer, or the Medical Executive Committee has the authority to: (1) afford a member of the Medical Staff an opportunity to voluntarily refrain from exercising all or any portion of privileges pending an investigation; or (2) suspend or restrict all or any portion of a member's clinical privileges pending an investigation. Such precautionary suspension shall be effective immediately.

B. Notification. If the precautionary suspension is implemented by an individual other than the Chief Medical Officer or the Medical Executive Committee, that individual shall notify the Chief Medical Officer or Associate Chief Medical Officer immediately. The Chief Medical Officer or Associate Chief Medical Officer shall notify the member of the precautionary suspension and underlying concerns as soon as practicable and report on such activity at the next Medical Executive Committee meeting.

C. Evaluation. Patient safety, the safety of other individuals and the security of any PHT facility is of paramount importance and all appropriate action to protect same shall be taken. When the life, health or safety of patients or others will not be adversely affected by a delay, additional information should be gathered before deciding whether or not to impose a precautionary suspension, including but not limited to the following interview the member and other witnesses; review any incident reports or medical records; consult with appropriate Chief of Service and other decisionmakers.

D. Least Restrictive Manner. A precautionary suspension should be utilized if no other action will eliminate the imminent danger such as the member voluntarily refraining from exercising privileges, taking a leave of absence or agreeing to a proctorship or other oversight activities. The precautionary suspension should be structured so that the member's privileges are limited in the least restrictive manner to reasonably protect the life, health or safety of an individual(s) or the security of the premises.

E. Medical Executive Committee Review. As soon as practicable, but no later than fourteen (14) days after imposition of the precautionary suspension the Medical Executive Committee shall convene to review the precautionary suspension. The member may attend the meeting and make a statement concerning the summary suspension on such terms and conditions as the Medical Executive Committee may establish. This meeting shall constitute only an interview and not a hearing within the meaning of these Bylaws. The member is not entitled to be represented by legal counsel at this interview but may be accompanied by a colleague or member of the Medical Staff. Following the presentation by the member, the Medical Executive Committee shall deliberate in closed session and make a recommendation for the continuation, modification, or termination of the precautionary suspension. The Medical Executive Committee shall take into consideration whether or not other less restrictive alternatives are available to protect the life, health and safety of individual(s) or protect the security of the PHT facility such as the member voluntarily refraining from exercising privileges, taking a leave of absence or agreeing to a proctorship, other oversight activities, or additional training or collegial

intervention. An accurate record of the hearing must be made through audio recordings, video recordings, or court reporter.

F. Periodic Review. If the Medical Executive Committee concludes that there is no less restrictive means for protecting the life, health and safety of individual(s) or protect the security of the PHT facility and, therefore, recommends that the precautionary suspension be continued or modified, the precautionary suspension shall be reviewed at every Medical Executive Committee pending the outcome of the disciplinary action investigation or the decision to not reappoint, including any hearings or appeals. If the Medical Executive Committee recommends termination of the precautionary suspension, the suspension shall be lifted pending the outcome of the disciplinary action investigation or decision to not reappoint, including any hearings or appeals.

G. Alternate Medical Coverage. Immediately upon the imposition of a precautionary suspension, the Chief Medical Officer or Associate Chief Medical Officer in consultation with the appropriate Chief of Service or in his/her absence, the Associate Chief of Service shall authorize alternative medical coverage for the patients of the suspended member. The wishes of the patient shall be considered when selecting alternative coverage.

Section 8.5 Investigation

A. Initiation of Disciplinary Action.

Disciplinary action against any member of the Medical Staff (hereinafter “member”) may be initiated by the Medical Executive Committee upon its own initiative or at the behest of the Chief Executive Officer, Chief Medical Officer, Associate Chief Medical Officer, Chief of Service or Chairperson of any standing committee of the

Medical Staff. However, the Medical Executive Committee should consider whether or not collegial intervention or additional collegial intervention may properly resolve the matter prior to initiating an investigation. If the Medical Executive Committee decides it is appropriate to commence an investigation, it shall state with specificity the grounds for initiating such investigation and shall so notify the PHT Chief Executive Officer. Precautionary suspension, monitoring or supervision may be initiated simultaneous with the initiation of disciplinary action or may be agreed to by the member. Precautionary suspension, monitoring and supervision are not appealable actions.

B. Grounds

The following are grounds for requesting disciplinary action:

1. Concern about a member's professional performance;
2. Concern that a member's activities, demeanor, or conduct are:
 - a. Inconsistent with the generally recognized professional standards or aims of the Medical Staff;
 - b. Disruptive of hospital or designated PHT facility operations;
 - c. Detrimental to patient care or safety; or
 - d. A negative reflection upon the reputation of the Medical Staff, JHS or the PHT.
3. Unethical practice;
4. Arrest for or conviction of a misdemeanor;
5. Recurring failure to maintain adequate medical records;

6. Reasonable belief of mental or physical impairment, including use of intoxicants or drugs, that is detrimental to patient safety or quality of patient care in the PHT facility;
7. Violation of these Bylaws, Medical Staff Rules and Regulations, or Policies and Procedures of the PHT;
8. Any of the grounds specified in § 395.0193 of Florida Statutes; and
9. Any other grounds reasonably believed to be inconsistent with medical staff membership or privileges granted to the medical staff member.

C. Appointment of Ad Hoc Investigating Committee. The Medical Executive Committee through its Chairperson shall delegate the responsibility of the investigation to an ad hoc investigating committee (“the Committee”). The Committee shall be comprised of members of the Medical Staff in good standing who: do not have a conflict of interest (economic competitors, business partners, known history of interpersonal disagreements, part of a referral pattern, etc); have not been involved in the underlying events; have not been involved in prior levels of review of the underlying events; and will not be involved in future levels of review. The Medical Executive Committee through its Chairperson shall appoint one of the Committee members to serve as Chairperson of the Committee. The members of the ad hoc committee shall be sent a letter of appointment by the Chief Medical Officer.

D. Notifying the Member. The Chief Medical Officer or designee shall notify the member of the initiation of the investigation, the basis for the investigation with specificity, the appointment of the Committee as well as his/her right to meet with the Committee as part of the investigation.

E. Investigation by the Ad Hoc Committee.

1. The member shall have the right to meet with the Committee as part of the investigation and shall be allowed to provide an oral or written response or explanation if so desired. This meeting shall be an informal part of the investigative process and not a formal hearing; the procedural rules provided for in these Bylaws shall not apply and the member shall not be entitled to representation by legal counsel but may be accompanied by a colleague or member of the Medical Staff. If a meeting does take place, a summary of the meeting, as well as the written statement of the member, if one is provided, shall be included in the Committee's findings and recommendations.

2. The Committee shall review all relevant documents and interview persons with first-hand knowledge of the events leading up to the request for disciplinary action. The Committee may utilize an external clinical reviewer if necessary to fully investigate the allegations.

3. The Committee shall meet as often as necessary to complete the investigation. The work of the Committee shall be supported by the quality department or other appropriate staff.

4. The member shall cooperate with the Committee's investigation, providing all information and documentation requested. Failure to cooperate with the Committee's investigation shall be considered an automatic relinquishment of membership and clinical privileges by the member.

5. The Committee shall submit its findings and recommendations to the Medical Executive Committee and the member within thirty (30) days of being

assigned the investigation, unless an extension is granted by the Chairperson of the Medical Executive Committee.

F. Presentation of Report and Appearance Before Medical Executive Committee. The Medical Executive Committee shall consider the report from the Committee as soon thereafter as is practicable. The member may, if desired, appear before the Medical Executive Committee. This appearance shall not constitute a hearing, shall be preliminary in nature, shall not follow the procedural rules provided in these Bylaws and shall not allow for appearance of legal counsel for the member. The member may be accompanied by a colleague or another member of the Medical Staff. A record of such appearance shall be made and included in the official minutes of the Medical Executive Committee.

G. Deliberation and Adverse Action. After receiving the Committee's report and recommendation and input from the member, if any was provided, the Medical Executive shall deliberate. If the Medical Executive Committee concludes that the findings of the Committee are insufficient to support disciplinary action, it may request that the Committee conduct further investigation. It may consider any of the following actions:

1. Determine that no action is justified;
2. Issue a letter of guidance, counsel, warning, admonition or reprimand;
3. Impose conditions for continued appointment;
4. Require mentoring, monitoring, proctoring, a second opinion or consultation;

5. Require additional education or training;
6. Require participation in a behavior program;
7. Recommend a reduction or modification in clinical privileges;
8. Recommend suspension of clinical privileges for a specified period of time;
9. Recommend revocation of clinical privileges;
10. Recommend demotion, suspension or revocation of medical staff membership.

H. Notice and Right to Hearing and Appeal. The member shall be provided notice of the Medical Executive Committee's decision and/or recommendation to the Governing Board of an Adverse Action as defined in Section 9.1(A) of these Bylaws. The member shall have the right to request a hearing and appeal on the recommended Adverse Action prior to final action by the Governing Board only if the recommended disciplinary action constitutes an Adverse Action as defined in Section 9.1(A) of these Bylaws. Additionally, the member shall have the right to a hearing and appeal if the Medical Executive Committee takes an action that does not constitute an Adverse Action, as defined in Section 9.1(A) of the Bylaws, and the Board Committee decides to implement an Adverse Action as defined in Section 9.1(A) of these Bylaws.

I. Review or Action by the Governing Board. If the decision of the Medical Executive Committee does not entitle the member to a hearing or appeal, the decision shall take effect immediately without action by the Governing Board and without any further process, hearing or appeal. A report of such a decision and the reasons therefore shall be made to the Board Committee, and the decision shall stand

unless explicitly modified or rejected by the Governing Board. Investigations under this Article of the Bylaws which result in a decision by the Medical Executive Committee that no disciplinary action is justified shall be reviewed by the Governing Board in accordance with this provision.

Any recommendation of Adverse Action, as defined in Section 9.1(A) of these Bylaws, by the Medical Executive Committee shall be forwarded, together with all supporting information, to the Governing Board for final action. Such a recommendation of Adverse Action may be accepted, modified or rejected by the Governing Board.

ARTICLE IX: HEARING AND APPELLATE REVIEW PROCEDURES

Section 9.1 Definitions and Preamble

A. Definitions. The following definitions shall apply to this Article only unless otherwise specified in these Bylaws:

1. “Adverse Action” shall have the meanings established in Section 5.3(G) for applicants and reapplicants for medical staff membership, and shall also mean any disciplinary action taken pursuant to Sections 8.5(G)(7), (8), (9) or (10).
2. Computation of Time. For the purposes of this Article, the day of receipt of notice or any other communication shall not be included in the computation of time. The last day of the time computed shall be included. If the time period is seven (7) days or less, the computation shall be business days; if the period is more than seven (7) days, the computation shall be calendar days, unless otherwise specified. If the last day is a Saturday, Sunday, or legal holiday, the period shall run to the next business day.

3. “Date of Receipt” shall mean the date on which notice or any other communication is received by the grievant as verified by the date of confirmation of delivery.

4. “Grievant” shall mean a member of the Medical Staff, a member of the Allied Health Professional Staff, or an applicant for medical staff membership and clinical privileges

5. Notice. All notices and requests provided for during the hearing and appellate review process shall be made in writing through the Chief Executive Officer or Chief Medical Officer, by any written means of communication, including electronic means that provides confirmation of receipt.

B. A grievant shall be entitled to only one hearing and one appellate review before receiving a final determination by the Governing Board.

C. The Medical Executive Committee and the Board Committee shall make best efforts to act on all recommendations and reports described in this article at the first regular meeting following receipt of such recommendations or reports. However, the Medical Executive Committee and Board Committee, acting through their Chair may postpone such review for good cause or may call a special meeting to consider the matter.

D. Legal Counsel.

1. The grievant has the right to legal counsel in connection with preparation for the hearing and may be represented by legal counsel at the hearing for purposes of advice. The grievant may be represented by an attorney or other person of the grievant’s choosing at his/her own expense.

2. The Medical Executive Committee, the Board Committee, the Governing Board and the Hearing Committee, as defined in Section 9.5, have the right to legal counsel in connection with preparation for the hearing/appeal and may be represented by legal counsel at the hearing for purposes of advice. At the discretion of the Chief Executive Officer, in consultation with Risk Management, outside counsel may be retained for this purpose.

3. The Hearing Committee in its sole discretion may permit the Medical Executive Committee/ Board Committee and the grievant to be fully represented by legal counsel at the hearing rather than for just advice.

4. The Medical Executive Committee/ Board Committee and the grievant may be fully represented by legal counsel for any appeal.

Section 9.2 Right to a Hearing

A. Medical staff members shall have the right to request a hearing pursuant to Sections 5.3(G) and 8.5(H).

B. Applicants for medical staff membership and clinical privileges shall have the right to request a hearing pursuant to Sections 5.3(G).

C. Applicants for allied health professional membership and clinical privileges shall have the right to request a hearing pursuant to Section 6.4.

Section 9.3 Notice of Adverse Action and Request for Hearing

A. Notice of Adverse Action. In all cases described in Section 9.2 of this Section, the grievant shall be promptly notified of the recommended Adverse Action, the right to a hearing pursuant to this Section, the time within which to request a hearing, and a summary of the grievant's rights during the hearing.

B. Request for Hearing. The grievant shall have thirty (30) days following the date of receipt of such notice to request a hearing. The request shall be in writing addressed to the Chief Executive Officer. If the grievant does not request a hearing within the time and in the manner described, the grievant shall be deemed to have waived his/her right to a hearing and appellate review and to have accepted the recommended Adverse Action.

C. Additional Grounds for Adverse Action. If any additional grounds for Adverse Action are discovered subsequent to the provision of the notice, the Chief Executive Officer shall send an amended notice of recommended Adverse Action which shall be heard in conjunction with the original grounds for Adverse Action.

Section 9.4 Notice of Hearing

Within fourteen (14) business days of receiving a grievant's timely request for a hearing, the Chief Executive Officer shall notify the grievant of the time, place, and date of the hearing as well as the witnesses expected to testify at the hearing. The hearing date shall not be less than thirty (30) days from the date of receipt of the notice to the grievant, except as is otherwise agreed to by the parties.

Section 9.5 Hearing Committee

A. Composition. The Chief Executive Officer in consultation with the President of the Medical Staff or the Chief Medical Officer shall appoint a Hearing Committee. The Hearing Committee shall be composed of at least three (3) members of the Active Medical Staff in good standing who are not on the Medical Executive Committee. The Chief Executive Officer may appoint alternates to the Hearing

Committee at his/her discretion. The Chief Executive Officer shall appoint one of the members as Chairperson.

B. Hearing Officer. The Chief Executive Officer may, at his/her discretion, appoint a Hearing Officer to preside at the hearing. The Hearing Officer shall not be a member of the Committee.

C. Conflict of Interest. No Hearing Committee member or the Hearing Officer: (1) shall be in direct economic competition with the grievant; (2) shall have personal knowledge of the events resulting in the Adverse Action; or (3) have participated in the investigation or issuance of the recommended Adverse Action. Members who are employed by or have a contract with the PHT are not precluded for that reason alone from serving on a hearing panel.

D. Consultation. The Public Health Trust may, but is not required to, consult with the grievant with regard to potential Hearing Committee members.

Section 9.6 Conduct of Hearing

A. Standard of Review. The Hearing Committee shall uphold the findings and recommendation of the Medical Executive Committee or Board Committee unless it is found that the recommendation is not supported by the evidence and is therefore arbitrary, capricious and an abuse of discretion.

B. Participation by Committee Members. There shall be at least three (3) members of the Hearing Committee present during the hearing and no member may vote by proxy. If any Hearing Committee member is not present for the full hearing, that Committee member may not participate in the deliberation or final recommendation.

C. Record of Proceeding. An accurate record of the hearing must be made through audio recordings, video recording, or court reporter. The PHT shall bear the expense of the recording, but the grievant shall bear the cost of the transcription or duplication if so desired for purposes of appeal or otherwise.

D. Presentation of Case. At the hearing, a designee of the Medical Executive Committee will present the case in support of the recommended Adverse Action, and the grievant will present the case against the recommended Adverse Action.

E. Failure to Appear. A grievant who fails to appear at the hearing without good cause shall be deemed to have waived his/her rights to the hearing and to have accepted the recommended Adverse Action. The recommended Adverse Action shall then be forwarded to the Board Committee or the Governing Board.

F. Responsibility of Hearing Officer or Chairperson. Either the Hearing Officer, if one is appointed, or the Chairperson of the Hearing Committee shall: preside over the hearing; determine the order of procedure; assure that all participants have a reasonable opportunity to present their case and be heard; maintain decorum; assure that the proceeding moves along efficiently and expeditiously; and grant requests for postponement upon good cause shown.

G. Evidence and Hearsay. The rules of evidence provided for in Florida law relating to the examination of witnesses or presentation of evidence shall not apply to a hearing conducted under this Article. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of admissibility of such evidence in a court of law. Hearsay is admissible and authentication of documents is not required. The Medical Executive Committee or Board

Committee shall be able to admit any documents or testimony that was the basis of its Adverse Action recommendation. The Chairperson of the Hearing Committee or Hearing Officer may order that oral evidence shall be taken only upon oath or affirmation.

H. Rights of Parties. Within reasonable limits, both parties shall have the following rights: to call, examine, and cross-examine witnesses; to confront witnesses; to introduce written evidence; and to rebut any evidence. Either party shall also be entitled to submit a written statement on any issue of fact or procedure before, during, or within three (3) days after the hearing and such statement shall become part of the record. The PHT or the grievant will be allowed three (3) days from receipt of such statement to submit a written response and such response shall become part of the record. If the grievant does not testify in his/her own behalf, he/she may be called and examined as if under cross-examination.

I. Discovery and Access to Documents. The Rules of Civil Procedure provided for in Florida law regarding discovery shall not apply to a hearing conducted under these Bylaws. The grievant shall be entitled to have access to all documents which were the basis of the Adverse Action; however, the grievant, his/her representative or any expert or witness must sign a confidentiality agreement in order to have access to these documents. If any of the documents contain protected health information, the grievant, his/her representative or any experts or witnesses must enter into a business associate agreement in order to have access to these documents. The grievant shall not be entitled to any documents or information that pertains to any practitioner other than himself or herself. If the grievant divulges any confidential information he/she automatically forfeits his/her right to a hearing. This forfeiture is not appealable. This does not

preclude the imposition of additional consequences resulting from the breach of confidentiality.

J. Pre-hearing Conference. The parties shall meet and conduct a pre-hearing conference. The purpose of the pre-hearing conference is: (1) to address any outstanding matters with regard to the composition of the Hearing Committee, the hearing officer, any exhibits or any witnesses; 2) to resolve any objections or motions; 3) to exchange exhibits and provide witness lists; and; 4) to agree to any stipulations of testimony or exhibits. If the parties cannot resolve these outstanding matters on their own, a hearing officer shall be appointed to do so.

K. Witnesses and Others.

1. The Hearing Committee does not have subpoena powers and cannot compel the testimony of any witness on behalf of the grievant.

2. Any PHT employee, member of the Medical Staff or other person affiliated with the Public Health Trust/Jackson Health System may appear as a witness on behalf of the grievant on a voluntary basis. The Public Health Trust shall provide any necessary reassurances that the potential witness will not suffer any adverse action or consequences as a result of providing such testimony.

3. The witnesses shall be sequestered, except for a representative of the Medical Executive Committee/ Board Committee who is serving as the PHT's representative and any expert witness serving as a consultant to the grievant or Medical Executive Committee/ Board Committee.

4. All other persons not essential to the conduct of the hearing, the prosecution of the case or defense of the case shall be excluded from the hearing.

L. Recess and Deliberation. The Hearing Committee may, without special notice, recess the hearing and reconvene it for the convenience of the participants or to obtain new or additional evidence. After presentation of all oral and written evidence, the hearing shall be closed. The Hearing Committee may then deliberate in closed session, applying the standard of review set out in Section 9.6(A).

M. Report and Recommendation. Within thirty (30) days after the hearing is closed, the Hearing Committee shall submit a written report of the findings and recommendation to the Board Committee and the grievant or his/her representative. The report may recommend upholding, modifying, or rejecting the recommended Adverse Action of the Medical Executive Committee. The Board Committee shall consider the Hearing Committee's report and recommendation as well as the Medical Executive Committees' report and recommendation when formulating its own recommendation to the Governing Board. The grievant shall have the right to appear before the Board Committee to present arguments as to why the recommendation of the Hearing Committee or Medical Executive Committee should not be adopted as per the procedures in Section 9.7.

N. If the hearing was conducted in response to an Adverse Action taken by the Board Committee, then the Hearing Committee shall submit its written report and recommendation to the Governing Board. The Governing Board shall consider the Board Committee's report and recommendation, the Hearing Committee's report and recommendation and the Medical Executive Committee's report and recommendation when making its final determination. The grievant shall have the right to appear before the Governing Board to present arguments as to why the recommendation of the Board

Committee, the Hearing Committee or the Medical Executive Committee should not be adopted as per the procedures established in Section 9.7.

Section 9.7 Appellate Review

A. Appellate Review. Within thirty (30) days of receipt of the Hearing Committee's recommendation, either the grievant or the PHT may request an appellate review by providing written notice to the Chief Executive Officer. The notice must state clearly and concisely the grounds for the appeal and the facts supporting it. The only grounds for appeal shall be: 1) failure to comply substantively with these Bylaws and therefore that the recommendation was arbitrary, capricious or an abuse of discretion; 2) the Hearing Committee's recommendation was not supported by the preponderance of the evidence and was therefore arbitrary, capricious or an abuse of discretion; or 3) newly discovered evidence has become available that would materially affect the outcome. If oral argument is desired, the request for appeal must specifically so state; otherwise, the appellate review shall be conducted only on the written record.

B. Waiver. If there is no request for appellate review in the time and manner provided, the right to appellate review shall be deemed to have been waived, and the recommendation of the Hearing Committee accepted.

C. Access to Record. The grievant shall have access to the record of the Hearing Committee but shall be charged a reasonable fee for copying the record. Unless otherwise provided by law, this shall not include minutes or proceedings of peer review committees.

D. Written Statement. The PHT and the grievant shall be permitted to submit a written statement, with a copy to the other party, to the Board Committee in

support of their positions, specifying the facts and procedures in dispute. These statements shall be submitted to the Board Committee no later than five (5) days prior to the appeal being heard.

E. Additional Evidence and Oral Argument. At the time of the appellate review, new or additional evidence may be accepted by the Board Committee in its sole discretion and only if it can be shown that such information could not reasonably have been made available to the Hearing Committee. Both parties shall have the right to cross-examination concerning such additional or new information at the time of the appellate review. If oral argument has been permitted, both parties shall be present at the appellate review to make oral arguments and answer questions of the Board Committee.

F. Review. The Board Committee shall review the record, and consider the written statements to determine whether: 1) there was a failure to comply substantively with the Medical Staff Bylaws and therefore the recommendation was arbitrary, capricious or an abuse of discretion; 2) newly discovered evidence materially affects the recommendation; or 3) the recommendation or decision was not supported by a preponderance of the evidence and was arbitrary, capricious or an abuse of discretion. Within thirty (30) days or at its next regularly scheduled meeting, the Board Committee shall uphold, modify, or reverse the recommendation of the Hearing Committee. The Board Committee shall provide a copy of its written recommendation to the Chief Executive Officer and the grievant. The Chief Executive Officer shall provide a copy of the recommendation to the Hearing Committee and Medical Executive staff.

G. The appellate review shall be conducted by the Board Committee at its next regularly scheduled meeting or by special meeting. The appellate review may be

postponed by the Chair of the Board Committee if so requested for good cause shown by either party. The Board Committee shall be provided with a copy of the record that shall include the transcript and any written or documentary evidence presented to the Hearing Committee.

H. If the appeal is a result of a recommendation from the Board Committee for Adverse Action, the appellate review shall be conducted by the Governing Board in the same manner described above.

I. The appellate review shall not be deemed to be final until all of the procedural steps provided in this Section have been completed or waived.

ARTICLE X: MEDICAL STAFF: OFFICERS AND MEETINGS

Section 10.1 Officers of the Medical Staff

A. Officers. The officers of the Medical staff shall be:

1. President
2. Vice President
3. Immediate Past President

B. Qualifications of Officers.

Candidates for office must be members of the Medical Executive Committee at the time of nomination and election.

C. Nominations of Candidates.

The Nominating Committee shall nominate from the membership of the Medical Executive Committee, no more than two (2) candidates for each office. The Nominating Committee shall complete and make available a report on the candidates no later than seven (7) days before the annual meeting. The report shall be submitted to the Medical

Executive Committee which shall accept such report and forward it to the full membership at the annual meeting for consideration. Additional nominations will be accepted from the floor of the annual medical staff meeting, provided the individual making the nomination submits evidence of the nominee's willingness to serve.

D. Election of Officers.

Officers may be elected at the annual meeting of the Medical Staff or through a voting process established by the Medical Executive Committee without necessity of a meeting. Only members of the Active Medical Staff shall be eligible to vote. The candidate receiving the majority of the votes cast shall be declared elected to the position in question.

E. Term of Office.

All officers shall serve a two-year term commencing with the beginning of the medical staff year. If an officer takes office after the start of the medical staff year, that officer shall serve until the next duly scheduled election for that office. No officer shall serve more than three (3) consecutive, two (2) year terms in one office. However, a former officer who has not served for at least one year is eligible for re-election to a former office.

F. Vacancies in Office.

Except for the office of President, vacancies shall be filled by the Medical Executive Committee from members of the Active Medical Staff. If there is a vacancy in the office of the President, the Vice-President shall serve out the remaining term.

G. Duties.

1. President.

The President shall serve as the Chief Administrative Officer of the Medical Staff and shall:

a. Act in coordination and cooperation with the Chief Executive Officer in all matters of mutual concern between the PHT and the Medical Staff.

b. Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff.

c. Serve as a non-voting, ex-officio member of all medical staff committees.

d. Be responsible for: the conduct of the Medical Staff; enforcement of the Medical Staff Bylaws, Rules and Regulations and policies and procedures; implementation of sanctions where indicated; and medical staff compliance with the procedural safeguards in all instances where disciplinary action has been initiated against a member.

e. Appoint medical staff members to all standing, and special medical staff committees, other than the Medical Executive Committee as well as all multidisciplinary committees. Where appropriate, the President shall designate a chair or co-chairs for each committee.

f. Represent the views, policies, needs and grievances of the Medical Staff to the PHT and to the Chief Executive Officer.

g. Receive and interpret the policies of the PHT pertaining to the Medical Staff's responsibility to provide medical care.

h. Speak for the Medical Staff in its external professional and public relations.

i. Serve on the Governing Body's committee with jurisdiction over medical staff matters, as allowed by the Governing Board's Bylaws.

j. Serve as non-voting ex-officio member of the Governing Board, as allowed by the Governing Board Bylaws.

2. Vice President. In the absence of the President, the Vice President shall assume all the duties and authority of the President. The Vice President shall be a voting member of the Medical Executive Committee and serve as Chair or Co-Chair of the Credentials Committee. The Vice President shall automatically succeed the President when the latter is unable or fails to serve for any reason.

3. Immediate Past President. The immediate past president shall chair the Bylaws Committee.

H. Removal from Office or Resignation

1. Removal. Any member of the Medical Executive Committee may request that an officer be removed for cause. Grounds for removal include, but are not limited to: dereliction of duty; conviction of a felony or misdemeanor; or inappropriate professional or personal behavior which interferes with carrying out of official duties. Requests for removal shall be in writing, addressed to the Medical Executive Committee, and specify the grounds for removal. The Medical Executive Committee shall furnish the affected officer with a copy of the request for removal. The request shall be acted upon

at the next regularly scheduled meeting of the Medical Executive Committee or at a special meeting called for that purpose. The affected officer shall have the right to: be present; to present facts, evidence, or other considerations to refute the charges; and to be accompanied by a colleague or a member of the Medical Staff. The Medical Executive Committee shall consider all facts and matters presented and shall act to retain or remove the officer. Removal shall require two thirds (2/3) vote of the Medical Executive Committee members present.

2. Resignation. An officer may resign by providing written notice to the Medical Executive Committee.

3. Replacement. The Vice President shall automatically succeed the President if the President is removed or resigns. The Medical Executive Committee shall choose a member of the Medical Executive Committee to serve as Vice President if the Vice President is removed, resigns or becomes President.

Section 10.2 Meetings of Medical Staff

A. Annual Medical Staff Meeting

The annual medical staff meeting shall be held in the last month of the medical staff year. The agenda shall include a review and evaluation of the work completed in the clinical services; a review and evaluation of the performance of the required medical staff functions; an overview of each medical staff or multidisciplinary committee; the election of officers of the Medical Staff and at-large members of the Medical Executive Committee or the announcement of the officers and at-large members elected through a process approved by the Medical Executive Committee; and if applicable, Bylaws revisions. The agenda at any regular medical staff meeting shall be:

1. Administrative. Call to order; acceptance of minutes of the last regular and of all special meetings; unfinished business; communications; report from the President of the Medical Staff; report from the Chief Executive Officer; reports of services; reports of committees; new business; elections or announcement of election results; and revisions to Medical Staff Bylaws.

2. Professional. Review and analysis of the clinical work of the PHT; Reports of medical and multidisciplinary committees; and discussion and recommendations for improvement of the professional work of the PHT;

3. Adjournment.

B. Regular Meetings and Special Meetings of the Medical Staff

1. Request. The President of the Medical Staff, the Medical Executive Committee, or no fewer than ten percent (10%) of the members of the Active Medical Staff may at any time file a written request with the President requesting that, a special meeting of the Medical Staff be called. The special meeting shall occur within thirty (30) days of filing the request.

2. Scheduling. The President of the Medical Staff shall designate the time and place of any special meeting.

3. Notice. Written notice stating the place, day, and hour of any special meeting of the Medical Staff shall be delivered (by U.S. mail, hand delivery, delivery service, facsimile, electronic mail or other electronic communication) to each member of the active staff not less than seven (7) days before the date of the meeting. Notice shall be sent to the address, facsimile number, email address or other contact information that the medical staff member provided to Medical Staff Office. If mailed,

the notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail addressed to each medical staff member. Notice may also be sent to members of other medical staff categories who have so requested. The attendance of a member of the Medical Staff at a meeting shall constitute a waiver of notice of the meeting.

4. No business shall be transacted at any special meeting except that stated in the notice calling the meeting. The agenda shall be: reading of the notice calling the meeting; transaction of the business for which it was called; and adjournment

C. Quorum

The presence of ten percent (10% percent) of the total membership of the Active Medical Staff at any meeting shall constitute a quorum.

ARTICLE XI: CLINICAL SERVICES

Section 11.1 Clinical Services

A. Organization of Clinical Services

1. Clinical Services Defined. Each clinical and consultative service (hereinafter “clinical service”) shall be organized as a separate part of the Medical Staff. The major clinical services of the Medical Staff are Ambulatory Services, Anesthesiology, Dermatology, Emergency Services, Family Practice, Medicine, Neurology, Neurological Surgery, Obstetrics/Gynecology, Ophthalmology, Orthopaedics, Otolaryngology, Pathology, Pediatrics, Psychiatry, Radiology, Radiation Oncology, Surgery, Rehabilitation Medicine, and Urology. The Medical Executive Committee may recommend that the Governing Board designate a new clinical service or dissolve an existing clinical service if it is determined that it will best meet the objectives of

promoting performance improvement, patient safety and effective credentialing and privileges.

2. Jackson Health System Chief of Service. Each clinical service shall have a Jackson Health System Chief of Service who shall report and be accountable to the Chief Executive Officer and the Chief Medical Officer.

3. Hospital-Based Associate Chief of Service. Each hospital within the Jackson Health System may have a Hospital-Based Associate Chief of Service for each clinical service within that hospital. Each Hospital-Based Associate Chief of Service shall report and be accountable to the appropriate Jackson Health System Chief of Service.

4. Individual Medical Staff Member. Each member of the Medical Staff and other individuals with clinical privileges shall be assigned to a service by the Governing Board based on the recommendation of the Board Committee and/or the Medical Executive Committee. Each individual member of the Medical Staff shall function under an attending physician job description as detailed in medical staff policy.

B. Functions of Clinical Services

Each clinical service shall perform the following activities:

1. Continuing Education;
2. Discussion of Patient Care;
3. Grand Rounds;
4. Discussion and recommendation of policies and procedures to appropriate committees; implementation of policies already adopted;
5. Discussion and recommendation of equipment needs;

6. Development of clinical practice guidelines related to patient care and service;

7. Development of its own criteria for granting, denying or withholding clinical privileges consistent with the policies of the Medical Staff and of the PHT and as procedure for applying these criteria to individuals requesting privileges;

8. Surgical Review. In addition to the functions described above, each surgical service of the Medical Staff shall conduct a review for justification of surgery performed whether or not tissue was removed, and for the acceptability of the procedure chosen. Specific consideration shall be given to the findings of the Tissue Committee concerning agreement or disagreement of the preoperative, postoperative and pathological diagnoses.

C. Liability

In all matters relating to peer review, credentialing, clinical privileges, quality improvement and review and patient safety, medical staff members and other practitioners, and all PHT officers, trustees, employees, and agents shall be acting pursuant to the same rights, privileges, immunities, and authority as are provided for in Article V, Section 5.2 (D) of these Bylaws and as provided by state and federal law.

Section 11.2 Jackson Health System Chief of Service

A. Qualifications

The Chief of Service shall be the Chief of Service for that particular clinical service for the entire Jackson Health System. Each Chief of Service shall be a member of the Active Medical Staff in good standing with relevant clinical privileges. Each Chief of Service shall be certified by the appropriate specialty board or the Credentials

Committee and the Medical Executive Committee shall affirmatively establish that he/she possesses comparable competence.

B. Appointment

The President of the Medical Staff, the Chief Medical Officer and the medical school dean(s) whose faculty provide program direction and supervision and training of residents on the service for which the Chief of Service is to be appointed, shall recommend the Chiefs of Service to the Chief Executive Officer. The Chief Executive Officer shall consider all recommendations and appoint the Chief of Service. Each Chief of Service shall serve in that capacity only for the Jackson Health System and shall not serve in a similar capacity in any other institution's health care facility or health system except as specified by agreement of the PHT. Nothing in these Bylaws shall prohibit a Chief of Service from also serving as a Hospital-Based Associate Chief(s) of Service within the Jackson Health System.

C. Removal

The Chief Executive Officer may remove a medical staff member from a Chief of Service position after consultation with the Chief Medical Officer, the President of the Medical Staff and the medical school dean(s) whose faculty provide program direction and supervision and training of residents on the service for which the Chief of Service is to be removed. Removal does not affect the individual's membership on the Medical Staff or clinical privileges.

D. Duties and Responsibilities

1. The position of Chief of Service shall have medical and administrative responsibilities. The Chief of Service shall be responsible for: maintaining

a single standard of patient care within his/her clinical service throughout the Jackson Health System; and for overseeing all clinical, professional and administrative activities within his/her specific clinical service throughout the Jackson Health System.

2. In addition to the responsibilities outlined in the Medical Staff Chief of Service job description policy, the specific responsibilities of each Chief of Service are as follows. Any conflict between the Medical Staff Chief of Service job description policy and the responsibilities detailed below shall be resolved in favor the responsibilities detailed below.

a. Overall Administrative Responsibilities. The Chief of Service shall:

i. Make regular visits to all patient care centers, including hospitals, assigned to the clinical service;

ii. Serve on appointed committees and participate in their designated purposes;

iii. Implement actions taken by the Medical Executive Committee, Governing Board or its committee of jurisdiction as it relates to the service or Jackson Health System including policies and procedures;

iv. Participate in the development and implementation of the Medical Staff Bylaws, Medical Staff Rules and Regulations and the PHT policies and procedures that guide and support the provision of care, treatment and services;

v. Enforce Pubic Health Trust and Medical Staff Bylaws, Rules and Regulations; policies and procedures and service policies and procedures;

vi. Meet regularly with the appropriate PHT administrator and nursing director for planning, priority setting, and problem solving;

vii. Participate with PHT administrators in: (A) preparation and submission of the annual budget, (B) assistance in the monitoring and control of the budget to ensure operations within budgetary limitations; (C) Implementation of space planning programs, capital equipment programs and public communications programs and integration of these programs within the service, in cooperation with other services, and into the strategic plan of the health system; and (D) identification of resources for the PHT, such as grants, endowments, third party payments, and others;

viii. Cooperate in planning, implementing and administering cost containment programs and revenue control procedures and programs;

ix. Participate in the planning, development, and implementation of the PHT risk management, loss prevention, and compliance programs;

x. Assess and recommend to the PHT administration any off-site sources for needed patient care, treatment and services not provided by the service or the Jackson Health System.

xi. Perform any other administratively related activities for the service, unless such activities are performed by the PHT;

xii. Assure the proper integration of the service into the primary functions of the Jackson Health Systems; and

xiii. Coordinate and integrate intradepartmental and interdepartmental services.

- b. Professional Performance. The Chief of Service shall:
- i. Provide continuing surveillance of the professional performance of all individuals in the service who have delineated clinical privileges;
 - ii. Make recommendations for appointment and reappointment to medical staff membership of a sufficient number of qualified and competent persons to provide care, treatment and services based on the prior evaluation and recommendation by the appropriate Associate Chief of Service;
 - iii. Make recommendations for clinical privileges for each member of the service based on the proper evaluation and recommendation of the appropriate Associate Chief of Service;
 - iv. Determine the qualification and competence of allied health professionals who provide patient care, treatment, and services within the service and make recommendations for allied health professional membership based on prior evaluation and recommendation by the appropriate Associate Chief of Service;
 - v. Provide for the orientation of and continuing professional education of members of the Medical Staff and Allied Health Professional Staff within his/her service, including but not limited to Jackson Health System initiatives;
 - vi. Report regularly to the Medical Review Committee on the professional performance of medical staff members, practitioners with privileges in the service and allied health professional members;
 - vii. Recommend to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the service; and

vii. Maintain compliance within his/her service for timely completion of medical records.

c. Clinical Activities and Quality Improvement Activities.

The Chief of Service shall:

i. Supervise clinically related activities;

ii. Ensure provision of consultative services;

iii. Review the utilization of ancillary and diagnostic support services;

iv. Review length of stay data and evaluate means by which improved bed utilization can be accomplished;

v. Provide for the continuous assessment and improvement of quality of care, treatment and services;

vi. Maintain quality control programs and patient safety programs;

vii. Assure that the quality and appropriateness of patient care provided within the service are monitored and evaluated; and

viii. Ensure cooperation and compliance within his/her service with physician accountability provisions.

d. Residency Training Program. The Chief of Service shall enable and support the Public Health Trust's graduate medical education residency training program for his/her clinical service. Specifically, the Chief of Service shall:

- i. Empower the Graduate Medical Education Program Director to recruit and recommend appointment of resident physicians to the Chief of Service and Chief Executive Officer;
- ii. Work with the Program Director to ensure resident physicians are aware of and are in compliance with overall PHT policies, procedures and objectives;
- iii. Work with the Program Director to ensure that resident physicians are appropriately supervised and evaluated;
- iv. Work with the Program Director to ensure that the appropriate attending physician is participating in and supervising in the care provided by resident physicians; and
- v. To advocate for provision of sufficient resources that support a fully accredited, high quality graduate medical education program.

3. Delegation of Responsibility to Hospital-Based Associate Chief of Service. The Chief of Service may delegate the responsibilities described in Section 11.2(D)(2) to the appropriate Hospital-Based Associate Chief of Service for each hospital within the Jackson Health System, but shall retain overall responsibility for these duties for the Jackson Health System. Such delegations of responsibilities may be rescinded by the Chief of Service at any time.

Section 11.3 Hospital-Based Associate Chief of Service

A. Qualifications

The Hospital-Based Associate Chief of Service shall be the Hospital-Based Associate Chief of Service at the hospital where s/he has clinical privileges. She shall

be an active member of the Medical Staff in good standing. Each Hospital-Based Associate Chief of Service shall be certified by the appropriate specialty board or the Credentials Committee shall affirmatively establish that he/she possesses comparable competence.

B. Appointment

The Chief of Service, in consultation with the Chief Medical Officer and Chief Administrative Officer, shall provide the Chief Executive Officer with at least two recommendations for appointment, from which the Hospital-Based Associate Chief of Service shall be selected. Each Hospital-Based Associate Chief of Service shall serve in that capacity only at the designated Jackson Health System hospital(s) and shall not serve in a similar capacity in any other institutional health care facility except as specified by agreement of the PHT. Nothing within these Bylaws shall prohibit a Hospital-Based Associate Chief of Service from serving as the Chief of Service for the Jackson Health System or serving as the Associate Chief of Service at more than one Jackson Health System hospital.

C. Removal

The Chief Executive Officer may remove a medical staff member from an Associate Chief of Service position after consultation with the appropriate Chief of Service and the Chief Medical Officer. Removal does not affect the individual's membership on the Medical Staff or clinical privileges.

D. Duties and Responsibilities

1. Each hospital within the Jackson Health System may have a Hospital-Based Associate Chief of Service for each clinical service within that hospital.

2. The Hospital-Based Associate Chief of Service shall be responsible for maintaining a single standard of patient care within his/her clinical service throughout the hospital where s/he is appointed and for all professional and administrative activities within the service at the hospital where s/he is appointed.

3. Each Hospital-Based Associate Chief of Service shall report and be accountable to the appropriate Jackson Health System Chief of Service.

4. Each Hospital-Based Associate Chief of Service shall report regularly to the Chief of Service on the professional performance of medical staff members, practitioners with privileges in the service and allied health professional members.

5. Each Hospital-Based Associate Chief of Service's specific responsibilities shall be defined by the Chief of Service and the Chief of Service may delegate the responsibilities described in Section 11.2(D)(2) to the Hospital-Based Associate Chief of Service for each hospital within the Jackson Health System

ARTICLE XII: COMMITTEES

Section 12.1 Committees in General.

A. Chair and Vice-Chair. Each committee shall have a chair/co-chair and/or a vice-chair either appointed by the President of the Medical Staff or as otherwise established in policies and procedures. The term for the chair and vice-chair shall be two years, which shall begin at the start of the medical staff year. If the chair or vice-chair begins his/her tenure after the start of the medical staff year, he/she shall serve until the end of the medical staff year of the second year. The chair/co-chair serves at the pleasure

of the President of the Medical Staff or as otherwise established in policies and procedures.

B. Appointment. Except as otherwise provided in these bylaws, members shall be appointed to committees by the President of the Medical Staff. On all even-numbered years, at least sixty (60) days prior to the annual meeting, the chair of each committee shall provide to the President of the Medical Staff a proposed slate of members for appointment or reappointment to that committee. The President of the Medical Staff, in consultation with the Chief Medical Officer and committee chair shall determine the final composition of each committee and shall publish same in the agenda packet for the annual meeting.

C. Length of Committee Appointment. A member shall serve on a committee for no more than six (6) years, unless so required by the member's title or position or if so approved by the President of the Medical Staff. However, a member who has not served on a particular committee for at least one year is eligible for reappointment to that particular committee. A member shall not serve on more than three (3) committees simultaneously unless so required by the member's title or position or if so approved by the President of the Medical Staff.

D. Regular Attendance. Attendance records will be reviewed when determining subsequent membership on committees.

E. Ex-Officio Members. Persons serving under these Bylaws as ex-officio members of a committee shall have all rights and privileges of regular members, except they shall not be counted in determining the existence of a quorum and shall not vote.

F. Eligibility/Vote. A member's eligibility to serve on a committee and the member's right to vote on matters before a committee is determined by the member's medical staff membership category.

G. Meetings.

1. Regular Meetings. Committees shall meet at regularly scheduled times and places or after notice in order to conduct their business.

2. Special Meetings.

a. A special meeting of any committee may be called by or at the request of the Chair, the President of the Medical Staff, or by one-third (1/3) of the committee's members, but not less than two (2) members.

b. Notice of Meetings. Written or oral notice (by U.S. mail, hand delivery, delivery service, facsimile, electronic mail or other electronic communications) stating the place, day, and hour of any special meeting shall be given to each member of the committee not less than five (5) days before the meeting, by the person or persons calling the meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited in the United States mail, postage paid, and addressed to the member.

H. Manner of Action.

1. Quorum. The presence of twenty-five (25%) of the Active Medical Staff of a committee or clinical service or service sub-unit, but no less than two (2) members, shall constitute a quorum at any meeting.

2. Formal Action. The action of a majority of the members present at a meeting at which there is a quorum shall be the action of a committee.

3 Informal Action No action of a committee shall be valid unless taken at a meeting at which a quorum is present except that any action may be taken without a meeting if approved by a majority of the members entitled to vote in writing or by electronic mail response.

I. Minutes. Minutes shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be signed by the presiding officer and copies shall be promptly submitted to the attendees for approval and after such approval is obtained, forwarded to the Medical Executive Committee. Each committee shall maintain a permanent file of the minutes of each meeting.

J. Required Attendance for Patient Review. A member whose patient's clinical course is scheduled for discussion at a regular service meeting, clinico-pathological conference, case review meeting, informal root cause analysis meeting or peer review meeting shall be notified and shall be expected to attend that meeting. If the member is not otherwise required to attend the meeting, the President of the Medical Staff, through the Chief Executive Officer or designee, shall give the medical staff member or practitioner advance written notice of the time and place of the meeting at which attendance is expected. Whenever apparent or suspected deviation from standard clinical practice is involved, the notice to the medical staff member or practitioner shall so state, shall be given by a means of written communication that requires confirmation of receipt and shall include a statement that attendance at the meeting at which the alleged deviation is to be discussed is mandatory.

K. All committees created by these Bylaws shall report to the Medical Executive Committee.

L. Sub-Committees. The Medical Executive Committee or any other committee may create a subcommittee to accomplish the purposes of these Bylaws. Each committee shall determine the need for a separate subcommittee for any PHT facility. The Medical Executive Committee may create rules and regulations consistent with these Bylaws governing such subcommittees.

Section 12.2 Medical Executive Committee

A. Composition

1. The Medical Executive Committee shall consist of the officers of the Medical Staff; the Chiefs of Service; the Chair of each Medical Executive Subcommittee; one representative from each Medical Executive Subcommittee; and one elected member at large from each Public Health Trust hospital (Mental Health, Holtz, Jackson Memorial, Jackson North and Jackson South). The following shall be ex-officio non-voting members: Dean of the Miller School of Medicine, University of Miami, or his designee; Dean of the Herbert Weirtheim College of Medicine of Florida International University, or his designee; Chief Executive Officer of the Public Health Trust, or his designee; and Chief Medical Officer of the Public Health Trust.

2. Chair. The President of the Medical Staff shall serve as Chair of the Medical Executive Committee. If the Chair of the Medical Executive Committee is unable to attend a meeting, the Vice-President of the Medical Staff shall chair the meeting. If the Vice-President is also unavailable, one of the Chiefs of Service shall chair the meeting.

3. Designee for Chiefs of Service. If a Chief of Service who is not an officer of the Medical Staff is unable to attend a Medical Executive Committee meeting, the Chief may send an Associate Chief of Service as his/her designee. Such designee shall count toward a quorum and shall be able to vote. The other members of the Medical Executive Committee shall not be so accommodated and are expected to attend.

4. Attendance. Matters of attendance for members who serve by virtue of their position (i.e., Chiefs of Service, Chair of Medical Executive Subcommittee) shall be addressed through counseling. If their attendance does not improve, the member shall be requested to send a designee. Representatives chosen from the Medical Executive Subcommittees who attend fifty percent (50%) or fewer of the Medical Executive Committee meetings during his/her first year of membership shall automatically be removed from the Committee. The appropriate Medical Executive Subcommittee shall be asked to fill the vacancy.

B. Elected Members at Large

1. Nominations. The Nominating Committee shall nominate no more than two (2) candidates for each vacancy of the members at large. The nominating committee shall complete and make available a report on the candidates no later than seven (7) days before the annual meeting. The report shall be submitted to the Medical Executive Committee which shall accept such report and forward it to the full membership at the annual meeting for consideration. Additional nominations will be accepted from the floor, provided the individuals making the nominations submit evidence of the nominees' willingness to serve. Those candidates receiving the greatest number of votes shall be elected to fill the available vacancies on the Medical Executive Committee. Any medical

or osteopathic physician, dentist, oral surgeon, podiatrist, psychologist or optometrist who has clinical privileges and is a member of the Active Medical Staff is eligible to be nominated. However, a majority of the Medical Executive Committee membership must consist of medical and osteopathic physicians.

2. Term. The members at large shall be elected for two (2) year terms commencing with the beginning of the medical staff year. No member at large shall serve more than two (2) consecutive and complete two (2) year terms. However, a former member at large who has not served for at least one (1) year is eligible for reelection. The terms of the members at large shall be staggered such that half of the member at large positions shall be elected each medical staff year.

3. Removal or Resignations.

a. A member at large who attends fifty percent (50%) or fewer of the Medical Executive Committee meetings during his/her first year of membership shall automatically be removed from the Committee. The Medical Executive Committee shall fill the vacancy or request that the nominating committee nominate candidates to fill the vacancy at the next annual meeting of the Medical Staff.

b. A member at large may resign by providing written notice to the President of the Medical Staff who shall notify the Medical Executive Committee. The Medical Executive Committee shall fill the vacancy.

C. Duties

The duties of the Medical Executive Committee, acting on behalf of the Medical Staff between annual meetings, shall be as follows:

1. Represent and act on behalf of the Medical Staff subject to such limitations as may be imposed by these Bylaws;
2. Coordinate the activities and general policies of the various services;
3. Receive and act upon medical staff and hospital multidisciplinary committee reports;
4. Implement policies of the Medical Staff not otherwise the responsibility of the services pursuant to Section 13.3 of these Bylaws;
5. Serve as liaison between the Medical Staff and the Chief Executive Officer and the Governing Board;
6. Recommend action to the Chief Executive Officer or the Governing Board on clinical and administrative matters;
7. Make recommendations on management matters to the Chief Executive Officer;
8. Fulfill the Medical Staff's accountability to the PHT for the medical care rendered to the patients in the hospital and other designated facilities;
9. Ensure that the Medical Staff is kept abreast of the accreditation status of the hospital and other designated facilities;
10. Provide for the preparation of all meeting programs, whether directly or through delegation to a program committee or other suitable agent;
11. Review the credentials of all applicants presented by the Credentials Committee and make recommendations for staff membership, assignments to services, and delineation of clinical privileges;

12. Review periodically all information available regarding the performance and clinical competence of staff members and, as a result of such reviews, make recommendations for reappointments, renewals, modifications, or changes in clinical privileges;

13. Take all reasonable steps to ensure professional ethical conduct and competent clinical performance on the part of all members of the Medical Staff, including the initiation of and/or participation in medical staff corrective or review measures when warranted; and

14. Report on annual activities at each annual medical staff meeting and to the Governing Board.

These delegated duties may be amended or removed from the Medical Executive Committee by amendment to these Bylaws; additional duties may be delegated to the Medical Executive Committee by amendment to these Bylaws.

D. Meetings. The Medical Executive Committee shall meet at least ten (10) times during a calendar year and shall maintain a permanent record of their proceedings and actions. A written agenda of the matters to be considered at the committee meeting shall be delivered to committee members prior to the meeting.

E. Mental and/or Physical Examinations. The Medical Executive Committee is empowered to require mental and/or physical examinations of members with clinical privileges in connection with a reappointment, a reinstatement after a leave of absence, a disciplinary action investigation, pursuant to the impaired practitioner policy, disruptive practitioner policy or as otherwise appropriate. These examinations shall be performed by medical staff members and/or practitioners mutually agreed upon

by the parties. In the event that no agreement is reached within thirty (30) days of notification to the member of the examination requirement, the examination(s) shall be performed by medical staff members and/or practitioners designated by the Medical Executive Committee. Written reports of examinations shall be submitted to the medical staff member or practitioner and the Medical Executive Committee.

F. Medical Executive Subcommittee(s). Each hospital may have a medical executive subcommittee which shall be a subcommittee of the Medical Executive Committee. Each Medical Executive Subcommittee shall develop and propose to the Medical Executive Committee rules and regulations governing the selection of its leadership (chair, vice-chair, etc), appointments to subcommittees, recommendations for positions such as Associate Chief of Service, and any other matters appropriate for hospital medical staff functioning.

Section 12.3 Medical Review Committee

A. Composition. The Medical Review Committee shall consist of the same members as the Medical Executive Committee, and shall follow the same requirements as the Medical Executive Committee for chairing the meetings and for allowing designees.

B. Duties.

1. The committee shall evaluate and seek to improve the quality of health care rendered by all clinical/professional services. It shall determine whether the health care services rendered were appropriate, necessary, and cost effective and were performed in compliance with approved standards of care.

2. The committee shall also actively participate, as appropriate, in significant unresolved issues or serious incidents from the clinical services or medical

staff committees as well as patient care problems and/or safety issues not resolved through the quality, patient safety, regulatory compliance or risk management programs with the understanding that these programs are operating in conjunction with the Medical Review Committee.

3. The committee shall make specific recommendations to the Chiefs of Service and to the Credentials Committee as appropriate based on investigations and reviews conducted by this committee. The committee is empowered by the President of the Medical Staff and the Chief Executive Officer to resolve issues and make recommendations to the Medical Executive Committee, the President of the Medical Staff, and the Chief Executive Officer.

C. Meetings. The Medical Review Committee shall meet as needed and shall maintain a permanent record of its proceedings and actions and shall make reports to the Medical Executive Committee.

Section 12.4 Credentials Committee

A. Composition The Credentials Committee shall consist of: members of the Active Medical Staff selected on a basis that will ensure representation of the major clinical specialties and all hospitals; members of the Medical Staff at large appointed by the President of the Medical Staff; such other medical staff members as approved by the committee's membership; and the Chief Nursing Executive or designee. The following shall attend the Credentials Committee meetings and provide support to the Credentials Committee: a representative from the quality department; a representative from risk management; and a representative from the Medical Staff Office. The Vice President of

the Medical Staff shall serve as Chair, but an active member may be nominated and approved by the President of the Medical Staff to serve as co-chair.

B. Duties

The duties of the Credentials Committee shall be to:

1. Review the credentials of all applicants for medical staff membership and make recommendations for membership and delineation of clinical privileges in compliance with these Bylaws;

2. Make a report to the Medical Executive Committee on each applicant for medical staff membership, including specific consideration of the recommendations for clinical privileges from the services and facility in which the applicant requests privileges;

3. Review every two years all information available regarding the competence of medical staff members and, as a result of such reviews, make recommendations for granting privileges, reappointments, and assignment of medical staff members and practitioners to the various services as provided in these Bylaws;

4. Investigate any breach of ethics that is reported to it; and

5. Review reports that are referred by the Medical Executive, Health Information Management, Medical Review and Utilization Review Committees or by the President of the Medical Staff.

C. Credentials Subcommittee. Each hospital may have a credentials subcommittee which shall be a subcommittee of the Credentials Committee. The Credentials subcommittee shall report to and make recommendations to the Credentials Committee on all matters that it reviews.

D. Meetings. The Credentials Committee shall meet at least ten (10) times during the calendar year and shall maintain a permanent record of its proceedings and actions.

Section 12.5 Peer Review Committee.

A. Composition. The Peer Review Committee shall consist of: members of the Active Medical Staff selected on a basis that will ensure representation of the major clinical specialties and hospitals; members of the Medical Staff at large appointed by the President of the Medical Staff if so desired; and such other medical staff members as approved by the committee's membership.

B. Duties. The duties of the Peer Review Committee shall be set out in the peer review policy.

C. Subcommittees. Each hospital may have a peer review subcommittee which shall report to and make recommendations to the Peer Review Committee on all matters that it reviews.

D. Meetings. The Peer Review Committee shall meet as often as is necessary to accomplish its goals but at least quarterly during the medical staff year.

Section 12.6 Graduate Medical Education Committee

A. Composition. The committee shall consist of the Chief Medical Officer, Program Directors of various graduate medical education training programs, representative(s) from the Medical Staff, the house staff, and nursing staff. The quality and physician services departments shall attend and provide support to the committee.

B. Duties. The committee shall: provide advice and monitor all aspects of residency education; establish and maintain appropriate liaison with residency directors

and with the administrators of other institutions participating in programs sponsored by the institution; establish institutional policies and procedures for graduate medical education including selection, evaluation, promotion, dismissal of residents, and the adjudication of complaints and grievances not already addressed in the collective bargaining agreement; perform reviews of programs regularly for compliance with institutional policies and the requirements of Accreditation Council for Graduate Medical Education; and review ethical, socioeconomic, medical/legal, and cost-containment issues that affect graduate medical education including assurance of appropriate and equitable funding for resident positions, benefits, support services, working conditions, and duty hours of residents.

C. Meetings. The committee shall meet at least ten times per year.

Section 12.7 Nominating Committee

A. Composition. The Nominating Committee shall consist of no more than five (5) members of the Active Medical Staff appointed by the President of the Medical Staff, a majority of whom shall be members of the Medical Executive Committee and one (1) of whom shall be designated the chair.

B. Duties. The Nominating Committee shall nominate candidates for the officers of the Medical Staff pursuant to Section 10.1(C) and candidates for the members at large of the Medical Executive Committee pursuant to Section 12.2(B) of these Bylaws.

C. Meetings. The Committee shall meet as frequently as necessary to discharge its duties.

Section 12.8 Bylaws Committee

A. Composition. The Bylaws Committee shall be composed of members of the Medical Staff as appointed by the President of the Medical Staff. The committee shall receive staff support from the Medical Staff Office, the quality department, risk management, the County Attorney's Office and any other appropriate staff. The immediate President of the Medical Staff shall serve as chair.

B. Duties. The Bylaws Committee shall:

1. Review the Medical Staff Bylaws and Medical Staff Rules and Regulations at least every other year to make recommendations to the Medical Executive Committee as necessary to reflect current staff practices and to assure compliance with accreditation, regulatory or legal requirements.

2. Review any proposed amendments to the Medical Staff Bylaws that may be referred to it by the Medical Executive Committee.

C. Meetings. The Bylaws Committee shall meet as frequently as necessary to discharge its duties.

Section 12.9 Health and Welfare Committee

1. Upon recommendation of the Medical Executive Committee, the President of the Medical Staff shall convene an ad hoc Health and Welfare Committee in connection with a reappointment, reinstatement after a leave of absence, a disciplinary action investigation, invocation of the Impaired Practitioner Policy, as amended or renamed, invocation of the Disruptive Practitioner Policy, as amended or renamed, or as otherwise appropriate.

2. The Medical Executive Committee may delegate the authority to require mental and/or physical examinations of members with clinical privileges to the Health and Welfare Committee in conjunction with one of the above-described events. These examinations shall be performed by medical staff members and/or practitioners mutually agreed upon by the Health and Welfare Committee and the affected member. In the event that no agreement is reached within thirty (30) days of notification to the member of the examination requirement, the examination(s) shall be performed by medical staff members and/or practitioners designated by the Health and Welfare Committee. Written reports of examinations shall be submitted to the medical staff member or practitioner and the Health and Welfare Committee.

3. Any ad hoc Health and Welfare Committee convened shall consist of members in good-standing with an interest in the health and welfare of medical staff members who: do not have a conflict of interest (economic competitors, business partners, known history of interpersonal disagreements, part of a referral pattern, etc); have not been involved in the underlying events; have not been involved in prior levels of review of the underlying events; and will not be involved in future levels of review. If a matter related to an allied health professional is referred to an ad hoc Health and Welfare Committee, the Chief Nursing Executive may serve as a member or appoint a designee.

4. Any ad hoc Health and Welfare Committee shall report to the Medical Executive Committee and shall be considered a medical review committee.

Section 12.10 Committees for Special Services and/or Functions

As PHT interests and services change, the Medical Executive Committee may develop appropriate committees to review and analyze these changes. These may

include, but are not limited to, committees for the following function: 1. Special care units, such as the intensive care unit, coronary care unit, burn unit, dialysis unit, recovery room, neonatal care unit, respiratory therapy, outpatient department, and emergency room; and 2. Resident physicians. The Chief Nursing Officer or designee may serve on a committee for special services and/or functions as deemed appropriate by the President of the Medical Staff.

Section 12.11 Multidisciplinary Committees

A. The Medical Staff and Allied Health Professional Staff shall appropriately participate in the maintenance and improvement of high professional standards throughout the hospitals and other designated facilities by maintaining physician representation on various multidisciplinary committees relating to safety and the quality of care rendered to patients. These include:

- Utilization Management Committee
- Pharmacy and Therapeutics Committee
- Infection Control Committee
- Health Information Management Committee
- Tissue Committee
- Transfusion Committee
- Cancer Committee
- Adult Bioethics Committee
- Pediatric Bioethics Committee
- Trauma Quality Management Committee
- Center for Bloodless Medicine and Surgery (CBMS) Steering Committee

- Cardiopulmonary Resuscitation (CPR) Committee
- Any other multidisciplinary committee created by the PHT pursuant to PHT Policies and Procedures, including any multi-disciplinary committee created by the Medical Executive Committee or the Chief Executive Officer.

B. The PHT shall maintain a clear statement of the duties and responsibilities of each committee and its chair in the JHS Administrative Manual Policy. This policy shall include: 1. the purpose and duties of the committee; 2. the composition of the committee; 3. the duties of the chair; 4. the frequency of the meetings; 5. the nature, frequency and mechanism for reporting on the activities of the committee; and 6. any other details relating to the operations and functioning of the committee and its members.

ARTICLE XIII: BYLAWS, RULES AND REGULATIONS AND POLICIES AND PROCEDURES; AMENDMENT

Section 13.1 Notification. Notification shall be made by U.S. mail, hand delivery, delivery service, facsimile, electronic mail or other electronic communication. Delivery shall be made based on the contact information provided by the medical staff member to the Medical Staff Office.

Section 13.2 Bylaws.

A. Scheduled Review. The Medical Staff Bylaws shall be reviewed every two years and revised as necessary to reflect current staff practices and to ensure compliance with accreditation, regulatory, and legal requirements. This review shall be conducted by the Bylaws Committee.

B. Approval Process. The Active Medical Staff shall adopt and approve any revision, adoption or update to the Medical Staff Bylaws through one of the following

procedures: at the annual meeting; through recommendation of the Medical Executive Committee; or by recommendation of the Active Medical Staff.

1. Annual Meeting. The Bylaws Committee review shall be conducted in sufficient time so that the recommendations of the Bylaws Committee can be presented to, considered by and acted upon by the Active Medical Staff at its annual meeting.

2. Recommendation of the Medical Executive Committee. A proposed amendment to these Bylaws shall be referred to the Medical Executive Committee. The Medical Executive Committee may refer the proposed amendment to the Bylaws Committee for recommendation, or may act upon the proposed amendment directly without recommendation from the Bylaws Committee. Any Bylaws amendment(s) approved by the Medical Executive Committee shall be deemed to be adopted by the Medical Staff on the fourteenth (14th) day after notification to the Active Medical Staff of the action taken by the Medical Executive Committee to amend the Bylaws. Unless the President of the Medical Staff is in receipt of timely written or electronic objection from at least ten (10) percent of the members of the Active Medical Staff, such amendment(s) shall be forwarded by the Medical Executive Committee to the Committee and the Governing Board for review and approval.

3. Recommendation of the Active Medical Staff. If a proposed amendment to the Bylaws is not recommended by the Medical Executive Committee or an amendment recommended by the Medical Executive Committee is objected to within fourteen (14) days after notification to the Active Medical Staff, any member of the Active Medical Staff may make a request that the President of the Medical Staff bring the

matter before the Active Medical Staff for determination. The President of the Medical staff may place the proposed amendment on the agenda at the next annual meeting, call a special meeting or arrange for a vote without necessity of a meeting, whichever is most expedient. To be adopted, the proposed amendment must be approved by a majority vote of the Active Medical Staff present at the annual or special meeting of the Medical Staff or by a majority of the responsive membership of the Active Medical Staff if vote is taken outside a meeting. If the members of the Active Medical Staff recommend adoption of such amendment, such amendment shall be forwarded to the Board Committee and the Governing Board for review and approval.

Section 13.3 Rules and Regulations

A. Scheduled Review. The Medical Staff Rules and Regulations shall be reviewed every two years and revised as necessary to reflect current staff practices and to ensure compliance with accreditation, regulatory, and legal requirements. This review shall be conducted by the Bylaws Committee or any other persons so appointed by the Medical Executive Committee.

B. Recommendation of the Medical Executive Committee. The Medical Executive Committee shall have the authority to approve rules and regulations on behalf of the Active Medical Staff. However, if the Medical Executive Committee proposes to adopt a rule or regulation or make an amendment to a rule or regulation, it shall first notify the Active Medical Staff of such rule, regulation or amendment. If the Medical Executive Committee recommends adoption of such rule, regulation or amendment, it shall be forwarded to the Board Committee and the Governing Board for review and approval

C. Recommendation of the Active Medical Staff. If the active members of the Medical Staff propose to adopt a rule, regulation or make an amendment to a rule or regulation, the active members shall notify the Medical Executive Committee of such rule, regulation or amendment. If the Medical Executive Committee declines to adopt such rule, regulation or amendment or if the Active Medical Staff disagrees with the adoption of a rule, regulation or amendment, then any member of the Active Medical Staff may make a request that the President of the Medical Staff bring the matter before the Active Medical Staff for determination. The President of the Medical Staff may place the proposed rule, regulation or amendment on the agenda at the next annual meeting, call a special meeting or arrange for a vote without necessity of a meeting, whichever is most expedient. To be adopted, the proposed rule, regulation or amendment must be approved by a majority vote of the Active Medical Staff present at the annual or special meeting of the Medical Staff or by a majority of the responsive membership of the Active Medical Staff if the vote is taken outside a meeting. If the members of the Active Medical Staff recommend adoption, it shall be forwarded to the Board Committee and the Governing Board for review and approval.

D. Urgent Amendment. If there is a documented urgent need to amend a rule or regulation in order to comply with a law or regulation, the Medical Executive Committee may provisionally adopt and the Governing Board may provisionally approve an urgent amendment without prior notification of the Active Medical Staff. However, the Medical Staff shall be immediately notified by the Medical Executive Committee. If there is any objection to the urgent amendment within fourteen (14) days of the notification, then the procedure detailed in Section 13.2(B) shall be followed.

Section 13.4 Policies and Procedures.

The Medical Executive Committee shall have the authority to approve policies and procedures on behalf of the Medical Staff, regarding but not limited to matters outlined in these Bylaws. The Medical Executive Committee shall notify the Medical Staff of the adoption of any policy or procedure. The Active Medical Staff may propose a policy or procedure or amendment to a policy and procedure by following the procedure detailed in Section 13.2(B) above.

Section 13.5 Approval by the Governing Board.

The Governing Board, pursuant to its own PHT Bylaws shall review and approve any amendment or revision to the Medical Staff Bylaws, except for committee membership and meeting procedures, or any amendment or revision to the Medical Staff Rules and Regulations. The amendment or revision shall be effective upon approval by the Governing Board. Policies that require Governing Board approval pursuant to a statutory, regulatory or accreditation requirement shall also be reviewed and approved by the Governing Board.

ARTICLE XIV: CONFLICT RESOLUTION

Conflict Management Between the Medical Staff and the Medical Executive Committee. If a conflict were to arise between the Medical Staff and the Medical Executive Committee, a special meeting shall be called by the President of the Medical Staff upon the request of any member of the Medical Staff. Such matters that may be the basis of a conflict are, but not limited to, proposals to adopt a rule, regulation, policy or amendment thereto. Nothing in this section is intended to prevent medical staff members from invoking the process detailed in Section 13.3(C).

ARTICLE XV: AUTHORITY OF PUBLIC HEALTH TRUST

Nothing contained in this or any other article of these Bylaws shall limit the authority of the PHT to make any and all decisions and to prescribe all Bylaws, rules, regulations, policies and procedures necessary for the proper operation, maintenance, control, and governance of PHT facilities; however, the PHT may not unilaterally amend these Medical Staff Bylaws, the Medical Staff Rules and Regulations or Medical Staff Policies and Procedures. Nothing contained in these Bylaws or in the Rules and Regulations, promulgated thereunder, shall conflict with the laws of the United States, State of Florida, Miami-Dade County or with the Bylaws, rules, regulations, and policies established by the PHT.

PREVIOUS COMPREHENSIVE AMENDMENTS

July 19, 2012

August 28, 2006

November 24, 2004

November 24, 2003

October 9, 2001

June 12, 2001

June 13, 2000