ADOPTION

These Bylaws shall be adopted at any regular or special meeting of the Active Medical Staff, shall replace any previous Bylaws, and shall become effective when approved by the Board of Directors of NuHealth.

REVISED November 23, 2009
APPROVALS
Executive Committee of the Medical Staff on November 3, 2009.

__________________________
Glenn Faust, M.D.
Chairperson

Medical Staff on November 4, 2009.

__________________________
Kamil Jaghab, M.D.
President

Approved by the Board of Directors of NuHealth on November 23, 2009.

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Martin D. Payson
Chairperson
NUHEALTH

BYLAWS

of the

MEDICAL STAFF

PREAMBLE

MISSION STATEMENT

NuHealth is a healthcare delivery system committed to providing high quality, personalized, culturally sensitive, and evidence based care to everyone through its community teaching hospital, extended care facility, and family health centers.

NuHealth recognizes its unique obligation to enhance care within the medically underserved areas of Nassau County, to address disparities in the health status and delivery of care to minority populations, and to serve the region as its premier Level I trauma center. To inspire the faith and confidence of its patients and forge strong ties with the communities it serves, NuHealth employs qualified and dedicated health professional and support staff, offers superior training to its medical students, residents, and other health profession students, and conducts research that translates to improved clinical outcomes.

VISION STATEMENT

- **National Recognition**: To be a nationally recognized, financially sound, state-of-the-art public hospital and community health care system;
- **A Leader in Quality**: To be a leader in the provision of health care services that meet the highest public standards of quality, and that are efficiently and effectively delivered through a staff of dedicated employees who regularly exceed patient expectations;
- **A Model for Accessibility**: To be a model for improving access to health care, reducing health care disparities, and offering culturally sensitive and community-connected health care services;
- **Setting Standards in Teaching and Research**: To set the standard in the training of medical students and residents, supporting and conducting research that contributes to improvements in health outcomes; and
- **A Respected Source of Health Care Information**: To be a leader in educating the general public about important health care issues.

VALUES

- **Create a Positive Impression**: First impressions are lasting impressions.
- **Anticipate and Respond**: Take the initiative to meet needs and exceed expectations.
- **Respect**: Value the opinion of others and appreciate each other's contributions and diversity.
- **Integrity and Compassion**: We perform our jobs in an ethical manner, with honesty, sincerity, and compassion for others.
• **Neat-Clean-Safe:** We pride ourselves on providing a safe and healing environment.
• **Going Above and Beyond:** Set high standards and strive to be the best.

To fulfill the goals and responsibilities above, a concerted effort must be made by all of the Hospital’s health professionals. As such, the Hospital Staff does hereby organize itself in conformity with these Bylaws.

**CONFIDENTIALITY**
All medical records and patient-specific information, records of peer review and other committee proceedings, quality assurance and risk management materials including incident reports, Medical Staff credentialing records and files, minutes of Medical Staff, Medical Board and NuHealth meetings, business plans of NuHealth and Medical Staff, and other confidential NuHealth and Medical Staff records, data, and information, may not be used for purposes other than patient care, peer review, risk management, and other proper NuHealth and Medical Staff functions. Such confidential materials (whether maintained in hard copy, in computer memory or diskette, on microfilm or microfiche, or in any other format), may not be removed from NuHealth, duplicated, transmitted, or otherwise disclosed to parties outside of NuHealth without proper authorization in accordance with NuHealth and Medical Staff policies. Compliance with this Confidentiality Policy shall constitute a condition of continuing Medical Staff membership.

**INTERPRETATION OF THE BYLAWS**
In construing these Bylaws, Rules and Regulations, and the policies of Departments, Sections, and Committees, the Medical Staff may take into account its usual and customary policies and practices, whether written or unwritten, and may also bring to bear the expert knowledge of members of the Medical Staff, provided that such policies, practices, and expert knowledge are applied in the manner fully consistent with the specific provisions of the Bylaws, Rules and Regulations, and policies.

All captions and titles used in these Bylaws, Rules and Regulations are for convenience only and shall not limit or otherwise affect in any way the scope or manner of interpretation of any provision.

It is intended that the reasonable construction of these Bylaws, Rules and Regulations and policies shall be recognized and deferred to by a court or administrative agency or accreditation body, and that the Bylaws, Rules and Regulations and policies shall be so interpreted with consideration given to the fact that the Medical Staff requires reasonable flexibility in interpretation and application.
ARTICLE I

DEFINITIONS

Allied Health Professionals ("AHP")

Shall include individuals who may be accorded specified practice privileges in the Hospital limited to their areas of competence. While such members of the allied health professions shall not be deemed eligible for Medical Staff membership, they shall, however, be subject in all respect to these Bylaws, Rules and Regulations, and they shall carry out their professional activities in the Hospital subject to appropriate Departmental rules, regulations, policies and procedures.

Applicant

An applicant for medical staff membership, clinical privileges, or both, as the context permits.

Attending Physician

The physician who has primary responsibility for the Patient.

Board Certified

Refers to medical, dental, or osteopathic specialty boards.

Board Of Directors ("Board")

The governing body of the Medical Center.

Chief Executive Officer ("CEO")

Individual appointed by the Board of Directors to act on its behalf as the President and Chief Executive Officer in the overall administrative management of the Hospital. The CEO may delegate any area of his authority and responsibility.

Chief Medical Officer

A physician qualified for membership on the Medical Staff, and appointed by and accountable to the Board of Directors, who shall be responsible for the day-to-day medical activities of the Hospital and directing the Medical Staff organization in accordance with the By-Laws, Rules and Regulations and applicable State and Federal laws and regulations.

Clinical Department ("Service")

Refers to a grouping of Practitioners according to clinical activities and interests.

Clinical Privileges

Permission granted to a Practitioner to render specific diagnostic, therapeutic, medical, dental, research, pediatric, psychological or surgical services to Patients of the Medical Center.

Clinical Service

Specific medical services, such as surgical services or emergency services, provided in an area of a Hospital designated for the provision of those medical services.

Concurrent Proctoring

Direct observation of the procedure being performed or medical management either through observation of practitioner interactions with
patients and staff members or review of clinical history and physical and review of treatment orders during the patient’s hospital stay.

Consultation
An evaluation of a patient requested by a Practitioner.

Credentialing
Process of granting authorization to a Practitioner by the Board of Directors to provide specific patient care and treatment services in the Hospital, within defined limits, based on an individual’s license, education, training, experience, competence, physical and mental ability to perform the activities which form the basis for privileges requested, and judgment.

Current
Up-to-date and extending to the present time.

Dentist
Any person who (i) holds the degree of Doctor of Medical Dentistry or Doctor of Dental Surgery; (ii) with an unlimited license; (iii) who is registered to practice dentistry in the State of New York.

Department Chairperson
Individual selected in accordance with the provisions of ARTICLE X of these Bylaws and responsible for the clinical work of the department.

Documentation
Information in written, photographic, electronic, or other permanent form.

Executive Committee
Executive Committee of the Medical Board.

Executive Committee of the Medical Board.

Ex Officio
Service as an appointee of a body by virtue of an office or position held. This may be with or without voting rights.

Fellow
A physician registered as a post graduate fellow in the Medical Center.

Focused Professional Practice Evaluation
A process to confirm an individual Practitioner’s current competence at the time new privileges are granted, either at initial appointment or as a current member of the medical staff. In addition to specialty-specific issues, proctoring will address the six general competencies of physician performance. FPPE monitoring methods include prospective, concurrent, or retrospective.

Focused Professional Practice Evaluation
A process to confirm an individual Practitioner’s current competence at the time new privileges are granted, either at initial appointment or as a current member of the medical staff. In addition to specialty-specific issues, proctoring will address the six general competencies of physician performance. FPPE monitoring methods include prospective, concurrent, or retrospective.

Hospital Administration
The Executive Staff of the Medical Center or their designees.

Hospital/Medical Center/Center
Shall refer to the NuHealth and any hospital or other Article 28 facility owned or controlled by NuHealth, now or in the future.

Hospital Staff
Includes Medical Staff members, House Staff, Clinical Fellows and Allied Health Professionals.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>House Staff</td>
<td>A physician who is in a Medical Center approved residency program.</td>
</tr>
<tr>
<td>In Good Standing</td>
<td>The Medical Staff member has met the attendance requirements during the previous medical staff year, is not in arrears in dues payment, and is not under a suspension or serving with any limitation of voting or other prerogatives imposed by operation of these Bylaws, Rules or Regulations, or policies.</td>
</tr>
<tr>
<td>Medical And Professional Affairs Committee (&quot;MPAC&quot;)</td>
<td>The Medical Committee of the Board of Directors.</td>
</tr>
<tr>
<td>Medical Board</td>
<td>The professional board more fully described in Article IX.</td>
</tr>
<tr>
<td>Medical Education</td>
<td>Education considered as embracing education in all of the disciplines, at all levels, in all the professional and technical fields that can contribute to the effectiveness of health and medical care.</td>
</tr>
<tr>
<td>Medical Staff (&quot;Staff&quot;)</td>
<td>That organized body of physicians, dentists, podiatrists, midwives, and nurse practitioners duly licensed and registered by the State of New York, and appointed by the Board in accordance with these By-Laws, who have clinical privileges at the Hospital’s inpatient and/or ambulatory care facilities. Members of the Medical Staff shall be considered part of the organized health care arrangement with the Hospital (as that term is defined in 45 CFR 164.501) when exercising their clinical privileges in the Hospital for purposes of the HIPAA Privacy Rule and Security regulations.</td>
</tr>
<tr>
<td>Medical Staff Bylaws</td>
<td>Standards, approved by the Medical Staff and Board of Directors, providing the framework for the organization, responsibilities and self-governance of the Medical Staff at the Medical Center.</td>
</tr>
<tr>
<td>Medical Staff Office</td>
<td>The Medical Staff Office, among other things, receives applications for Staff membership and clinical privileges from practitioners wishing to be members of the Hospital’s Hospital Staff, processes the application along with making all appropriate inquiries, and forwards completed applications to the Department Chairpersons, the Credentials Committee and Medical Board for their review and approval.</td>
</tr>
<tr>
<td>Medical Staff Rules And Regulations</td>
<td>Standards, approved by the Medical Board that governs the day-to-day activities and conduct of Staff members at the Medical Center.</td>
</tr>
<tr>
<td>Medical Staff Year</td>
<td>Shall mean the Calendar Year or to whatever period of time the Board of Directors shall, from time to time, designate as its &quot;medical staff year.&quot;</td>
</tr>
</tbody>
</table>
Midwife

Any person who (i) is a graduate of midwifery educational program; (ii) with an unlimited midwifery license; (iii) who is registered to practice midwifery in the State of New York; (iv) has satisfied the pharmacotherapeutic requirements; and (v) has established a written agreement with an obstetrician-gynecologist physician member of the Active Staff who has obstetric privileges.

Nurse Practitioner

Any person who (i) is a graduate of nurse practitioner educational program; (ii) with an unlimited Registered Nurse license; (iii) who is certified in the specific specialty area of practice; (iv) has satisfied the pharmacotherapeutic requirements; and (v) has established a written collaborative agreement with a physician member of the Active Staff who has privileges in the specific specialty area of the nurse-practitioner.

On Call

A time during which an individual is available and required to come to a hospital when requested by the Hospital.

Ongoing Professional Practice Evaluation (“OPPE”)

A focused evaluation process to confirm a Practitioner's current competence as a current member of the Medical Staff. In addition to specialty-specific issues, proctoring will address the six general competencies of physician performance.

Other Hospital Staff

Includes House Staff, Clinical Fellows, and Allied Health Professional Staff.

Patient

Includes all patients admitted or treated in any of the departments, divisions or services of the Medical Center, whether in-patient or out-patient.

Patient Care Units

Means the Nassau University Medical Center, the A. Holly Paterson Extended Care Facility, the Family Health Centers, associated Part-time Clinics, the Correctional Unit, and any other hospital or facility owned or controlled by NuHealth.

Physician

A (i) medical physician with an M.D. degree, or an osteopathic physician with a D.O. degree; (ii) with an unlimited license; (iii) who is registered to practice medicine in the State of New York.

Podiatrist

Any person who (i) has graduated from an accredited College of Podiatric Medicine; (ii) with an unlimited license; (iii) who is registered to practice podiatry in the State of New York.

Practitioner

Unless otherwise expressly limited, any appropriately licensed physician or other qualified individual applying for, or exercising, staff membership and/or clinical privileges at the Hospital.
<table>
<thead>
<tr>
<th>Term</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Prospective Proctoring</td>
<td>Presentation of cases with planned treatment outlined for the proctor's treatment concurrence, review of case documentation for treatment concurrence, or completion of a written or oral examination or case simulation.</td>
</tr>
<tr>
<td>Retrospective Proctoring</td>
<td>Review of the case record after care has been completed. May also involve interviews of personnel directly involved in the care of the patient.</td>
</tr>
<tr>
<td>Specialty</td>
<td>A specific area of medicine practiced by a licensed individual who has obtained education or qualifications in the specific area in addition to the education or qualifications required for the individual’s license.</td>
</tr>
<tr>
<td>Special Notice</td>
<td>Written notification sent by certified mail to address of record, return receipt requested.</td>
</tr>
<tr>
<td>Surgical Services</td>
<td>Medical services involving the excision or incision of a patient’s body for the i) correction of a deformity or a defect; ii) repair of an injury; or iii) diagnosis, amelioration, or cure of disease.</td>
</tr>
<tr>
<td>Telemedicine</td>
<td>The use of electronic communication or other communication technologies to provide or support clinical care at a distance.</td>
</tr>
<tr>
<td>Verification</td>
<td>A documented telephone call, observation or confirmation of a fact including the information obtained; the date, and the name of the documenting individual.</td>
</tr>
</tbody>
</table>
ARTICLE II

PURPOSE

The purposes of this Organization are:

1. To carry out the mission of the Medical Center.
2. To render to all Patients admitted to or treated in any of the Patient Care Units care which is without discrimination as to race, color, religion, gender, national origin, disability, sexual orientation age, their ability to pay or source of payment.
3. To promote a high level of professional performance of all Practitioners authorized to practice in the Medical Center through the appropriate delineation of clinical privileges that each Practitioner may exercise in the Medical Center and the regular review and evaluation of the activities of all individuals granted clinical privileges in the Medical Center.
4. To provide education and maintain the highest standards in cooperation with the Hospital’s affiliated medical schools and to ensure an optimum atmosphere for continuous progress in professional knowledge and skill of all members of the Medical Staff and those Allied Health Practitioners affiliated with the Medical Staff.
5. To stimulate and foster approved clinical and laboratory research by members of the Medical Staff and to assist the Medical Center in obtaining funds therefore.
6. To promulgate and enforce rules and regulations for the proper self-government of the Medical Staff.
7. To promote discussion of issues concerning the Patients, the Medical Staff and the Medical Center with the Board of Directors, the Chief Executive Officer through authorized representatives and structures of the Medical Staff, such as the Medical Board.
8. To establish and maintain programs review and improve the quality and efficiency of patient care, medical education, research and related training programs including providing reliable and valid measures for the continuous evaluation of the overall quality of care provided to all Patients of Medical Center and to make recommendations thereon to the Board of Directors so that all Patients admitted or treated at any of the facilities, departments or services of Medical Center receive a safe and high quality of care.
9. To provide mechanisms through which the Medical Staff, the Board of Directors and the Administration of the Medical Center may discuss matters of mutual concern.
10. To recommend to the Board of Directors the limitation or suspension of the privileges of Practitioners who do not practice in accordance with the scope of their privileges, Medical Staff Bylaws, standards of performance in policies and procedures, and to assure that corrective measures are developed and put into place, when necessary.
11. To assist the Board of Directors in identifying community public health needs and in setting appropriate organizational goals and implementing programs to meet those needs and goals.
12. To render other services as are reasonably necessary to carry out the foregoing purposes as well as any other related purposes.
13. To provide a work environment which reflects the opportunity for advancement and worker safety.
ARTICLE III

MEDICAL STAFF MEMBERSHIP

Section A. Qualifications for Membership

1. Membership on the Medical Staff shall be extended to physicians, dentists, podiatrists, midwives and nurse practitioners who continuously meet the requirements, qualifications, and responsibilities set forth in these Bylaws, Rules and Regulations and who are appointed by the Board of Directors.

2. No applicant shall be denied Staff membership and/or practice privileges on the basis of race, religion, sex, national origin, creed, or disability except where that disability renders the person incapable, despite reasonable accommodation, of performing the essential functions of the medical staff appointment. Fitness of a candidate shall be judged solely on the basis of professional academic qualifications, training and physical and mental competency.

3. No physician, dentist, podiatrist, midwife, or nurse practitioner shall admit or provide services to Patients in the Hospital unless s/he is a member of the Medical Staff or has been granted temporary, disaster, or emergency privileges in accordance with the procedures set forth in these Bylaws.

4. Every member of the Medical Staff privileged to admit, attend to or consult on Patients in the Medical Center, shall be licensed without any limitations and registered to practice in the State of New York.

5. Every member of the Medical Staff privileged to admit, attend to or consult on Patients in the Medical Center, shall be eligible to participate in the Medicare, Medicaid and other federally sponsored health programs.

6. Every member of the Medical Staff privileged to admit, attend to or consult on Patients must be board certified or become board certified within five (5) years of completing training by an ABMS or AOA approved board as determined by department criteria. Board certification is a continuing requirement and all Staff members must be and remain certified within the specific areas for which s/he has requested clinical privileges. Failure to recertify within one reappointment cycle following Board expiration date shall result in termination of privileges, unless due to special circumstances, the Department Chairperson waives recertification and the Board of Directors approves the waiver. Any member of the Medical Staff appointed prior to June 5, 2007, who is not board certified in his/her specialty or holds an expired time-limited certification, must request a permanent waiver from the Department Chairperson and for the waiver to be recommended for approval to the Board of Directors by the Medical Board. Any applicant or member of the Medical Staff initially appointed on or after June 5, 2007, who will not be board certified within five (5) years of training, or recertified as required herein at the time of appointment or recommended, must request a waiver from the Department Chairperson and for the waiver to be recommended for approval to the Board of Directors by the Medical Board prior to appointment or reappointment. If a waiver is requested, the individual requesting the waiver bears the burden of demonstrating exceptional circumstances and that his/her qualifications are equivalent to, or exceed, the criterion in question.
7. The Staff member shall agree to contribute such time to the work of the Medical Center in teaching, clinical research, patient care, or participation on Medical Board Committees, as may be required by the Department Chairperson.

8. Every member of the Medical Staff being reappointed shall be required to participate in, maintain and attest to 50 hours of CME Category I biennially. At least one-half of the CME will be related to the privileges requested. Additional Category I hours may be required at the discretion of the Department Chairperson.

9. Every member of the Medical Staff is required to carry sufficient malpractice insurance, the level to be determined by the Medical Board from time to time as well as demonstrate a satisfactory malpractice and claims loss history. A lapse in coverage for any reason must be reported in writing to the Medical Staff Office. A current "certificate of insurance" must be on file at all times in the Practitioner's credentials file.

10. Every member of the Medical Staff is required to possess a current and valid certificate of infection control training as authorized by the State of New York.

11. An annual health assessment is required for all members of the Medical Staff, except for Emeritus Staff. All elements of the NYS Hospital Code 10 NYCRR 405.3(b)[10] must be met.

12. These qualifications shall apply to all reappointments and promotions.

13. Practitioners acting on behalf of outside Federal or State designated organ procurement organizations engaged solely at the Hospital for the harvesting of tissues and/or other body parts for transplantation, therapy, research or educational purposes pursuant to the Federal Anatomical Gift Act and/or parallel New York State statute or regulations (currently Section 405.25 of the Hospital Code) shall be exempt from the requirement to obtain staff privileges.

14. Members of the House Staff of the Medical Center, or of any other hospital, and Fellows, shall not be eligible for membership on the Medical Staff or for privileges in the area in which they are in clinical training, and shall be under the supervision of the Department Chairperson and the Attending Physician. The Department Chairperson may request privileges for trainees to perform clinical work in the medical discipline for which they have had previous training if the privilege requested is unrelated to the area of their current training. Such applicants must meet all requirements, qualifications, and responsibilities of the Medical Staff, and are subject to such policies as may be established by the Department Chairperson. Members of the House Staff are expected to participate in the continuous quality improvement program of their department, and the Hospital, as outlined in the House Staff policies. House Staff appointments and job qualifications, including job descriptions, are maintained by the Office of Academic Affairs.

15. Every member of the Medical Staff and AHP must document on initial application and/or reapplication an email address to ensure efficient notification of issues and agrees to read messages from the Hospital received at such address regularly. Notice by email constitutes notice for all purposes herein, unless another form of delivery is specified.

16. In clinical services in which the Hospital contracts for the provision of Hospital-based professional services including plastic surgery, orthopedics, and other contracted professional services, appointment to the Medical Staff and access to
Hospital resources is restricted to Practitioners who are members of the group under contract or who are designated by the Department Chairperson as adjunct members of the group so as to enable the service to fulfill its obligations for patient care, education and research.

17. Notwithstanding any other provision of the Bylaws, or of the Rules and Regulations, the Hospital may provide by agreement that a Practitioner's membership on the Medical Staff and clinical privileges are contingent on and shall expire simultaneously with such agreement or understanding. In the event that an agreement has such a provision or there is such an understanding, the provisions of these Bylaws, Rules and Regulations and policies of the Medical Staff with respect to hearings, appeals, appellate review, etc., shall not apply.

18. All Medical Staff members are required to comply with their obligations under the Emergency Medical Treatment and Labor Act and its corresponding regulations. The purpose of this requirement is to assure that all patients are screened and stabilized within the capability of this Hospital, as required by law. All physician and dentist members of the Medical Staff are authorized to conduct appropriate medical screening examinations. Midwives are authorized to conduct medical screening examinations on pregnant patients who are experiencing pregnancy-related symptoms. Other members of the Medical Staff and members of the AHP Staff are authorized to conduct medical screening examinations if appropriately delineated to do so.

Section B  Conditions and Duration of Appointment

1. Appointments to the Medical Staff shall be made in accordance with the Bylaws of NuHealth and approved by the Board of Directors upon recommendation by the Medical Board. All initial appointments are provisional and for the period of one (1) year. Upon satisfactory completion of this probation, all subsequent appointments will be made in conjunction with the departmental two (2) year appointment cycle.

2. The Board of Directors, in order to fulfill its commitment to assure balanced use of Hospital resources, may impose restrictions upon or designate special circumstances for Staff selection pursuant to Article V, Section G.

3. Appointment to the Medical Staff shall confer on the appointee only such privileges as may hereinafter be provided.

4. Application for membership on the Medical Staff shall constitute the Staff member's agreement to abide strictly and conduct their professional activities in accordance with the ethical code of their organized professional associations (i.e., the Principles of Medical Ethics of the American Medical Association, the Code of Ethics of the American Dental Association, Principles of the American Osteopathic Association), in accordance with the education law covering professional practice, and in accordance with the Rules and Regulations and policies of NuHealth (i.e., Code of Ethics, Code of Conduct, documentation and completion of patient's medical history and physical examination).

5. All appointments, reappointments and promotions to the Medical Staff will be contingent on the Practitioner signing, in writing, an agreement to abide by the Bylaws and Rules and Regulations of the Medical Staff of the Medical Center and certifying his/her mental and physical competency.
6. Any Practitioner who suffers a physical or mental illness or undergoes a procedure, which may impair his/her clinical ability, must promptly notify his/her Department Chairperson. At any time, the Department Chairperson or the Chief Medical Officer may require any Practitioner to submit to a physical and/or mental examination by a physician(s) acceptable to the Department Chairperson for the purpose of determining if the Practitioner is free from health impairments which pose potential risk to Patients or personnel or which may interfere with the performance of clinical duties. This may be in addition to submitted medical history and physical examination required for appointment and/or annual assessment. Failure to undergo such examination when requested shall be grounds for immediate suspension of clinical privileges until the examination occurs and the results are evaluated.

7. The process of appointment will be the same for applicants holding or proposed for administrative positions. Practitioners who diagnose or treat any of the Hospital’s Patients via telemedicine link are subject to the credentialing and privileging process of the Hospital.

Section C  Ethics and Ethical Relationships

1. Members of the Medical Staff shall pledge themselves not to receive from, or pay to, another physician, dentist, podiatrist, or any other person, directly or indirectly, any part of a fee received for professional services, except as otherwise authorized by federal, state, or local statutory or administrative law.

2. No member of the Medical Staff may delegate responsibility for the diagnosis or care of Patients admitted to, or treated in, this Hospital to another Medical Staff member who is not fully qualified to undertake this responsibility. Members of the House Staff and Fellows, acting within the scope of their appointment shall be considered qualified to undertake such delegated responsibility.

3. All Medical Staff members and employees will abide by the letter and spirit of all applicable legal requirements and adhere to the highest ethical standards of conduct in all Hospital activities; will deal fairly and honestly with those who are affected by their actions and treat them as they would expect to be treated if the situation were reversed.
ARTICLE IV

CATEGORIES OF THE HOSPITAL STAFF

SECTION A. MEDICAL STAFF

The Medical Staff shall be divided into the following categories:

1. The Active Staff

1.1 The Active Staff shall be composed of duly licensed physicians, dentists, podiatrists, midwives, and nurse practitioners privileged to admit, attend to and consult on Patients in the Medical Center. All privileges for admitting must be so specified at the time of appointment.

1.2 Dentist members of the Active Staff shall be responsible for the admission, management, and discharge of dental Patients, including all related written documentation. An oral-maxillofacial surgeon with the requisite qualifications outlined in 10 NYCRR 405.4(d)(2) may be granted the privilege of performing an admission history and physical examination to determine the Patient’s ability to undergo a proposed dental procedure. Dental Patients with medical problems present upon admission or arising during hospitalization shall be referred to appropriate physician members of the Active Staff for consultation and/or management.

1.3 Patients admitted to the Hospital for podiatric care must be admitted jointly by an appropriate physician member of the Active Staff (vascular surgical or medical attending, as the case may be) who will assume responsibility for the surgical/medical workup and surgical/medical care of the Patient and the podiatrist who will assume responsibility for the podiatric care of the Patient.

1.4 Appointees to this category shall:

1.4.1 Regularly admit Patients, without limitations, or be otherwise regularly involved in the care of Patients in this Hospital;

1.4.2 Vote on all matters presented at general and special meetings of the Medical Staff, and of the department, division, service or committees to which the Practitioner is appointed;

1.4.3 Hold office and sit on or be the chair of any committee;

1.4.4 Exercise such Hospital clinical inpatient and outpatient privileges as are granted to the Practitioner;

1.4.5 Have fair hearing rights as specified in Article VIII of these Bylaws.

1.5 Appointees to this category must:

1.5.1 Contribute to the organizational and administrative affairs of the Medical Staff;

1.5.2 Contribute to the organizational and administrative affairs of the clinical service to which they are appointed and participate in recognized functions of staff appointment including administrative responsibilities, quality improvement and monitoring activities, committee service, and attend departmental, divisional and service meetings, supervise initial appointees during their provisional period,
and discharge other staff and special purpose functions as may be required from time to time;

1.5.3 Pay all Medical Staff dues and assessments promptly;
1.5.4 Comply with all provisions of these Bylaws, Rules and Regulations and the policies and procedures of the Hospital;
1.5.5 Notify the Medical Staff Office, in writing, within thirty (30) days, when staff status changes at any hospital where membership is held. These changes include, but are not limited to, appointments, licensure, registrations or other factors, which limit the Practitioner’s rights of practice.

1.6 Transfer of Active Staff member: After two (2) consecutive years in which a member of the Active Staff fails to regularly care for Patients in this Hospital, or be regularly involved in Medical Staff functions as determined by the Medical Board, that member shall be automatically transferred to the appropriate category, if any, for which the member is qualified.

2. Affiliate/Referring Staff
Appointees to this category shall:

2.1 Relate to the Hospital primarily through the direct referral of Patients to the Active Medical Staff for admission and/or evaluation;
2.2 Be permitted to visit Patients, review medical records, but shall have no admitting privileges nor be permitted to write inpatient orders, progress notes or participate actively in the direct provision of inpatient care;
2.3 Be eligible to serve special purpose functions, serve on Medical Board committees and attend staff and continuing education meetings at the discretion of the appointing medical department at the Hospital;
2.4 Have fair hearing rights as specified in Article VIII of these Bylaws.
2.5 Contribute to the organizational and administrative affairs of the clinical service to which they are appointed and contribute to the medical staff organization by fulfilling assignments and attending meetings as requested;
2.6 Pay Medical Staff dues and assessments promptly;
2.7 Not be permitted to hold office or vote;
2.8 Comply with all provisions of these Bylaws, Rules and Regulations of the Medical Staff and the policies and procedures of the Hospital; and
2.9 Notify the Medical Staff Office, in writing, within thirty (30) days, when staff status changes at any hospital where membership is held. These changes include, but are not limited to, appointments, licensure, registrations or other factors, which limit the Practitioner’s rights of practice.

3. Courtesy Admitting Staff
Appointees to this category shall consist of physicians, dentists, podiatrists, and midwives, and nurse practitioners who:

3.1 Do not conduct a major portion of their hospital work at the Medical Center;
3.2 Shall be permitted to admit and provide consultation in the diagnosis and treatment of Patients;
3.3 Are members in good standing of the Medical Staff at another facility. If not members of an accredited facility, chart review may be required at time of
reappointment, as determined by the Department Chairperson, who will also

determine the scope and selection process for review. Exceptions to this

requirement may be made by the Medical Board for good cause;

3.4 Notify the Medical Staff Office, in writing, within thirty (30) days, when staff

status changes at any hospital where membership is held. These changes include,

but are not limited to, appointments, licensure, registrations or other factors,

which limit the Practitioner’s rights of practice.

3.5 Shall not be entitled to vote, hold office, or participate in malpractice insurance

programs sponsored by the Hospital.

3.6 Shall not be required to attend Medical Staff or Department meetings;

3.7 Pay Medical Staff dues and assessments promptly;

3.8 Have fair hearing rights as specified in Article VIII of these Bylaws;

3.9 Courtesy Admitting staff members who regularly admit or care for more than ten

(10) Patients per year at this Hospital shall, upon review of the Medical Board, be

obligated to seek appointment to the appropriate staff category.

4. **Courtesy Teaching Staff**

   Appointees to this category shall consist of physicians, dentists, podiatrists,

   midwives, and nurse practitioners who:

   4.1 Meet Membership criteria;

   4.2 Hold a current teaching appointment (Faculty, Clinician Educator or Adjunct

       Clinical Faculty) with an affiliated medical school or accredited Institution of

       Higher Learning;

   4.3 Shall not be entitled to vote, hold office, or participate in malpractice insurance

       programs sponsored by the Hospital.

   4.4 Shall participate in Medical Board or Department committees of which s/he is a

       member;

   4.5 May, but is not required to, attend meetings of the Medical Staff or Department of

       which s/he is a member;

   4.6 Shall be exempt from paying Medical Staff dues;

   4.7 Shall not have fair hearing rights as specified in Article VIII of these Bylaws.

5. **Visiting Staff**

   Appointees to this category shall consist of physicians, dentists, podiatrists,

   midwives, and nurse practitioners who:

   5.1 Shall not be privileged to admit, attend to, or consult on Patients in the Medical

       Center;

   5.2 Shall have no assigned duties or responsibilities;

   5.3 Shall support the Medical Center’s programs of education in such a manner as is

       deemed appropriate by the Department Chairperson. Any exception to this rule

       shall be a matter for action by the Medical Board on the individual case as

       recommended by the Department Chairperson concerned;

   5.4 If it is determined that a Medical Staff member has had no clinical activity during

       the previous two (2) years, s/he may be placed in this category;

   5.5 Shall not be entitled to vote, hold office, or participate in malpractice insurance

       programs sponsored by the Hospital;

   5.6 Shall be exempt from paying Medical Staff dues;
5.7 Shall not have fair hearing rights as specified in Article VIII of these Bylaws.

6. Emeritus Staff
6.1 Healthcare professionals who are no longer practicing their profession or no longer caring for hospitalized patients, but have served the Medical Center with distinction or who are not duly licensed but have exceptional qualifications as educators or investigators may be recommended by the Medical Board for appointment to this category;
6.2 A change of practitioner status to Emeritus Staff shall be initiated by the Department Chairperson, the Chairperson of the Medical Board or the Medical Board;
6.3 Shall not be privileged to admit, attend to, consult on, or supervise the care of any Patients in the Medical Center;
6.4 Shall be eligible to receive Medical Staff meeting notices and to attend Medical Staff and Department meetings but shall not be required to attend those meetings;
6.5 Shall not be entitled to vote, or hold office;
6.6 Shall be exempt from paying Medical Staff dues;
6.7 Shall not have fair hearing rights as specified in Article VIII of these Bylaws.

SECTION B. OTHER HOSPITAL STAFF

1. House Staff
1.1 Shall consist of duly qualified physicians, dentists, and podiatrists enrolled in an established training program at the Medical Center. Appointments shall require a recommendation of the Department Chairperson upon acceptance to an established program of graduate education set forth in Article V, Section A.;
1.2 Are employees of the Medical Center, or are trainees from other established training program who rotate at the Medical Center, and their scope of practice is defined by the Graduate Medical Education Program. Specific policies and procedures governing the oversight of House Staff within the Medical Center are set forth in the Academic Affairs policies and procedures;
1.3 Do not have independent privileges to admit or treat Patients at the Medical Center. House Staff will act under the supervision and credentials of a Medical Staff member in accordance with all relevant Medical Staff and Hospital policies and procedures;
1.4 Are not subject to dues or fees;
1.5 Shall not have fair hearing rights as specified in Article VIII of these Bylaws;
1.6 An official list of current House Staff members will be kept in the Office of Academic Affairs.

2. Clinical Fellows
2.1 Shall consist of duly qualified physicians, dentists, and podiatrists enrolled in an established fellowship training program at the Medical Center. Appointments shall require a recommendation of the Department Chairperson upon acceptance to an established program of graduate education set forth in Article V, Section A.;
2.2 Are employees of the Medical Center and their scope of practice is defined by the Graduate Medical Education Program. Specific policies and procedures
governing the oversight of House Staff within the Medical Center are set forth in the Academic Affairs policies and procedures;

2.3 Do not have independent privileges to admit or treat Patients at the Medical Center. Clinical Fellows will act under the supervision and credentials of a Medical Staff member in accordance with all relevant Medical Staff and Hospital policies and procedures;

2.4 Fellows who intend to function as attending physicians and who are qualified for Medical Staff membership must apply for and be granted Active or Courtesy Admitting Staff privileges/status before acting in an attending physician capacity. In these cases, the delineation of clinical privileges will specify which attending physician functions are authorized and which functions are considered in training;

2.5 Shall not have fair hearing rights as specified in Article VIII of these Bylaws;

2.6 Are not subject to dues or fees;

2.7 An official list of current Clinical Fellow members will be kept in the Office of Academic Affairs.

3. Allied Health Professions (“AHP”)

3.1 Members of allied health professions, also known as Allied Health Practitioners, may be appointed to the Medical Staff and receive titles appropriate to their qualifications and pursuant to their job descriptions.

3.2 Members of AHP are listed as, but not limited to: Certified Registered Nurse Anesthetists; Certified Physician Assistants; Evoked Potential Technicians; Psychologists; Mental Health counselors; and Orthotists/Prothetists. Such individuals shall submit an application and supporting documentation equivalent to that required of applicant to the Medical Staff under Article V, Section A. Except as otherwise provided herein, the appointment, reappointment and termination of such AHP Staff shall be in accordance with Article V of these Bylaws. Each individual AHP member shall submit his/her qualifications for review to the Department Chairperson or designee concerned. If appointed, the Medical Board may grant such individual privileges to attend to or consult on Patients in the Medical Center as are appropriate for the individual’s special professional qualifications. Their services shall be performed only at the request of, and under the direct supervision of, a member of the Active Staff who will be responsible for the Patient and the Patient’s records in all respects. AHPs have the right to submit any grievances to the Credentials Committee, where they shall be heard and processed accordingly.

3.3 A member of the AHP Staff who is required to have a sponsoring (or collaborating) physician may not exercise any clinical privileges if there no longer is a sponsoring (collaborating) physician who is a member of the Active Medical Staff. In the event that the AHP is no longer sponsored by that Active Medical Staff member, the AHP immediately shall notify the Department Chairperson and provide the name of the new sponsoring physician who is a member of the Active Medical Staff or be deemed to have resigned from the Staff.

3.4 AHPs shall be appointed for a term of one (1) year initially (provisional status) then every two (2) years.

SECTION C. PROVISIONAL STATUS
1. **Qualifications:**

1.1 All initial Medical Staff appointees to the Active, Courtesy-Admitting, or Courtesy-Teaching Staff or appointees to the Active, Courtesy-Admitting, or Courtesy-Teaching Staff after termination of a prior appointment, and AHP Staff shall be in provisional status. They shall be assigned to a clinical service in which their performance shall be evaluated to determine their eligibility for advancement to a non-provisional status in the Active, Courtesy-Admitting, or Courtesy-Teaching Staff. The requirements of this Section shall not apply to re-appointees when there has been no prior termination of appointment or to Affiliate/Referral, Visiting, or Emeritus Staff.

1.2 Active Staff members in provisional status shall consist of those physicians, dentists, podiatrists, midwives and nurse practitioners who meet the Membership criteria set forth in Article IV, Section C., but who have not completed the proctoring requirements set forth in Section C.3. below, if applicable, and/or have been in provisional status for less than twelve (12) months.

2. **Term:**

2.1 Members shall remain in provisional status of a minimum period of twelve (12) months and may remain a maximum of twenty-four (24) months.

2.2 The Executive Committee of the Medical Board shall initiate action to terminate the membership and privileges of an Active Staff member in provisional status who does not qualify for advancement to non-provisional status within twenty-four (24) months following the initial appointment and the individual is so notified; provided however, that such termination of appointment shall not be contingent upon notification.

2.3 A member so terminated may reapply for membership and clinical privileges twelve (12) months following such termination. If termination was due to insufficient patient activity, the Practitioner may treat Patients with temporary privileges until such time as patient activity is sufficient to meet levels required for membership on the Medical Staff.

2.4 The member shall not be entitled to the procedures set forth in Article VIII if advancement was denied because of a failure to have a sufficient number of cases proctored, or because of a failure to maintain a satisfactory level of clinical activity. The member shall be entitled to the procedures set forth in Article VIII if advancement was denied for medical disciplinary cause or reason.

3. **Proctoring:**

3.1 Each member in provisional status shall complete such proctoring (Focused Professional Practice Evaluation) as may be required by the Department. Proctoring shall be in accordance with criteria set forth in the appropriate Department policies, and/or the Proctoring (FPPE and OPPE) Policies, and may include direct observation of performance and/or chart review.

3.2 A member in provisional status shall remain subject to proctoring until the Department Chairperson has determined that proctoring has been successfully completed based on Department criteria. Documentation attesting to such shall be signed by the Department Chairperson, along with an evaluation of performance,
and a statement as to whether the member meets all of the qualifications and had discharged all of the responsibilities of the category to which s/he was appointed.

3.3 Medical Staff members who change Medical Staff classification to one of greater clinical responsibility, or who are granted additional privileges, shall also complete a period of proctoring in accordance with procedures outlined in this Subsection 3.

3.4 Proctoring shall be performed by a member of the Medical Staff in Good Standing, with privileges in the specialty area being proctored. Each Department shall establish, in its policies, a term of, and process for, proctoring.

3.5 If a sufficient amount of clinical activity has not occurred during the provisional period, proctoring may be extended beyond the provisional period upon formal request to, and approval by the Department Chairperson and approval by the Credentials Committee.

3.6 If a sufficient amount of clinical activity has not occurred to evaluate a Practitioner’s ongoing professional competence, the Department Chairperson may impose proctoring with the concurrence of the Credentials Committee. Such proctoring shall not entitle the Practitioner to the procedures set forth in Article VIII.

3.7 If an initial appointee fails to receive the documentation required under Subsections 3.1-3.3 above within the proctoring term, his/her Medical Staff membership, particular clinical privileges or request for additional privileges, as applicable, may be terminated. The Department Chairperson shall give the Staff member so affected written notice that s/he has a right to request a hearing pursuant to Article VIII, Section B. Thereafter, the procedures set forth in Article VIII shall be followed unless the failure to receive the documentation required above was because of failure to have a sufficient number of cases proctored because of limited clinical activity.
ARTICLE V

PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

SECTION A. Application for Appointment

1. Applications for membership on the Medical Staff shall be made available via the Hospital website or mail by the Medical Staff Office. The appropriate Department Chairperson shall be notified when an application for membership and privileges in his/her Department is released.

2. Applicants must apply for primary appointment in at least one (1) of the Departments and must apply to a specific Section within that Department if the applicant requests approval to practice the clinical function delineated within that Section. The primary appointment shall be chosen based on the applicant’s training and experience and intended area of clinical practice. In addition, an applicant may request a secondary appointment in another of the Hospital’s Departments and Sections if appropriate based on training and experience.

3. Applicants attest that all statements, answers and information contained in their application are true, correct and complete and that they understand that falsification, misrepresentation (including material misstatements) or omission of any fact(s) will be sufficient cause for ceasing processing and/or denial of an application and/or subsequent termination of any privileges granted upon the basis of the application and/or automatic suspension or dismissal from the Medical Staff. Hearing rights will not apply in such instances.

4. All applicants shall submit in writing and signed:

   4.1 A Hospital Staff Application form as prescribed by the Medical Board to include appropriate professional biographic data;
   4.2 A Clinical Privilege Application as prescribed by the appropriate Department to include a request for desired clinical privilege level;
   4.3 A Certification of Mental and Physical Competency, following the performance of a physical examination as prescribed by the Medical Board. The certification required annually must be performed by a physician, licensed midwife or nurse practitioner, who is permitted by ethical standards to treat the applicant (i.e. anyone other than a first-degree relative, spouse, significant other, and/or the applicant’s associate).
   4.4 A statement that pledges the applicant to;

   4.4.1 Read and uphold the Bylaws, the Rules and Regulations of the Medical Staff and policies and procedures of the Medical Center;
   4.4.2 Practice in accordance with the high ethical standards;
   4.4.3 Maintain malpractice insurance coverage in such forms and amounts as specified by the Medical Board;
   4.4.4 Release from liability all representatives of the Medical Center, its employees and of its Medical Staff for their acts performed (in good faith and without malice) in connection with evaluating the applicant. This may include a review of otherwise privileged or confidential information;
4.4.5 Comply with the Medical Center’s Compliance Program including its Conflict of Interest policy.

However, the submission of an application shall be deemed to constitute automatically such a pledge.

4.5 A statement in which the applicant provides to the Medical Center all information required to be obtained by the Medical Center under applicable Federal, State or local law, including but not limited to the following information:

4.5.1 The name of any hospital or facility with or at which the applicant had or has any association, employment, privileges or practice;

4.5.2 Where such association employment, privileges or practice was discontinued the reasons for its discontinuation;

4.5.3 Any pending professional misconduct investigations or any pending medical malpractice actions in this State or another state, and the substance of the allegations in such proceedings or actions; any challenges to licensure or registration, or voluntary or involuntary relinquishment of such; voluntary or involuntary termination of medical staff membership; voluntary or involuntary limitation, reduction, or loss of clinical privileges; any allegations related to any form of impairment or disruptive behavior; been investigated for or convicted of or charged with or pled guilty to any offense other than a minor traffic violation by any local, state or federal authority, official or agency or foreign/international equivalent;

4.5.4 The substance of the findings in such actions or proceedings;

4.5.5 A waiver by the applicant of any confidentiality provisions concerning information required to be provided to hospitals pursuant to this subdivision; and

4.5.6 Verification by the application that the information provided is complete, true, and accurate.

4.6 Evidence of current New York State licensure and registration;

4.7 Curriculum vitae, which includes appropriate professional biographical data;

4.8 Evidence of training in Infection Control approved by NYSDOH;

4.9 All information provided by an applicant pursuant to Subsections 4.1-4.8 above, shall be verified from any hospital or facility with or at which the applicant had or has any association, employment, privileges or practice, and shall be maintained in the Practitioner’s credential file in the Medical Staff Office. The Medical Center shall also solicit information from the National Practitioner Data Bank and other agencies, as may be required by Federal, State or local law;

4.10 The applicant shall have the burden of producing adequate information for a proper evaluation of the applicant’s clinical competency, character, and other qualifications and for resolving any doubts about such qualifications;

4.11 By applying for appointment to the Staff, each applicant thereby signifies his/her willingness to appear for an interview and abide by the Bylaws, Rules and Regulations of the Medical Staff;
4.12 All forms shall be sent by the applicant to the Medical Staff Office. The Medical Staff Office, on behalf of the Credentials Committee, shall verify the professional credentials of the applicant. Once processed, the Medical Staff Office shall forward the application to the Chairperson of the applicant’s Department or designee who shall review the requested level of clinical privileges within the framework of the applicant’s education, training, experience, and where applicable, demonstrated clinical competency. The Department Chairperson or designee may request additional information, including an interview with the applicant.

4.13 Upon completion of this review, the Department Chairperson or designee shall complete a Medical Staff or AHP appointment review form reflecting the Departmental recommendation as to acceptance of the application and clinical privilege level of the applicant. This form shall be sent with the Clinical Privilege and Medical Staff Application forms to the Credentials Committee.

5. A copy of these Bylaws and Rules and Regulations will be provided each applicant.

6. Nothing in this section shall be deemed to create a right of an individual to an application; the release of applications shall be governed solely by these Bylaws, Rules and Regulations.

SECTION B. Appointment Process

1. Within a reasonable time after receipt of the Departmental recommendation and the verified information, the Credentials Committee shall review all recommendations to assure that they are in keeping with the verified education, training, experience and, if applicable, demonstrated clinical competency, as well as the certified physical and mental competency of the applicant. Performance with respect to the ACGME six (6) general competences (Patient Care, Medical/Clinical Knowledge, Practice Based Learning & Improvement, Interpersonal and Communication Skills, Professionalism and Systems Based Practice) is taken into account in the evaluation of the applicant.

2. Upon completion of such review, the Credentials Committee shall record its recommendation on the recommendation form and send it to the Medical Board. This recommendation shall be one of the following: that the applicant be appointed with specification of clinical privilege level, not appointed for staff membership, or that the application be deferred for further consideration. If the applicant is recommended for appointment, a letter granting temporary privileges may be issued to the applicant within thirty (30) days of the recommendation by the Credentials Committee. The granting for privileges is subject to final approval of the Medical Board and MPAC at which time a letter of provisional appointment to the Hospital Staff shall be issued.

3. At the next regular meeting after receipt of the report and recommendations of the Credentials Committee, the Medical Board shall review the applicant’s qualifications and endorsements and recommend acceptance with clinical privilege level, non-acceptance or deferral.

4. When the recommendation of the Medical Board is to defer the application for further consideration, it will be returned to the Department Chairperson concerned for further consideration, resubmission or withdrawal. If the application is to be resubmitted, it must be done within thirty (30) days.
5. When the recommendation of the Medical Board is favorable to the Practitioner, it shall be promptly forwarded to MPAC for action.

6. In the event that MPAC does not concur with the recommendation of the Medical Board, the application must be reviewed by the Chief Medical Officer and referred back to MPAC for further consideration and recommendation. MPAC will make the final determination as to clinical privileges.

7. All initial appointments granted by MPAC are for a period of one (1) year. The initial appointment year shall be considered provisional. The Department Chairperson shall determine the process for monitoring provisional appointments and submit those recommendations to the Credentials Committee. As such, the Department Chairperson shall appoint a reviewer for each new appointment who shall be responsible for focused review of the Practitioner’s work and recommending full appointment, extension of provisional appointment (additional 6-12 months), or non-reappointment, at the end of the year’s period.

8. When the recommendation of the Medical Board is adverse to the Practitioner, either in respect to reappointment or desired clinical privilege level, the Chief Medical Officer shall promptly so notify the Practitioner by certified mail, return receipt requested within thirty (30) days of the decision. The Practitioner may appeal this decision as prescribed in the procedure outlined in Article VIII of these Bylaws.

SECTION C. Emergency and Temporary Appointments

1. In case of an emergency, any Staff member, regardless of his/her Department or Staff status shall be permitted to do anything possible to save the life of a Patient, using every facility of the Hospital necessary, including the calling for any consultation necessary or desirable. When an emergency situation no longer exists, such Staff member must request the privileges necessary to continue to treat the Patient. In the event such privileges are denied or he/she does not desire to request privileges, the Patient shall be assigned to an appropriate member of the Medical Staff. For the purpose of this subsection, “emergency” shall mean a condition in which serious permanent harm would result to a Patient or in which the life of a Patient is in immediate danger and any delay in administering treatment would increase that danger.

2. In case of an officially declared emergency and/or situation in which the Hospital’s Emergency Preparedness Plan has been activated (“official emergency”), licensed Practitioners, who do not have privileges as members of the Medical Staff, may provide medical care during such official emergency period, in accordance with the following procedure:

   2.1 Key identification (valid professional license/passport and one of the following: hospital photo ID; or member ID of a Disaster Medical Assistance Team/Medical Reserve Corps/Emergency System for Advance Registration of Volunteer Health Professional/or other recognized state or federal organizations or group; or verification of ID by current Staff member and verification of current hospital affiliation where practitioner holds active privileges) must be available and verified within seventy-two (72) hours;

   2.2 A record of the identification verification must be retained;
2.3 If possible, the practitioner will be paired with and supervised by a credentialed member of the Active Medical Staff who will assign the practitioner the patients to be treated;

2.4 Such privileges will be granted by the Chief Medical Officer, or the CEO or their designee;

2.5 Such privileges will terminate upon notice to the practitioner that his/her services are not longer needed, as determined by the Hospital.

Licensed practitioners requesting emergency privileges during an official emergency are to be referred to the Medical Staff Office. If the Medical Staff Office is not open, they shall be referred to the Chief Medical Officer.

3. Temporary (interim) appointments, not to exceed one hundred and twenty (120) days, may be made to the Medical Staff and AHP Staff in any of the categories described by joint action of the Department Chairperson concerned and the Credentials Committee. These appointments shall be valid only for such periods as may be designated by the Department Chairperson and the Credentials Committee, and may only be made, in the case of Practitioners eligible for Active Medical Staff, after the Practitioner has submitted to the Medical Center the statement required by Article V. Such temporary appointments in general will be limited to i) outstanding practitioners who can contribute to the educational activities within the Medical Center; ii) to practitioners with special skills or qualifications not available within the Medical Center Staff; iii) to other circumstances where, in the judgment of the Department Chairperson, patient care would benefit; or iv) when the completed application raises no concerns to the Credentials Committee and is awaiting review and approval of the Medical Board and MPAC. Such temporary appointments must be accompanied by a specific delineation of clinical privilege level and shall be reported promptly to the Medical Board and to MPAC. Temporary appointments will automatically terminate if the applicant’s initial membership application is withdrawn.

SECTION D. Reappointment, Promotion and Non-Reappointment Process

1. Each Staff member, including Department Chairpersons, must be reappointed every two (2) years.

2. The Medical Staff Office shall initiate a Request for Reappointment and a Certification of Mental and Physical Competency to the Staff member. At the time such request for reappointment is submitted, the Staff member shall also submit to the Medical Staff Office a statement containing all information required to be obtained by the Medical Center under applicable Federal, State and local law, including but not limited to the information described in Article V Section A. Subsection 4.5 above of these Bylaws. A Staff member desiring a change of clinical privileges must also file a Clinical Privilege Application and professional data supporting the request for additional privileges.

3. The Department Chairperson or designee shall review all reappointment requests. The Credentials Committee shall review the reappointment requests from the Department Chairperson. In the case of reappointment of the Department Chairperson, Medical Board shall have discretion to appoint a committee to advise concerning reappointment. The Department Chairperson or designee shall conduct ongoing evaluation of the
members of his/her Department by reviewing the Practitioner’s profile periodically. Consideration shall be given as to the Practitioner’s performance as evaluated by the standing committees of the Medical Board, as well as to the information provided as required in Section D.2. above, and also to the probation report of the practitioner’s reviewer, if applicable.

4. The recommendation of the Department Chairpersons or designees for Practitioners in their departments or the Chief Medical Officer for the Department Chairpersons, as well as information provided as required in Section D.2. above, and any deficiency reports from the above mentioned committees, and information requiring external validation shall be sent to the Credentials Committee of the Medical Board. The Credentials Committee shall review the information and recommend reappointment with no change in clinical privilege level, reappointment with a change in clinical privilege level, or no reappointment.

5. At the next regular meeting after receipt of the reported recommendation of the Credentials Committee, the Chairperson of the Credential Committee shall present these to the Medical Board, which shall review the report and recommend reappointment with no change in clinical privilege level, reappointment with a change in clinical privilege level or no reappointment.

6. Following approval by the Medical Board, these recommendations shall be forwarded to MPAC for approval or disapproval and final action.

7. Upon final action, the Medical Staff Office shall notify the Practitioner concerned of the action taken within thirty (30) days of the decision.

8. In cases of non-reappointment or reduction in privileges, the Practitioner shall be notified by certified mail, return receipt requested, within thirty (30) days of the decision, and be entitled to an appeal as outlined in Article VIII of these Bylaws.

SECTION E. Leaves of Absence

1. Members of the Medical Staff may request a leave of absence if they will not be practicing their profession at the Medical Center for a period of three (3) or more months. A request is to be made in writing to the Department Chairperson and must state the reason and expected duration of the leave of absence. The Department Chairperson will respond in writing with a copy to the Credentials Committee. During the period of leave of absence, a Staff member is required to maintain and show evidence of malpractice insurance if s/he participates in a claims-made policy. If the coverage is cancelled, evidence of retroactive coverage is required.

2. A leave of absence may not exceed one (1) year with the exception of medical or military leave. In order to re-establish clinical privileges upon return from a leave of absence, the Staff member must notify the Department Chairperson and apply for reappointment and privileges to the Staff. Evidence of malpractice insurance will be required at this time. This application will be processed as any other application for reappointment and privileges.

3. In the event of a medical leave of absence, privileges cannot be reinstated without a medical clearance acceptable to the Department Chairperson. The Department Chairperson may also recommend to the Credentials Committee a specific member of the Staff to serve as an evaluator for a period not to exceed one (1) year. Other requirements may be established in order to ensure a high level of professional performance.
SECTION F. Resignation from the Medical Staff

1. To resign from the Medical Staff, the Staff member must submit a letter of resignation to the Department Chairperson. The letter shall include the reason(s) for his/her resignation, and shall include a statement to the effect that s/he has on or prior to the date of the letter fulfilled all the obligations of his/her Medical Staff membership, including, but not limited to, the completion of all of his/her outstanding charts and records.

2. Upon receipt of a Staff member’s letter of resignation, the Department Chairperson shall confirm that the Staff member has fulfilled all of the obligations of his/her Medical Staff membership, including, but not limited to, the completion of all of his/her outstanding charts and records and any quality management obligations. The Department Chairperson shall only recommend acceptance of the Staff member’s application to resign, the Medical Board and MPAC shall only accept such recommendation, if the Staff member has fulfilled all of the obligations of his/her Medical Staff membership. In the event that the Staff member shall not have completed all of the obligations of his/her Medical Staff membership, s/he will not be considered to have resigned in Good Standing from the Medical Center and any appropriate facility or credentialing body contacting the Medical Center to inquire as to the status of the Staff member shall be so notified.

3. A Staff member who shall have resigned in Good Standing may reapply for membership to the Medical Staff at any time in accordance with the procedures contained in these Bylaws.

SECTION G. Procedure for Implementing Departmental Plans for Staff Selection and Establishing Temporary Moratoriums on New Staff Appointments

1. The designation by the Board of Directors of limitations upon or moratoriums for either Staff appointment or for access to specific clinical privileges, as provided in Article III, Section B, will be in accordance with the following procedures:

a. A Department Chairperson, after consultation with, and review by, the Division Chief and/or Departmental Committee, the CEO and the Chief Medical Officer, may recommend to the Medical Board the categories of specialties, the number of members of the Department and/or the number of applicants for access to a specified clinical privilege that appropriately can be supported by resources available within the Hospital. Where the clinical privileges in question are available to applicants in more than one Department, the Department Chairpersons of the respective services shall submit a joint plan. If agreement cannot be reached, the opinions of all the affected Department Chairpersons shall be submitted. Any recommendation of limitation shall include a written statement of justification. The recommendation(s) of the Chair(s) shall be subject to the review and approval of the Medical Board, MPAC, and the Board of Directors.

b. Any limitation on Departmental or Section size or limitations on the number of Medical Staff members possessing a specific clinical privilege will not affect existing staff or privileges. Such a limitation, however, will affect a current Medical Staff member who does not yet possess a requested clinical privilege that has been limited.
c. If one or more Department Chairpersons believe that an immediate need exists for consideration of a moratorium, either for new staff appointments or for specific clinical privileges, such Department Chairpersons may, after consultation with the appropriate Departmental committee, submit a written request for a moratorium to the Chief Medical Officer. A request for a moratorium may also be made by the Chief Medical Officer after consultation with the affected Department Chairpersons(s). The written request for a moratorium shall delineate the type and extent of any limit requested, whether it be for new staff appointments or for access to a specified clinical privilege, the evidence justifying the moratorium request, the goal to be achieved by the moratorium, and such other pertinent documentation or information, including evidence of review by the Departmental or Sectional Committee, its recommendation, if any, and the views of other Department Chairpersons whose Department will be affected if any.

d. The Chief Medical Officer shall, upon generation of or receipt of the request, immediately forward written notification of the request and its documentation to the CEO and to ECMB. The Chief Medical Officer shall also provide written notification to any applicant for appointment to the Medical Staff or any applicant for the specified additional clinical privilege whose application may be affected if the request for moratorium is approved.

e. ECMB shall review the request for the moratorium within thirty (30) days and shall forward its recommendation to MPAC.

f. MPAC shall submit its recommendations to the Board of Directors within sixty (60) days of generation of or receipt of the recommendation by the Chief Medical Officer.

g. The Board of Directors shall take final action within sixty (60) days after receipt of the recommendation from MPAC.

h. If the Board of Directors approves a moratorium as requested, unless otherwise specifically provided by the Board of Directors, the moratorium shall apply to all new Medical Staff applications and/or all pending applications for the additional specified clinical privilege(s) that have not been forwarded by the Credentials Committee pursuant to Article V, Section B, Subsection 2.

i. The initial moratorium period will not exceed one (1) year. To extend, modify or eliminate the moratorium, the, or an affected Department Chairperson may request an extension, modification or elimination that shall be processed in accordance with the provisions of this section.

j. MPAC, at its discretion, may declare a moratorium on processing applications either for Medical Staff appointments or applications for specified clinical privileges, as the case may be, upon the receipt of the written request by the Chief Medical Officer. Candidates for appointment or for the privilege in question whose applications are pending or are received during the period of the moratorium shall be so notified by the Chief Medical Officer immediately, and their applications shall be processed upon denial of the moratorium by the Board of Directors, or upon termination or non-renewal of the moratorium, whichever comes first.
ARTICLE VI

DELINEATION OF PRIVILEGES

SECTION A. Clinical Privileges
1. All Staff members shall be eligible for clinical privileges as demonstrated by their individual education, training, experience and currently demonstrated professional competence and judgment, current proficiency in the Hospital’s general competencies, and as recommended by the Department Chairperson, the Credentials Committee, the Medical Board and approved by MPAC. These privileges must be consistent with the objectives and programmatic needs of the Medical Center.

2. No Staff member shall be permitted to perform any diagnostic or therapeutic procedure which does not fall clearly under the commonly accepted and established guidelines of their specialty and has not been specified in the delineation of privileges, except in an emergency as further delineated in Article V, Section C.

3. Each applicant shall have the burden of establishing their qualifications and competency for the clinical privileges desired or requested.

4. Clinical privileges will be renewed every two (2) years at the time of the Staff reappointment. Renewal every two (2) years will follow the same process as renewal at appointment. Increase of privileges will require a review by the respective Department Chairperson and the Credentials Committee. Renewal of clinical privileges, and the increase or curtailment of those privileges, shall be based upon direct observation of care provided, the review of patient records, the performance of a sufficient number of procedures to develop and maintain the Practitioner’s skills and knowledge; and compliance with any specific criteria applicable to the privileges, including in-house training which may be required. Other reviews should include any records, which can document the Staff member’s participation in the delivery of medical care, quality review and monitoring, and consistency with the objectives and programmatic needs of the Medical Center. When available, relevant practitioner-specific data as compared to aggregate data and mortality and morbidity data shall be considered.

5. The decision to grant or deny a privilege and/or to renew an existing privilege shall also be based on peer recommendation which address the applicant’s medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, professionalism, and health status.

6. Each Clinical Service shall define the privileges delineation and criteria the Service shall use for recommending privileges in the initial appointment, reappointment, and evaluation of Staff members. If privilege delineation is based primarily on experience, the individual’s credentials file reflects the specific experience and successful results that form the basis for the granting of privileges.

SECTION B. Provisional Clinical Privileges
1. All clinical privileges initially granted to a Staff member are provisional and subject to the terms of Article IV, Section C.

SECTION C. Additional Clinical Privileges
1. A Staff member may apply for additional clinical privileges on a form prescribed for that purpose by the Medical Board. The application shall, in all respects, be processed in the
same manner as applies under Article V to an application for appointment or reappointment to the Medical Staff, and the applicant shall, in all respects, have the same rights and be subject to the same requirements as apply under Article V to an application for appointment or reappointment to the Medical Staff.

SECTION D. Temporary (Interim) Privileges
1. There is no right to temporary privileges.
2. When appropriate and consistent with Article V, Section C.3., a Practitioner may be granted temporary privileges.
3. The Department Chairperson to which the Practitioner is assigned shall be responsible for monitoring the performance of the Practitioner granted temporary privileges or for designating a Staff member who shall assume this responsibility.
4. Special requirements on consultation and reporting may be imposed by that Department Chairperson.
5. Temporary privileges will automatically terminate if the applicant’s initial membership application is withdrawn.
6. The denial or termination of temporary privileges shall not be reviewable according to Article V. In the event of any such denial or termination, the Practitioner’s Patients in the Hospital shall be assigned to another practitioner by the Department Chairperson. The wishes of the Patient shall be considered, when feasible, in choosing a substitute practitioner.

SECTION E. “Cross-specialty” Privileges within the Hospital
1. Any request for clinical privileges that are either new to the Hospital, or that overlap more than one Clinical Service, shall initially be reviewed by the appropriate Department, in order to establish the need for, and appropriateness of, the new procedure or service.
2. All such privileges will be processed in accordance with the Medical Staff policy on new privileges.

SECTION F. Locum Tenens
1. Upon receipt of a written application for specific temporary privileges, a practitioner of documented competence who is serving as a locum tenens (temporary substitution) for a Medical Staff member, and who is a member of the Medical Staff in good standing of another Joint Commission accredited New York State licensed Article 28 facility, may, without applying for membership on the Hospital Staff, be granted temporary privileges for an initial period of up to one-hundred and twenty (120) days, not to exceed two (2) such non-concurrent occurrences per year. The requirement of being a Staff member at another NYS Article 28 facility may be waived by the Medical Board. Such privileges may not exceed his/her service as locum tenens, and shall be limited to treatment of Patients of the practitioner or practitioner group for whom s/he is serving as locum tenens.
2. S/he shall not be entitled to admit his/her own patients to the Hospital.
ARTICLE VII

DISCIPLINARY PROCEDURES

SECTION A. General

Disciplinary action, including suspension, probation for a definite period not to exceed one (1) year, dismissal, censure or such other action as may be appropriate, may be imposed against any Practitioner who:

1. fails to demonstrate an acceptable level of professional competence or clinical judgment in the treatment of Patients;
2. commits an act, which constitutes professional misconduct under the New York State Education law or a breach of professional ethics;
3. fails to abide by a material provision of these Bylaws, Rules and Regulations of the Medical Staff or Medical Center, including the Hospital’s Information and Confidentiality policies and the Medical Center’s Code of Conduct;
4. Engages in any activity that is a threat to the welfare or safety of Patients, employees, other staff members of the Medical Center;
5. For all House Staff and Clinical Fellows, the Hospital delegates the responsibility for disciplinary action through and including the applicable hearing and appellate review procedure to the Office of Academic Affairs, as set forth in its “Academic Remediation, Institutional Probation and Adverse Actions Affecting Residents” policy.
6. The disciplinary policy and procedures set forth in this Article VII, and the Academic Remediation, Institutional Probation and Adverse Actions affecting Residents policy, including the applicable hearing and appellate review proceedings conducted thereto, are part of the Hospital’s Quality Assurance Program. The proceedings are conducted in accordance with the New York Public Health Law Section 2805 and the New York Education Law to promote the quality of patient care through peer review.

All requests for disciplinary action, summary suspension, and automatic administrative suspension/termination will be reviewed by the Office of Legal Affairs to ensure compliance with applicable New York State and federal reporting requirements.

Subsection 1: Investigation

1. Whenever, on the basis of information and belief, the Chairperson of the Medical Board, the Chief Medical Officer, the Department Chairperson, or the CEO has cause to question the clinical competence of any Practitioner or the known or suspected existence of any other basis for disciplinary action as defined above, an investigation may be initiated against the Practitioner as provided in this Section.
2. Such investigation shall be initiated by the Chairperson of the Medical Board or the Department Chairperson by forwarding a written request for such investigation to the Chief Medical Officer, which request shall include a description of the basis for initiation of the investigation. In any case in which a Department Chairperson is the subject of such an investigation, all functions of the Department Chairperson described in this Article VII shall be performed by the Chief Medical Officer. In any case in which the Chief Medical Officer is the subject of such an investigation, all functions of the Chief
Medical Officer as described in this Article VII shall be performed by the Chairperson of the Medical Board. In any case in which the Chairperson of the Medical Board is the subject of such an investigation, all functions of the Chairperson as described in this Article VII shall be performed by the Vice-Chairperson of the Medical Board.

3. After the investigation has been requested, the Chief Medical Officer, in consultation with the Department Chairperson, shall appoint an ad hoc fact finding committee to investigate the matter.
   a. This investigation shall not constitute a “hearing” as that term is used in Article VIII, nor shall the procedural rules with respect to hearings apply.
   b. The affected Practitioner shall have neither the right to be represented by legal counsel before the investigating body nor to compel the medical staff to engage external consultation.
   c. Despite the status of any investigation, the Medical Board shall at all times retain authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process, or other action.

4. The ad hoc committee shall consist of at least three (3) medical staff members, at least two (2) of whom are on the Active Staff and are active in clinical practice. The membership of the ad hoc committee must exclude the Department Chairperson, any members of the affected Practitioner’s Department, and any Staff members with a history of more than minimal professional or personal interaction with the Practitioner.

5. The affected Practitioner shall be advised in writing by the Chief Medical Officer of the appointment of the ad hoc committee and the basis for initiation of the investigation.

6. The affected Practitioner shall be entitled to an interview before the ad hoc committee.

7. The ad hoc committee shall conduct interviews and review documents, including medical records, as the ad hoc committee deems necessary or helpful to conduct the investigation. A record of all interviews shall be made. The ad hoc committee may require a physical and/or mental evaluation of the affected Practitioner in any investigation where the ad hoc committee sees reason to consider the physical or mental competency of the Practitioner. Such evaluation shall be carried out by the appropriate consultants and a report of the evaluation shall be forwarded to the Practitioner as well as to the ad hoc committee.

8. The ad hoc committee shall forward a written report of its findings and recommendations based on a majority vote, including recommendations as to whether or not grounds for disciplinary action exists, to the Department Chairperson, and to the Chief Medical Officer. The Chief Medical Officer shall forward a copy of the report to the Practitioner.

9. The ad hoc committee shall forward the records of its interview to the Chief Medical Officer, with copy to the CEO. The proceedings of the ad hoc committee shall be, so far as possible, confidential, but shall be retained as an institutional record.

Subsection 2: Determination

1. Upon receipt and review of the report of the ad hoc committee, the Department Chairperson shall confer with the Chief Medical Officer. If the report of the ad hoc committee recommends disciplinary action, or if the Department Chairperson in consultation with the Chief Medical Officer concludes that the facts recorded in the report warrant disciplinary action despite the failure of the ad hoc committee to
recommend disciplinary action, the Department Chairperson shall determine the disciplinary action to be imposed. The Department Chairperson may consult with the Credentials Committee (or a subcommittee of the Credentials Committee designated for this purpose by the Credentials Committee) and seek its recommendation with respect to the disciplinary action to be imposed.

2. The decision of the Department Chairperson and Chief Medical Officer shall be final, subject to notice and opportunity for a hearing pursuant to Article VIII hereof, and may include, without limitation:
   a. Determining no corrective action be taken;
   b. Deferring action for a reasonable time where circumstances warrant;
   c. Issuing letters of admonition, warning, reprimand, or censure to be placed in the Practitioner’s credentials file in the Medical Staff Office. In the event such letters are issued, the Practitioner may make a written response that shall be placed in his/her file in the Medical Staff Office;
   d. Requiring professional education or other training;
   e. Requiring the Practitioner to undergo a medical and/or psychiatric examination and/or to obtain professional counseling by a physician chosen by the Medical Board;
   f. Retrospective or prospective review of records;
   g. Setting fines;
   h. Entering into a binding remedial agreement from which no appeal is permitted but reporting may be required;
   i. Recommending the imposition of terms of probation or limitation upon continued medical staff membership or the exercise of clinical privileges including, without limitation, requirements for co-admission, mandatory consultation, or monitoring or supervision;
   j. Recommending reduction, modification, suspension, or revocation of clinical privileges;
   k. Application of a mandatory concurring consultation requirement or increase in the stringency of a pre-existing mandatory consultation requirement when such applies only to an individual medical staff member and is imposed for more than fourteen (14) days;
   l. Recommending reduction or limitation of any prerogatives directly related to membership on the medical staff;
   m. Recommending suspension, modification, probation, or revocation of medical staff membership;
   n. Recommending termination of medical staff appointment or denial of reappointment;
   o. Or any other appropriate corrective action.

Subsection 3: Notice
1. If the Department Chairperson and the Chief Medical Officer determine that disciplinary action should be imposed, the Department Chairperson shall send the Practitioner written notice, via certified mail return receipt requested, of the:
   a. proposed disciplinary action;
   b. reason for the decision;
c. In cases of j. through n. above only, Practitioner’s rights under Article VIII including the right to request a hearing on the decision within thirty (30) days of the receipt of the Practitioner’s notice of the decision.

2. The Chief Medical Officer shall continue to keep the CEO fully informed of all action taken in connection with such an investigation.

Subsection 4: Finality of Disciplinary Action
1. The disciplinary action shall not become final until either:
   a. The time to request a hearing or appeal regarding such action has lapsed, or
   b. The resolution of all hearing and appeal procedures provided in Article VIII.
2. Actions taken which do not entitle the Practitioner to a hearing and appellate review shall be reported by the President/Chief Executive Officer to the Board of Directors for informational purposes.

SECTION B. Summary Suspension
Subsection 1: Determination
1. The Department Chairperson, after consultation with the Chief Medical Officer, may summarily suspend the admitting and/or clinical privileges, or specific admitting or clinical privileges, of any Practitioner where the failure to take such action may, in the opinion of the Department Chairperson and/or the Chief Medical Officer, result in an unacceptable risk of harm to any individual or the Medical Center.
2. Unless otherwise stated, such summary suspension shall become effective immediately upon imposition.

Subsection 2: Notice
1. If the Department Chairperson summarily suspends a Practitioner’s privileges, the Practitioner shall be notified verbally by the Department Chairperson and Chief Medical Officer; followed thereafter promptly in writing (via certified mail, return receipt requested) of the:
   a. Summary suspension;
   b. Reason for the decision;
   c. Practitioner’s right to request a hearing on the decision in the manner provided by Article VIII, within thirty (30) days of receipt by the Practitioner of notice of the decision; and
   d. Practitioner’s rights under Article VIII.
2. Copy of written notice will be sent to the Chairperson of the Medical Board, Office of Legal Affairs, the CEO and Medical Staff Office.
3. If the Practitioner does not request a hearing within the thirty (30) days of receipt of the written notice, the terms of the summary suspension shall become final. However, in any event, the terms of such suspension shall remain in effect until a final determination.

SECTION C. Automatic Administrative Suspension or Termination
Subsection 1: Automatic Termination
1. A Practitioner shall be automatically terminated from the Staff if:
   a. His/her license to practice his/her profession has been revoked or suspended;
   b. S/he fails to maintain malpractice insurance coverage;
c. S/he is excluded from participation in Medicare, Medicaid or other federally funded health insurance plan;
d. A conviction or guilty plea in a healthcare fraud action;
e. Material misstatements or omissions on appointment or reappointment applications and any materials submitted in support thereof will be grounds for automatic suspension or termination from the Medical Staff for which the applicant shall have no right of appeal granted under these Bylaws.

2. Any Practitioner who remains on suspension for a period of ten (10) weeks shall be automatically terminated from the Hospital Staff.

3. There shall be no appeal process for automatic termination.

**Subsection 2: Automatic Suspension**

1. A temporary suspension of all or any portion of admitting and/or clinical privileges may be imposed by the Chairperson of the Medical Board or the Chief Medical Officer if:
   a. The Practitioner’s drug enforcement administration controlled substance registration number is revoked, he/she shall immediately and automatically be divested of his/her right to prescribe substances governed by that number and the same divestiture shall be automatic upon suspension of the Practitioner’s drug enforcement administration control substances registration number or when he/she is placed on probation with respect to the use of said number. Whenever such registration is suspended or revoked, the Practitioner’s staff membership and clinical privileges shall be immediately and automatically suspended for at least the term of the suspension;
   b. The Practitioner’s license, certificate or other legal credential authorizing him/her to practice in the State of New York is limited or restricted by the applicable licensing or certifying authority. Those clinical privileges which he/she has been granted and which are within the scope of said limitation or restriction shall be immediately and automatically revoked. Whenever such legal credentials are suspended, his/her staff membership and clinical privileges shall be immediately and automatically suspended for at least the term of the applicable licensing or certifying authority’s suspension. The procedural mechanisms afforded by Article VIII of these Bylaws are not available for such suspension and/or subsequent resignation;
   c. The Practitioner’s license, certificate or other legal credential authorizing him/her to practice in the State of New York has expired and the Practitioner has not provided the Medical Staff Department with such a renewed credential (a “lapse”), his/her Medical Staff membership and clinical privilege shall be immediately and automatically suspended;
   d. The Practitioner fails to provide documentation as to adequate levels of malpractice insurance coverage;
   e. Malpractice insurance coverage is not maintained during any leave of absence which may be approved by the Department Chairperson;
   f. The Practitioner at any time does not have on file with the Medical Center a current signed Physician Acknowledgment of the Notice to Physicians, as required for reimbursement under Federal and New York State laws and regulations;
   g. The Practitioner fails, after receiving a certified letter, return receipt requested, to forward to the Medical Center by the date indicated any document required under
Federal, State or local laws or regulations for credentialing or for reappointment to the Staff;

h. The Practitioner fails to complete a New York State mandated course after two weeks notice that failure to complete the program will lead to automatic suspension;

i. The Practitioner fails to comply with the Rules and Regulations regarding consultation, coverage and emergency admissions;

j. The Practitioner fails to complete medical records within thirty (30) days of a Patient’s discharge, after warning of such delinquency by Medical Records Department;

In the event the Practitioner has been suspended for six (6) consecutive months, or for six (6) months in any one calendar year for failing to complete medical records, the Practitioner shall be deemed to have resigned from the Medical Staff. Any such Practitioner must therefore seek admission to the Medical Staff ab initio. The procedural mechanisms afforded by Article VIII of these Bylaws are not available for such suspension and/or subsequent resignation for failure to complete medical records.

k. The Practitioner fails to submit CMS mandated time-sheets after two (2) weeks notice that failure to complete these will lead to automatic suspension;

l. The Practitioner fails to complete a required course (i.e., HIPAA, Compliance) after two (2) weeks notice that failure to complete such course will lead to automatic suspension;

m. Unless excused for cause by the Medical Board, the failure to meet the Staff attendance requirements shall be grounds for corrective action leading to revocation of Medical Staff membership. Reinstatement of staff members whose membership has been revoked because of absence from staff meetings shall be made only upon application, and all such applications shall be processed in the same manner as applications for original appointment.

2. If the recommendation is for suspension for longer than one (1) week, the Practitioner shall be notified in writing, via certified mail, return receipt requested, of the:

a. suspension;

b. reasons for the decision;

c. Practitioner’s rights under Article VIII, including the right to request a hearing on the decision within thirty (30) days of the receipt by the Practitioner of the notice of the decision.

Temporary suspension under this Section shall be in addition to, not in lieu of, any disciplinary action that may be recommended pursuant to Article VII., Section A. The affected Practitioner shall not be entitled to the hearing and appellate review provided in Article VIII of these Bylaws if suspended pursuant to an automatic suspension.

Subsection 3: Care of Suspended/Terminated Practitioner’s Patients
Immediately upon the imposition of a summary suspension or termination, the responsible Department Chairperson, or designee, shall have authority to assign to another individual
with appropriate clinical privileges responsibility for the care of the suspended individual’s Patients still in the Hospital. The assignment shall be effective until such time as the Patients are discharged. The wishes of the Patients shall be considered in the selection of such alternative Practitioner.

SECTION D. Notice to Hospital of Disciplinary Proceedings and/or Actions
The Practitioner is obligated to immediately inform the Medical Center of any proceedings pending and/or disciplinary actions taken or malpractice claims, suits, settlements or arbitration proceedings taken by New York State, another state, or any health facility with which the Practitioner is/was affiliated. Failure to do so may result in disciplinary action.

SECTION E. Institutional Reporting Requirements
1. Whenever any denial, suspension, restriction, termination or curtailment of training, employment, association or professional privileges or the denial of certification of completion of training of any physician, registered physician’s assistant or specialist licensed/registered by the NYS Department of Education (“NYSDOE”) is for reasons related in any way to any of the following:
   a. Alleged mental or physical impairment, incompetence, malpractice, misconduct or endangerment of patient safety or welfare; or
   b. Voluntary or involuntary resignation or withdrawal of association or of privileges with the Hospital to avoid the imposition of disciplinary measures; or
   c. The receipt of information concerning conviction of a crime,

the Medical Center, through its Chief Medical Officer or his/her designee, shall make a report in writing to the NYS Department of Health (“NYSDOH”) within thirty (30) days after the occurrence.

The Medical Center shall make such other reports to NYSDOH and such agencies as may be required by New York State, Federal and local law.

2. The Medical Center, through its Chief Medical Officer or his/her designee, shall make a report to the NYSDOE in writing within thirty (30) days after the occurrence of any of the following: any denial, withholding, curtailment, restriction, suspension or termination other than automatic administrative termination of any membership or professional privileges in employment by, or any type of association with a hospital relating to an individual who is a health profession student serving in a clinical clerkship, an unlicensed health professional serving in a clinical fellowship or residency, or an unlicensed health professional practicing under a limited permit or a state licensee such as an audiologist, certified social worker, dental hygienist, dentist, nurse, occupation therapist, ophthalmic dispenser, optometrist, pharmacist, physical therapist, podiatrist, or speech-language pathologist which is for reason related in any way to any of the reasons stated in Section E.1. above.

SECTION F. Practitioner’s Reporting Requirements
1. It is the obligation of every Practitioner and any person licensed pursuant to Title VIII of the NYS Education Law to report to the Office of Professional Medical Conduct any
information which such person has which reasonably appears to show that a physician (or physician assistant or specialist assistant) is guilty of professional misconduct as defined under applicable law.

2. It is the obligation of every Practitioner and any person licensed pursuant to Title VIII of the NYS Education Law to report to the Office of Professional Discipline any information which such person has which reasonably appears to show that a licensed Practitioner (other than a physician, physician assistant or specialist assistant) is guilty of professional misconduct as defined under applicable law.

3. These obligations may be discharged by reporting such information to the Chairperson of the Medical Board, the Department Chairperson, the Chief Medical Officer, or the Office of Legal Affairs who shall initiate a review of the facts in accordance with the Bylaws of the Medical Staff and who shall make such reports to governmental and professional agencies as are required by State, Federal and local law.

4. In the event that circumstances suggesting a deterioration of a Practitioner’s level of physical or mental competency shall come to the attention of any Hospital administrator or other personnel licensed pursuant to Title VIII of the NYS Education Law, it shall be the responsibility of that person to report it to the Chairperson of the Medical Board, or the appropriate Department Chairperson or to the Chief Medical Officer, and Office of Legal Affairs.
ARTICLE VIII

HEARING AND APPELLATE REVIEW PROCEDURE

SECTION A. Right to Hearing and Appellate Review
Except as otherwise provided in these Bylaws, any Practitioner who has received notice of a non-reappointment, curtailment of privileges, or proposed disciplinary action, or who has been the subject of a summary or automatic suspension pursuant to Article VII or whose application for additional privileges has been denied is entitled to a hearing and appellate review pursuant to the procedure set forth in this Article VIII.

SECTION B. Request for Hearing
1. The Chief Medical Officer shall be responsible for giving prompt written notice of an adverse recommendation or action to any affected Practitioner who is entitled to a hearing by certified mail, return receipt requested.
2. Failure of the Practitioner to request a hearing within thirty (30) days after receipt of such notice shall be deemed a waiver of the right to a hearing. A request for a hearing shall be made in writing to the Chief Medical Officer by certified mail, return receipt requested.
3. No individual who is in direct economic competition with the Practitioner, who has actively participated in the initiation of the adverse recommendation or action, or who has a history of more than minimal professional or personal interaction with the Practitioner shall be qualified to participate in the hearing as a member of the Professional Conduct Committee.

SECTION C. Notice of Hearing
1. Within ten (10) days after receipt of the request for hearing from a Practitioner entitled to the same, or from a Department Chairperson or the Chief Medical Officer pursuant to Article VI hereof, the Professional Conduct Committee shall schedule and arrange for such a hearing to commence and shall give the Practitioner notice of hearing and of the time, place and date so scheduled by certified mail, return receipt requested. The first hearing date shall be not less than thirty (30) days and not more than forty-five (45) days from the date of the receipt by the Practitioner of the notice of hearing except where the hearing has been requested in connection with a summary suspension, in which event, the Practitioner may request an expedited hearing, and, upon receipt of a proper and timely request for an expedited hearing on a summary suspension, the date of the hearing shall be no later than fifteen (15) days from the date the request for hearing is received.
2. The notice of hearing shall state in concise language the acts or omissions with which the Practitioner is charged and/or the other reasons or subject matter that was considered in making the adverse recommendation or decision; the notice of hearing shall also include a list of witnesses expected to testify at the hearing at the request of the Professional Conduct Committee. The notice of hearing shall have appended a copy of Article VIII.
3. If the hearing is continued, the Practitioner shall be advised of the date, time and place of each session of the hearing. If, in the course of the hearing, the Professional Conduct Committee concludes it is necessary to hear additional witnesses whose names were not included in the notice of hearing, the Professional Conduct Committee shall advise the Practitioner of the names of any such additional witness(es) in a timely manner.
The notice required under this Section C, Subsection 3., shall be given to the Practitioner in the same manner and within the same time frame that such notice is given to the members of the Professional Conduct Committee.

SECTION D. Conduct of Hearing Before the Professional Conduct Committee

1. No individual who is in direct economic competition with the Practitioner, who has actively participated in the initiation of the adverse recommendation or action, or who has a history of more than minimal professional or personal interaction with the Practitioner shall be qualified to participate in the hearing as a member of the Professional Conduct Committee. Attendance at a meeting of the Medical Board or its committees at which the recommendation, act or related facts were discussed or acted upon shall not of itself disqualify a member of the Professional Conduct Committee. There shall be at least fifty percent plus one (50% +1) of the members of the Professional Conduct Committee present when any session of the hearing takes place. If it appears to the Chairperson of the Professional Conduct Committee that fifty percent plus one (50% +1) of the members of the Professional Conduct Committee cannot be present for all sessions of the hearing and the voting, the Chairperson of the Medical Board may appoint another member of the Active Staff who is not in direct economic competition with the Practitioner and who has not actively participated in the initiation of the adverse recommendation or action to substitute for a member whose absence is anticipated.

2. The Chairperson of the Professional Conduct Committee, or a designee thereof, shall preside over the hearing and determine the procedures. The Professional Conduct Committee shall make rules it deems necessary to assure prompt, fair and expeditious handling of the appeal. The Professional Conduct Committee shall be permitted to have legal counsel present during the hearing.

3. At the hearing, the Practitioner may elect to be accompanied or represented by an attorney or other person of his or her choice. The role of this representative shall be limited to: (1) providing advice and counsel to the Practitioner; and (2) addressing the members of the Professional Conduct Committee. The role of the representative shall not include the presentation of evidence or the questioning of witnesses; provided, that the Professional Conduct Committee may, in its discretion, further define, expand or limit the role of any such representative.

4. The rules of law relating to the examination of witnesses or presentation of evidence shall not apply. Any relevant matter upon which responsible persons may rely in the conduct of serious affairs shall be considered.

5. Postponement of hearings beyond the time set forth in these Bylaws shall be made only with the approval of, and in the sole discretion of, the Professional Conduct Committee.

6. All testimony of the hearing shall be made under oath and a transcript of the hearing shall be made. A copy of such transcript shall be provided to the Practitioner within the same time frame that it is provided to the Professional Conduct Committee.

7. The personal presence of the Practitioner for whom the hearing has been scheduled shall be required. Failure of appearance without good cause shall be deemed a waiver of the Practitioner's right to the hearing provided in this Article VIII, and shall be considered an acceptance of an adverse decision.
8. No later than ten (10) days prior to the scheduled date of the hearing, the Practitioner and the party initiating the adverse recommendation or action shall each submit to the Chairperson of the Professional Conduct Committee two (2) copies of:
   a. all documents the party wishes to be considered by the Committee;
   b. a written statement setting forth the party’s position; and
   c. a list of names of witnesses that will be called by that party to testify at the hearing together with copies of the curriculum vitae of any witness being called as an expert.

Upon receipt of material from both parties, the Chairperson of the Professional Conduct Committee shall provide one copy of all submitted material to the other party. Two (2) copies of any supplemental documentation; including but not limited to written rebuttal statements and names of additional witnesses expected to be called to testify at the hearing, shall be submitted by the parties to the Chairperson of the Professional Conduct Committee no later than three (3) working days prior to the scheduled date of the hearing. Upon receipt of rebuttal material, if any, from both parties, the Chairperson of the Professional Conduct Committee shall provide one (1) copy of all submitted material to the other party. Additional witnesses and documentary evidence shall be permitted at the hearing in the discretion of the Professional Conduct Committee. All documents shall, insofar as possible, be treated as confidential.

9. The Practitioner shall have the right to introduce in writing evidence and rebuttal evidence. The Practitioner shall also have the right to request the presence of Medical Center witnesses and to question any witness, either by putting questions directly to the witness or by asking questions through members of the Professional Conduct Committee. The method shall be determined by the Professional Conduct Committee and may be altered by it at any time. If the Practitioner does not testify on his/her own behalf, the Practitioner may be called and examined by the Professional Conduct Committee at the request of any member of the Professional Conduct Committee.

10. The Practitioner and the party initiating the adverse recommendation or action shall each be entitled to submit memoranda concerning any issue of procedure or fact, and such memoranda shall become a part of the hearing record. Each party shall also have the right to submit a written statement after all witnesses have been heard by the Professional Conduct Committee. If a party elects to submit such a statement, the party shall so advise the Chairperson of the Professional Conduct Committee within five (5) days after the conclusion of all testimony and shall submit such statement within ten (10) days after the conclusion of testimony.

11. Within ten (10) days after the conclusion of all testimony or after receipt of the statements as provided above, if any, whichever is later, the Professional Conduct Committee shall convene to consider all the testimony, evidence and memoranda, if any, received by the Professional Conduct Committee and reach its conclusions by a majority vote. The Professional Conduct Committee shall prepare a written report of its recommendations, which report shall include a statement of the basis for such recommendations determining whether the adverse action was arbitrary and capricious. The recommendation may be to confirm, modify or reject the adverse recommendation under consideration.
12. Only members who have been present for all the testimony or who, having been present for a majority of testimony, have reviewed a written transcript of the testimony for which they were not present, may vote; no member may vote by proxy.

13. The Professional Conduct Committee shall forward its written report together with a hearing record and all of the documentation to the Chief Medical Officer within thirty (30) days after the close of testimony or after receipt of the Practitioner's statement, if any, whichever is later. Chief Medical Officer shall forward a copy of the report to the Medical Board, to the Practitioner, and to the Department Chairperson. No later than at the next regularly scheduled meeting, the ECMB shall then decide whether to accept, reject or modify the Professional Conduct Committee's recommendation or to remand the matter for further consideration. The transcript of the hearing, together with all exhibits and related documentation, shall be available for review in the Office of the Chief Medical Officer by any member of the ECMB. The ECMB shall also have the right to request the appearance before it of the Practitioner, the Chairperson of the Professional Conduct Committee or other persons to assist the ECMB in its deliberations. Members of the ECMB who actively participated in the initiation of the adverse recommendation or action or who are in direct economic competition with the physician shall not vote. The decision of the ECMB shall be effective immediately or as of such other date specified in the minutes of the meeting of the ECMB and final, subject only to the right of appeal in Section E. of this Article VIII. The ECMB shall forward a copy of the decision, including a statement of the basis therefore, to Chief Medical Officer. The Chief Medical Officer shall promptly notify the affected Practitioner of the ECMB's decision and of the Practitioner's status by certified mail, return receipt requested.

SECTION E. Appeal to the Board of Directors

1. The decision of the ECMB may be appealed to MPAC by the Practitioner, the party initiating the adverse recommendation or action or by the Chairperson of the Professional Conduct Committee, acting on behalf of the Professional Conduct Committee. A request for appellate review shall be sent in writing to the Chief Medical Officer by certified mail, return receipt requested within ten (10) days after receipt of the decision of the ECMB. If no request for appeal is made within such ten (10) day period, the decision of the ECMB shall become final. Appellate review shall be conducted on the written record on which the adverse recommendation is based and upon such other written documentation as the Practitioner or the Appellate Review Committee shall submit as provided in Section E., Subsection 3 below. The scope of review shall be limited to determining whether there is a reasonable basis on which to support the findings and conclusions of the ECMB.

2. Promptly after receipt of such a notice of request for appellate review, the Chief Medical Officer shall notify the Chairperson of the Medical Board and the Chairperson of MPAC of the request for appeal.

3. The person making the appeal and the person opposing the appeal each shall have access to the report and record of the Professional Conduct Committee and all other material that was considered in making the adverse recommendation, and each shall have five (5) days to submit a written statement in his/her own behalf, in which those factual and procedural matters with which the person agrees or disagrees and the reason for such agreement or disagreement shall be specified.
4. An Appellate Review Committee consisting of at least three (3) persons, who are members of the MPAC and two (2) members of the Medical Board but not members of the ECMB or the Professional Conduct Committee, appointed for such purpose by the Chairperson of the Medical Board, shall review the record created in the proceedings and any statements provided pursuant to Section E., Subsection 3., above, for the purpose of determining whether or not there is reasonable basis on which to support the findings and conclusions of the ECMB. The Appellate Review Committee shall at any time make rules it deems necessary to assure prompt, fair and expeditious handling of the appeal, such Appellate Review Committee shall report its recommendations to the MPAC.

5. Within thirty (30) days after the conclusion of the appellate review, MPAC shall make its final decision in the matter to either accept, reject or modify the Appellate Review Committee’s recommendation, by majority vote at a meeting at which a quorum is present, and shall send notice thereof to the Professional Conduct Committee and, through the Chief Medical Officer, to the affected Practitioner, by certified mail, return receipt requested. If the decision is adverse, it shall be immediately effective and final, and shall not be subject to further review.

SECTION F. Interpretation of Rules
The foregoing procedures are intended to establish fair and reasonable guidelines to be followed by the Medical Board and their respective committees. Breaches of such rules shall be grounds for a new proceeding only if the breach is of such a material nature that the validity of the result is prejudiced.
ARTICLE IX

MEDICAL BOARD AND OFFICERS

SECTION A. Medical Board
1. The Medical Board of NuHealth shall consist of the CEO of NuHealth, ex-officio nonvoting, the Chief Medical Officer, the Medical Director and Associate Medical Director of any hospital or other Article 28 facility owned or controlled by NuHealth, now or in the future; the Officers of the Medical Board, the Officers of the Medical Staff, the Chairperson of MPAC, ex-officio, nonvoting, the Chief Financial Officer, ex-officio nonvoting, the Department Chairpersons, the Chief Nursing Officer, ex-officio voting, the Chief Compliance Officer, ex-officio nonvoting, the V.P. Quality Management, ex-officio nonvoting, the Chairpersons of All Standing Medical Board Committees, the Designated Institutional Officer, ex-officio nonvoting, if not a member of the Active Medical Staff, two (2) representatives of the House Staff, ex-officio nonvoting, and four (4) other members of the Medical Staff, who shall be members-at-large elected at the annual meeting of the Medical Staff for a term of two (2) years. The ex-officio nonvoting members may designate an alternate to attend these meetings.

2. The Medical Board shall conduct all business of the Medical Staff organization, and shall have general charge and supervision of the professional conduct of the hospitals, clinics and institutes of the Medical Center. It will coordinate the activities and general policies of the various Departments; receive and act upon Committee reports; implement policies of the Staff not otherwise the responsibility of the Departments; provide liaison between the Medical Staff, the Chief Medical Officer, the Chief Executive Officer and the Board of Directors; recommend action to the Chief Medical Officer and Chief Executive Officer on matters of a medico-administrative nature; review of clinical contracts, review the credentials of all applicants and make recommendations for staff membership; review periodically all information available regarding the performance and clinical competency of staff members and other practitioners with clinical privileges and, as a result of such reviews, make recommendations for reappointments and renewal or changes in clinical privileges; take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all members of the Staff, including the initiation of and/or participation in Medical Staff corrective or review measures when warranted.

3. The CEO of NuHealth shall appoint a physician as the Chief Medical Officer who is qualified for membership on the Medical Center Staff and who shall also serve as the Medical Director of the Nassau University Medical Center and be responsible for directing the Hospital Staff organization. Such appointment shall be made after consultation with the Medical Board and approval by the Board of Directors. The Chief Medical Officer acts as liaison between the Hospital’s governing and administrative bodies and its medical staff and between the Hospital and regulatory and accrediting agencies.

The Chief Medical Officer is:
   a. a member of the Executive Committee of the Medical Board;
b. responsible through the CEO to the Board of Directors and for working with and assisting the Chairperson of the Medical Board and providing assistance to the Department Chairpersons;

c. responsible for the quality and safety of patient care provided in or under the auspices of the Hospital and promoting the integration of patient care, education and research by fostering relationships that bring the newest innovations in research to the bedside, working collaboratively with leaders to ensure translation of that integration into both an ideal educational experience for training and education as well as the highest quality of care; and

d. expected to develop and recommend changes in policy, facilities, equipment and programs that affect patient care, lead the medical staff and clinical programs, and work closely with the Medical Board.

The Chief Medical Officer will:

a. monitor the activities of the standing committees of the Medical Board;

b. enforce and implement the Medical Staff Bylaws and Rules and Regulations;

c. implement and assure compliance with Hospital Bylaws and required policies from regulatory and accrediting agencies;

d. represent the medical staff to governing and administrative bodies of the Hospital keeping each informed on issues of mutual concern;

e. monitor all medical staff activities and report the findings periodically to the Hospital governing board and administration;

f. establish and maintain ongoing analysis and evaluation of medical staff performance in all Services;

g. ensure professional standards and criteria regarding appointment and reappointment to the Medical Staff and privileging;

h. provide guidance to the Department Chairpersons and committees in establishing and fulfilling proper functions of the medical staff;

i. promote compliance of the medical staff with the Hospital’s service standards;

j. participate in the continuing development, implementation and utilization of clinical information technology;

k. establish and monitor the extensive procedures required by The Joint Commission, Centers for Medicare and Medicaid Services (“CMS”) and the NYS Department of Health for documentation of the professional qualifications and performance of the medical staff, and the quality of patient care provided in all clinical services;

l. be an active member in the planning process for facility renovation and development;

m. collaborate with nursing and clinical services to ensure that a multidisciplinary, integrated approach to patient care is continuously provided;

n. establish a culture of respect and collaboration, reinforcing the organization’s core values into relationships between all care providers and other professional staff, and promote the use of effective teams.

4. The Medical Director of any hospital or other Article 28 facility owned or controlled by NuHealth, now or in the future, will be appointed by the Chief Medical Officer in
consultation with the Senior Administrator of such hospital or Article 28 facility and the CEO of NuHealth; reports to the Chief Medical Officer and to the Senior Administrator of any such hospital or other Article 28 facility owned or controlled by NuHealth; is responsible for day to day coordination of medical staff affairs, clinical quality improvement activities, care coordination, utilization management, risk management and infection surveillance and control at such hospital or Article 28 facility.

5. The Medical Board shall make recommendations to the Board of Directors and the leadership of NuHealth regarding the welfare and management of the hospitals, health centers and institutes. The Medical Board shall provide professional care and treatment for Patients in accordance with the highest standards of medical science. Members of the Medical Board shall be eligible to vote, to serve on Medical Board committees, and shall be required to attend Medical Board meetings.

SECTION B. Officers
1. The Officers of the Medical Board shall be Chairperson, Vice Chairperson, Past Chairperson and Secretary.
2. The Officers of the Medical Staff shall be the President, Vice-President, Secretary and Treasurer.

SECTION C. Qualification of Officers
Officers must be members of the Active Attending Staff holding rank of Active Attending at the time of nomination and election, and must remain members in such Good Standing during their term of office.

SECTION D. Election of Officers of the Medical Board
At the meeting of the Medical Board immediately following the Annual Meeting of the Medical Staff, the Medical Board shall elect the Officers of the Medical Board, as applicable.

SECTION E. Election of Officers and At-Large Members of the Medical Staff
1. Officers and At-Large Members of the Medical Staff shall be elected at the Annual Meeting of the Medical Staff (the “Annual Meeting”). Members of the Active Attending Staff shall be eligible to vote.
2. At least two (2) months prior to the Annual Meeting, the President shall recommend to the Medical Staff a Nominating Committee consisting of three (3) members, whose duty it shall be to nominate candidates for election as Officers of the Medical Staff and as members-at-large of the Medical Staff. None of the members of the Nominating Committee shall be Officers of the Medical Board or the Medical Staff, and not more than one (1) shall be a member of the outgoing Nominating Committee. Their list of nominations shall be sent to each member of the Active Attending Staff at least four (4) weeks prior to the Annual Meeting.
3. Nominations may also be made from the floor at the time of the Annual Meeting, or by petition signed by at least five (5) members of the Active Attending Staff and filed with the Secretary at least ten (10) days prior to the Annual Meeting.
4. For a nominee to be elected to a Medical Staff office, s/he must receive a majority of the votes of those participating in the election.

SECTION F. Term of Office
All Officers and At-Large Members of the Medical Staff shall serve a two (2) -year term from their election date or until a successor is elected. Officers and At-Large Members shall take office on the date of their election. No Officer or At-Large Member of the Medical Staff shall be elected to the same office for more than two (2) successive full terms without a lapse of at least one (1) year. Each year, two (2) new members at-large shall be elected to provide for staggered terms.

SECTION F. Vacancies in Office
Except for the Chairperson of the Medical Board, vacancies in officer during the year shall be filled by Medical Board appointments. If there is a vacancy in the office of the Chairperson, the Vice-Chairperson shall serve out the remaining term.

SECTION G. Duties of Officers
1. Medical Board
   • Chairperson
     The Chairperson’s duties shall include:
     1. presiding at Medical Board meetings;
     2. serving as chairperson of ECMB, preparing agendas in consultation with the Chief Medical Officer, and presiding at meetings;
     3. serving, consulting and advising other committees as an ex-officio member with power to vote;
     4. appointing committee members and chairpersons as required by these Bylaws;
     5. advising the Chief Medical Officer on matters affecting the Medical Staff and the Services;
     6. transmitting to the appropriate authority medical staff views, concerns and recommendations on matters affecting policy, planning, operations, governance and relationships with external agencies;
     7. serving on the QPAC Committee; and
     8. The Chief Medical Officer, Medical Director(s) and Associate Medical Director(s) are prohibited from serving as Chairperson (and Vice-Chairperson) of the Medical Board.

   • Vice-Chairperson
     In the absence of the Chairperson, the Vice-Chairperson shall perform all duties and have all authority of the Chairperson. The Vice-Chairperson shall also perform such duties as are assigned by the Chairperson. During the Chairperson’s last year in office, the Vice-chairperson shall assume the office of Chairperson-Elect, and shall thereby be deemed to be the immediate successor to the Chairperson of the Medical Board, unless otherwise determined by the Medical Board, at its sole discretion.

   • Immediate Past Chairperson: Duties shall be advisory in nature.

   • Secretary
     The Secretary shall assure that accurate and complete minutes are kept of all meetings, call meetings on order of the Chairperson, attend to correspondence, and perform such other duties as ordinarily pertain to his/her office. In the absence of the Chairperson and Vice Chairperson, the Secretary shall assume all of the duties and have the authority of the
Chairperson. S/he shall keep the minutes of the ECMB meetings and be the custodian of their records; shall maintain a register of the membership of the Medical Board, the ECMB and all standing and special committees; notify the Officers of the Medical Board and members of committees of their elections or appointment, and send notices to the membership of all meetings of the Medical Board and ECMB. S/he shall keep the official copy of the Medical Staff Bylaws, Rules and Regulations and other official documents of the Medical Staff. S/he shall also perform such other duties as may be assigned to him/her by the Chairperson and shall be the secretary of the ECMB.

2. Medical Staff
   - **President**
     The President of the Medical Staff shall preside at the Annual Meeting and any Special Meetings of the Medical Staff; promote cooperation between the Medical Staff, Medical Board and Medical Center; represent the views, policies, needs and grievances of the Medical Staff to the Medical Board and vice-versa; serve as the Chairperson of the Professional Conduct Committee of the Medical Board; and shall be a member of the Medical Board.

   - **Vice-President**
     The Vice-President shall assist the President and perform such other duties as may be assigned to him/her by the President; in the absence of the President, shall perform the duties of the President; shall be a member of the Medical Board, and shall participate on a committee of the Medical Board.

   - **Secretary**
     The Secretary shall assure that accurate and complete minutes are kept of all meetings of the Medical Staff; call meetings on order of the President, attend to correspondence, and perform such other duties as ordinarily pertain to his/her office. In the absence of the President and Vice-President, the Secretary shall assume all of the duties and have the authority of the President. S/he shall maintain a register of the membership of the Medical Staff; notify the Officers of the Medical Staff of their elections, and send notices to the membership of all meetings of the Medical Staff. S/he shall also perform such other duties as may be assigned to him/her by the President, shall be a member of the Medical Board, and shall participate on a committee of the Medical Board.

   - **Treasurer**
     The Treasurer shall be accountable for all the funds of the Medical Staff entrusted to him/her; shall be responsible for the deposit of such funds; shall be responsible for the disbursement of such funds as approved by the Medical Board; shall be responsible for any necessary filings/submissions; shall be a member of the Medical Board; and shall participate on a committee of the Medical Board.

**SECTION H. Removal of Officers**

**Subsection 1. Authority and Mechanism**

1. Removal of any Officer may be effected by a majority vote of the members of the Medical Board present at a Special Meeting called for that purpose, provided that at least twenty (20) members of the Medical Board are in attendance at such meeting.
2. Removal of an Officer by a vote of the Medical Board shall be initiated upon a petition signed by five (5) members of the Medical Board. Such a petition shall be presented to the Chairperson of the Professional Conduct Committee. If the Chairperson is the subject of the petition, then it shall be presented to the Vice-Chair of this Committee. Upon receipt of such a petition, the Chairperson (or Vice-Chair as the case may be) of the Professional Conduct Committee shall refer the matter to a special committee composed of six (6) members of the Medical Board appointed by the highest ranking officer not the subject of the removal action. The Chief Medical Officer shall sit with this special committee as a non-voting participant. The special committee shall review the matter and report its recommendations and reasons therefore to the Medical Board at the next regularly scheduled meeting of the Medical Board. After receiving the special committee's report, the Medical Board shall vote on removal. The action of the Medical Board shall be the final decision in the matter.

3. The Officer who is the subject of the removal action shall be given ten (10) days prior written notice of the meeting of the Medical Board at which the vote on removal is to be taken and of the grounds therefore and shall be afforded the opportunity to speak on his/her own behalf before the Medical Board, prior to the taking of any vote on his/her removal.

Subdivision 2. Grounds

Permissible bases of removal of an Officer include, without limitation:

a. Failure to perform the duties of the position held in a timely and appropriate manner.

b. Failure to continuously satisfy the qualifications of the position.

c. Having an automatic or summary suspension imposed by operation of Article VII., Section B., or Section C of these Bylaws or a corrective action matter pursuant to Article VII., Section A., of these Bylaws resulting in a final decision other than to take no action.

d. Conduct or statements inimical or damaging to the best interests of the Staff or the Medical Center or to their goals, programs or public image.

e. Physical or mental infirmity that renders the Officer incapable of fulfilling the duties of his/her office, as determined pursuant to Article VII., Section B., of the Bylaws.
ARTICLE X
SERVICES

SECTION A. Services
1. The Staff shall be divided into Services as follows:
   a. Anesthesiology
   b. Cardiology
   c. Community Medicine
   d. Dentistry and Oral Surgery
   e. Emergency Medicine
   f. Family Medicine
   g. Medicine
   h. Neurology
   i. Obstetrics and Gynecology
   j. Ophthalmology
   k. Orthopedic Surgery
   l. Pathology & Laboratory Medicine
   m. Pediatrics
   n. Physical Medicine and Rehabilitation
   o. Psychiatry & Behavioral Science
   p. Radiology
   q. Surgery

2. Services may be organized or abolished from time to time by the Medical Board. Divisions of Services may be organized or abolished from time to time by the Department Chairperson, with the approval of the Chief Medical Officer.

SECTION B. Organization of Services
1. Each Service shall have as its head a Department Chairperson, who shall be responsible to the Medical Board and the Chief Medical Officer for the organization and operation of that Service. Each Department Chairperson shall be certified by an appropriate specialty board or have affirmatively established comparable competence through the credentialing process and shall be responsible for the appointment, reappointment, recommendation of clinical privileges and discipline of members of the Hospital Staff in his/her Service.

2. Each Department Chairperson is responsible to the Medical Board and the Chief Medical Officer for the day to day organization, operation and teaching functions of that Service, and shall have supervision and control over the quality of care provided to all Patients on that Service, including:
   a. Clinically related activities of the Service;
   b. Administratively related activities of the Service unless otherwise provided by the Hospital;
   c. Recommending clinical privileges for each member of the department;
   d. Continuing surveillance of the professional performance of all individuals in the Service who have delineated clinical privileges;
   f. Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the Service;
g. Assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization;

h. The integration of the Service into the primary functions of the organization;

i. The coordination and integration of interdepartmental and intradepartmental services;

j. The development and implementation of policies and procedures that guide and support the provision of care, treatment, and services;

k. The recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services;

l. The determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;

m. The continuous assessment and improvement of the quality of care, treatment, and services;

n. The maintenance of quality improvement programs, as appropriate;

o. The orientation and continuing education of all persons in the department or service;

p. Recommending space and other resources needed by the department or service;

q. The optimum utilization of hospital resources and patient flow to reduce length of stay and reduce reimbursement denials;

e. Ensuring that all service activities conform to applicable standards and regulations including those of NYSDOH, The Joint Commission, and CMS;

r. Ensuring compliance with ACGME/RRC guidelines;

s. Providing service coverage to support emergency care and in the Emergency Department; and

t. Preparing periodic reports to Hospital Administration as requested concerning the department’s operation and the quality of care aspects of the department.

SECTION C. Functions of Services

1. Each Service shall establish its own criteria for the granting of clinical privileges.

2. In addition, each Service shall be responsible for assuring and continuously improving the quality and safety of patient care delivered by its members and shall establish a Quality Assurance and Improvement Committee that shall meet at least quarterly. The Committee shall be maintain a record of its meetings and include any findings, conclusions, recommendations and actions taken. A copy of this record shall be submitted to the Department of Quality Management, the Chief Medical Officer, and Medical Director, as applicable.

3. The criteria and procedures utilized in the delineation of privileges and the peer review activity shall be consistent with the policies and procedures of the Medical Board and Board of Directors.

4. The Department Chairperson shall serve at the pleasure of the Board of Directors and upon termination the individual holding such position shall revert to his/her prior position, either as attending physician or the other position held prior to such appointment.
5. Department Chairperson may recommend the employment of certified physician assistants with privileges as described in the Rules and Regulations.
ARTICLE XI
COMMITTEES OF THE MEDICAL BOARD

Committees of the Medical Board shall be Executive, Standing and Special. All Standing and Special Committees of the Medical Board shall be responsible to the Medical Board. Members are expected to attend not fewer than two-thirds (2/3) of the meetings. Records of attendance will be maintained.

SECTION A. Executive Committee (“ECMB”)
1. The Medical Board may establish an Executive Committee of the Medical Board at any time these Medical Staff Bylaws are in force. The composition and number of members of such ECMB shall be determined by resolution of the Medical Board.
2. Except as otherwise specifically provided within these Bylaws, all powers of the Medical Board, when not in session, shall be vested in the Executive Committee.
3. ECMB, if formed, shall have no less than six (6) members and shall be comprised of, at a minimum: the Chairperson, Vice-Chairperson, Secretary, and President of the Medical Staff, Chief Medical Officer and Chief Nursing Officer.

SECTION B. Standing Committees of the Medical Board
At the first Medical Board meeting following the Annual Meeting, the Chairperson shall appoint, subject to Medical Board approval, the following Standing Committees and such other Standing Committees as may be deemed necessary:

1. Bylaws Committee
2. Cancer Committee
3. Credentials Committee
4. Critical Care Committee
5. Emergency Preparedness Committee
6. Environment of Care Committee
7. Executive Committee of the Medical Board
8. Graduate Medical Education Committee
9. Infection Prevention and Control Committee
10. Health Information Management Committee
11. Medical Ethics Committee
12. Nutrition Committee
13. Perioperative Services Committee
14. Performance Improvement Coordinating Group
15. Pharmacy and Therapeutics Committee
16. Professional Conduct Committee
17. Radiation Safety Committee
18. Tissue Review Committee
19. Blood Utilization Committee

The detailed functions and responsibilities of the above Committees are set forth in the Rules and Regulations of the Medical Staff and are, by reference, made part hereof.

SECTION C. Special Committees of the Medical Board
Special committees may be appointed by the Chairperson of the Medical Board in such number and of such composition as the Medical Board may deem necessary or desirable to properly carry out the responsibilities of the Medical Board. Such committees shall confine their activities to the purposes for which they were appointed, shall report to the Medical Board, and shall have only such power of action as is specifically granted by the Medical Board.
ARTICLE XII

MEDICAL BOARD and MEDICAL STAFF MEETINGS

SECTION A. Regular Meetings
The Medical Board shall hold its regular meetings once a month.

The Medical Staff shall hold meetings of the Staff semi-annually, 1st Wednesday in May and November. The Annual Meeting shall be held the 1st Wednesday in November each year. The Active Attending Staff, in Good Standing, shall be invited and permitted to vote on all matters presented at the meetings of the Medical Staff. The Secretary of the Medical Staff shall notify the members of the date, time and place at least ten (10) days prior to each meeting.

SECTION B. Special Meetings
Special Meetings may be called at any time by the Chairperson of the Medical Board or the President of the Medical Staff, provided forty-eight (48) hours notice is given. Special Meetings may be initiated at the request of the Chief Medical Officer, the Board of Directors, President/Chief Executive Officer, upon the written request of ten (10) members of the Medical Board or upon the written request of not less than five percent (5%) of the Staff stating the purpose for which the meeting is to be called. No business shall be transacted except that stated in the notice calling the meeting. The attendance of a member of the Medical Board or Medical Staff, as the case may be, at a meeting shall constitute a waiver of notice of such meeting.

SECTION C. Quorum
For meetings of the Medical Board, attendance of 25% of the members of the Medical Board shall constitute a quorum.

For Medical Staff semi-annual meetings- Fifty (50) Active Staff members in Good Standing shall constitute a quorum. However, once a determination has been made that a quorum is present at a Medical Staff meeting, the group does not lose its ability to transact business if members who were previously counted leave the meeting, thereby reducing the number of members physically present to less than 50, and are not present when the transaction of business takes place.

Absentee votes shall count towards a quorum only for the discussion of the question for which the absentee vote is presented. If an absentee vote is voided for any reason, it will no longer count towards a quorum.

SECTION D. Attendance Requirements
Records of attendance will be maintained. Members are expected to attend not fewer than two-thirds (2/3) of the meetings.
SECTION E. Voting Requirements
Unless otherwise specified in these Bylaws, the approval of any action taken or recommendation made by the Medical Staff at any Medical Staff meeting shall require a majority vote. Abstentions shall not be counted as votes cast.

Absentee voting by mail shall be allowed in Medical Staff elections. Ballots and return envelopes shall be mailed by the Secretary of the Medical Staff to the then existing Active Staff members in good standing with the notice of the meeting for which the vote will be called. Absentee votes must be received by the designated recipient no later than two (2) days prior to the meeting during which the official vote will take place. Absentee votes shall be counted and tallied prior to the Medical Staff meeting and the results shall be sealed. The results will only be revealed after the official vote has been taken at the Medical Staff meeting. All absentee ballots must be cast in writing and signed by the absent member. Those members having cast ballots shall be crossed off the membership roster to avoid duplication of votes at the meeting.

SECTION F. Agenda
1. The agenda at the Medical Board meetings shall be:
   a. Reading of the minutes of the last Regular and of any Special Meetings;
   b. Report of the ECMB;
   c. Communications;
   d. Report of the Chief Executive Officer;
   e. Report of the Chief Medical Officer;
   f. Report of the Medical Staff;
   g. Reports of other committees;
   h. Election of officers;
   i. Unfinished business;
   j. New business;
   k. Adjournment.

2. The agenda at the Medical Staff semi-annual meetings shall be:
   a. Reading of the minutes of the last Regular and of any Special Meetings;
   b. Communications;
   c. Election of officers;
   d. Unfinished business;
   e. New business;
   f. Adjournment.

3. The agenda at Special Meetings shall be:
   a. Reading of the notice calling the meeting;
   b. Transaction of business for which the meeting was called;
   c. Adjournment.
ARTICLE XIII

COMMITTEE AND SERVICE MEETINGS

SECTION A. Regular Meetings
1. Committees may establish the time for the holding of regular meetings by resolution. Such resolution supersedes the needs for notification of the individual meeting. In no event shall meetings be held less frequently than quarterly.
2. Services shall hold regular meetings at least monthly to review and evaluate the clinical care provided by the Service.

SECTION B. Special Meetings
A Special Meeting of any Committee or Service may be called by or at the request of the Chairperson, by the Chairperson of the Medical Board, by the Chief Medical Officer or by one third (1/3) of the group's then members, but not fewer than two (2) members.

SECTION C. Quorum

Forty percent (40%) of the Active Staff members of a Committee or Service, but not fewer than three (3) members, shall constitute a quorum at any meeting.

SECTION D. Conduct of Meetings
1. Minutes shall be kept of all meetings, with record copies and maintained on file within the Medical Center. Copies shall be sent to the Medical Board with recommendations.
2. Members are expected to attend not fewer than two-thirds (2/3) of the meetings for each Medical Board Committee appointment and not fewer than one-half (1/2) of the relevant Service meetings.
3. Records of attendance will be kept.

SECTION E. Rights of 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, unless otherwise specified.
ARTICLE XIV

IMMUNITY FROM LIABILITY

SECTION A. General
The following shall be express conditions to any Practitioner’s application for, or exercise of, clinical privileges at this Hospital:

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

2. that such privilege shall extend to members of the Staff and its governing body, its other Practitioners, its Chief Executive Officer and representatives thereof, and to third parties who supply information to any of the foregoing authorized to receive, release or act upon the same. For the purpose of this Article XIV, the term "third parties" means both individuals and organizations from which information has been requested by an authorized representative of the governing body or of the Staff.

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

4. that such immunity shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health care institution’s activities.

5. that in furtherance of the foregoing, each Practitioner shall, upon request of the Hospital, execute a release in accordance with the tenor and import of this Article XIV in favor of the individuals and organizations specified in paragraph 2 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 the laws of the State.

SECTION B. Peer Review Activities
Any physician or other member of the Staff who is asked to perform peer review activities on behalf of the Medical Center, and who does so without additional compensation for such activities, shall be afforded the same degree of legal protection by NuHealth with respect to legal claims arising out of such activities.

The following shall be express conditions to any Practitioner’s application for, or exercise of, clinical privileges at this Hospital:

First, that any act, communication, report, recommendation or disclosure, with respect to any such Practitioner, performed or made in good faith and without malice and at the request of an authorized representative of this or any other health care facility, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extent permitted by law.
Second, that such privilege shall extend to members of the NuHealth’s Medical Staff and of its Board of Directors, its other Practitioners, its President/CEO and his or her representatives, and to third parties, who supply information to any of the foregoing authorized to receive, release, or act upon the same. For the purpose of this Article XIV, the term “third parties” means both individuals and organizations from which information has been requested by an authorized representative of the Board of Directors or of the Medical Staff.

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

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

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

Sixth, that in furtherance of the foregoing, each Practitioner shall upon request of the NuHealth execute releases in accordance with the tenor and import of this Article XIV in favor of the individuals and organizations specified in paragraph Second 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 the laws of this State.

Seventh, that the consents, authorizations, releases, rights, privileges and immunities provided by Sections A and B of Article V of these Bylaws for the protection of this Hospital’s Practitioners, other appropriate hospital officials and personnel and third parties, in connection with applications for initial appointment, shall also be fully applicable to the activities and procedures covered by this Article XIV.
ARTICLE XV

RULES AND REGULATIONS

The Medical Center shall adopt such Rules and Regulations as may be necessary for the proper conduct of its work. Such Rules and Regulations may be amended at any meeting of the Medical Board by a majority vote of those present.
ARTICLE XVI

CONSTRUCTION

In the event of an inconsistency between any provision of these Bylaws and any provision of the Bylaws of any hospital or other Article 28 facility owned or controlled by NuHealth, now or in the future, the Bylaws of NuHealth shall take precedence.

In the event of any inconsistency between any provision of these Bylaws and any Rules or Regulations adopted by the Medical Board, these Bylaws shall take precedence.
ARTICLE XVII

ANNUAL DUES

1. All members of the Medical Staff shall be assessed annual dues. Members of the Emeritus, Courtesy-Teaching, Visiting, and Other Hospital Staffs are not required to pay dues.
2. Annual dues are payable as billed each medical staff year.
3. Payment will be a condition of appointment and reappointment.
4. The amount of the dues will be reviewed on an annual basis by the Medical Board.
5. Dues of members joining the Medical Staff during the designated staff year shall be prorated for the appropriate fraction of that Staff year.
6. Unless extenuating circumstances are presented to, and accepted by the Medical Board, non-payment of dues 90 days after the billing date shall be grounds for suspension or termination of medical staff membership.
7. The dues collected shall be used to defray the expenses of the Medical Staff as approved by the Medical Board. The vouchers, therefore, shall be signed by Chairperson of Medical Board and the Treasurer of the Medical Staff.
8. In the event that the Medical Staff of NuHealth should be dissolved for any reason, all funds and monies then remaining in the treasury of said organization at the time of such dissolution, shall be donated to the Nassau Health Care Foundation, Inc.
ARTICLE XVIII

AMENDMENTS

Proposed amendments to these Bylaws shall be initiated by the Medical Board, either on its own motion or on petition to the Bylaws Committee by not fewer than ten (10) members of the Medical Staff.

After review and approval of a proposed amendment, the Medical Board shall cause a notice of the proposal and its recommendation for adoption to be included in the notice of the next Annual Meeting of the Medical Staff or at a special meeting call for this purpose. An amendment may be adopted at the Annual Meeting of the Medical Staff by the vote of two-thirds (2/3) of the members of the Active Attending Staff present and shall become effective upon approval by a majority of the members present at any meeting of the Board of Directors.

Where changes are required to bring the Medical Staff Bylaws into compliance with the requirements of applicable statutes, regulations, standards of accrediting agencies and/or the Certificate of Incorporation or Bylaws of NuHealth, as determined by the Board, the ECMB shall consider such changes as are proposed by the Board at a special meeting called for such purpose after reasonable notice from the CEO. If, notwithstanding the determination by the Board, the ECMB fails to recommend the approval of the required changes to the reasonable satisfaction of the Board, the Medical Staff Bylaws shall nevertheless be deemed amended to the extent necessary to bring them into compliance with requirements of the applicable statutes, regulations, standards of accrediting agencies and/or the Bylaws or any charter instrument of the Corporation.

Amendments limited to renumbering, reorganizing, grammatical corrections, spelling, punctuation, and similar technicalities that can be made without changing the substantive contents of these Bylaws ("Technical Amendments") may be made by the ECMB, subject to the approval of the Board of Directors, and without the approval of the Medical Staff.
ADDITION

These Bylaws shall be adopted at any regular or special meeting of the Active Medical Staff, shall replace any previous Bylaws, and shall become effective when approved by the Board of Directors of NuHealth.

REVISED November 23, 2009
APPROVALS
Executive Committee of the Medical Staff on November 3, 2009.

_________________________________________
Glenn Faust, M.D.
Chairperson

Medical Staff on November 4, 2009.

_________________________________________
Kamil Jaghab, M.D.
President

Approved by the Board of Directors of NuHealth on November 23, 2009.

_________________________________________
Martin D. Payson
Chairperson