

Bylaws of
The Medical Staff
of
Indiana University Health Blackford Hospital
Hartford City, Indiana

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DEFINITIONS

1. The term "Medical Staff" includes all licensed physicians and dentist who are privileged to attend patients in the Hospital. The Medical Staff is further subdivided into admitting physicians which includes all medical doctors and doctors of osteopathy and the co-admitting Practitioners which include dentists.
2. The term "Governing Body" means the Board of Directors of the Hospital. When the Governing Body is considering appointments to and delineation of privileges for any practitioner within the Hospital, it shall be acting as a professional review by as defined by the Health Care Quality Improvement Act of 1986 and as a peer review committee as defined by the Indiana Peer Review Act, I.C. 34-4-12.6-1.
3. The term "Hospital Chief Executive Officer" or "CEO" means the individual appointed by the Governing Body to act in its behalf and the overall management of the Hospital.
4. The term "Practitioner" includes all members of the Medical Staff as a group and also includes Allied Health Care Providers who have been privileged to attend patients in the Hospital.
5. The term "Licensed Health Care Provider" means those individuals who are qualified under the Indiana Medical Malpractice Act and are not members of the Medical Staff or have no privileges as an Allied Health Care Provider.
6. The term "Professional Review Action" means any corrective action and or potentially adverse recommendation or decision made by a peer review committee as defined in the Health Care Quality Improvement Act of 1986.
7. The term "Medical Staff President" means the member of the Medical Staff elected as the person chiefly responsible for overseeing the peer review, educational, and organizational functions of the Medical Staff and who shall also serve as the chief representative of all the Practitioners in the Hospital Governing Board.
8. The term "Allied Health Care Provider" means all individually Licensed Health Care Providers who are not Hospital employees and who may qualify to exercise specified privileges within the Hospital but who are not allowed to admit or co-admit patients.
9. The term "Physician Extenders" means persons who may provide specified health care within the Hospital as the employees of physicians and who do not qualify for independent privileges.
10. The term "Peer Review Committee" shall mean the Governing Body of the Hospital, the Medical Staff Credentials Committee, and any other committee of the Medical Staff,

11. Hospital, or Governing Body which recommends or takes actions based on the competence or professional conduct of an individual Practitioner and which affects or may affect the clinical privileges or membership on the Medical Staff of any Practitioner including any recommendations or decision whether the Practitioner may have clinical privileges with respect to or membership in the Medical Staff of the Hospital, the scope or conditions of such privileges or membership, or any changes or modifications in such privileges or membership.
12. The term "Personnel of a Peer Review Committee" means not only members of the committee, but also all of the committee's employees, representatives, agents, attorneys, investigators, assistants, clerks, staff, and any other person or organization who serves a peer review committee in any capacity, including any person acting as a member or staff to the committee, any person under a contract or other formal agreement within the committee, and any person who participates with or assists the committee with respect to the action.
13. The term "Medical Staff Year" shall mean the period January 1 through the next December 31 each twelve month period.
14. The term "employed physician" shall refer to any physicians employed by the Hospital for purposes of treating patients (clinical purposes). Physicians employed by the Hospital for solely administrative purposes shall not be included in the meaning of this term.

ARTICLE I: NAME

- 1.15 The name of this organization shall be the Medical Staff of IU Health Blackford Hospital.

ARTICLE II: PURPOSES

- 2.1 The purposes of this organization are:
 - 2.1-1 To carry out the function of peer review as the agents of the Governing Body by reviewing the credentials of all persons who wish to provide health care to patients of the Hospital (other than the employees of the Hospital) to recommend specific delineations of privileges for each such individual to the Governing Body, and to monitor the quality of patient care and safety within the Hospital;
 - 2.1-2 To carry out the function of continuing education by providing an appropriate educational setting for the review of scientific standards and advancements in the provision of health care;
 - 2.1-3 To provide for organization and representation of the Practitioners who offer patient care at IU Health Blackford Hospital in carrying out these functions, in representing the Practitioners to the Governing Body and to the community, and in planning for the future; and

2.1-4 To exercise the authority granted by these Bylaws, as necessary, to fulfill the responsibilities contained herein.

ARTICLE III: MEDICAL STAFF MEMBERSHIP

3.1 Nature of Medical Staff Membership. The granting of privileges as a member of the Medical Staff or as an Allied Health Care Provider at IU Health Blackford Hospital is a privilege which may be extended by the Governing Board only to professionally competent physicians and dentists who continuously meet the qualifications, standards, and requirements set forth in these Bylaws. It is the duty of the Medical Staff, as the agents of the Governing Body, to examine the credentials of all persons who wish to be granted privileges as members of the Medical Staff or as Allied Health Care Providers and to recommend to the Governing Body specific delineations of privileges as may be appropriate. It is the duty of each individual member of the Medical Staff or Allied Health Care Provider continuously to maintain and continuously to demonstrate the appropriate level of competence, skill, training, and aptitude which would justify the continuance of those privileges if granted. The failure of any Practitioner to demonstrate the requisite level of skill, health, and cooperative attitude in providing patient care will necessitate the conditioning, suspension, or termination of any privileges which that Practitioner may have been granted.

3.2 Qualification for Membership On The Medical Staff

3.2-1 Basic Qualifications. Physicians and dentists licensed to practice in the State of Indiana, who can document their education, training, experience, and demonstrated competence, their adherence to the ethics of their profession, their good reputation, their ability to work with others in the provision of patient care, their ability and willingness to make efficient use of Hospital facilities so as not to jeopardize the financial stability institution, and their good health, with sufficient adequacy to assure the Medical Staff and the Governing Body that any patient treated by them in the Hospital will be given an appropriate level of medical care, may qualify for membership on the Medical Staff. No physician or dentist shall be entitled to membership on the Medical Staff or to the exercise of particular clinical privileges in the Hospital merely by virtue of the fact that he or she is duly licensed to practice medicine or dentistry in this or in any other state, or that he or she is a member of any professional organization, or such privileges at this or another hospital. All such privileges shall be granted or denied based upon criteria developed by the Medical Staff and approved by the Governing Body.

3.2-2 Effect of Application. Application for and/or acceptance of membership on the Medical Staff shall constitute the applicant's or staff member's agreement that he or she will strictly abide by the Principles of Medical Ethics of the American Medical Association, American Osteopathic Association, or the Code of Ethics of the American Dental Association, and by all of the terms and provisions of these Bylaws as they now exist or hereafter shall be amended.

- 3.2-3 Verification of Information. Application for and/or acceptance of membership on the Medical Staff shall constitute an agreement to authorize the members of the Medical Staff as agents of the Governing Body to inquire and to gather any and all information concerning the applicant and/or staff member with regard to his or her qualifications to exercise privileges in the Hospital, shall constitute and authorization to any and all persons and organizations to release such information to the Governing Body, its agents and/or employees and shall constitute and agreement to release and hold harmless all persons, organizations, including the Governing Body, its agents and employees and all others who participate in good faith in providing such information regarding the applicant and/or staff member.
- 3.2-4 Nondiscrimination. Medical Staff membership or the granting of privileges shall not be denied on the basis of sex, race, creed, color, national origin, or handicap, or on the basis of any other criterion unrelated to the delivery of quality patient care in the Hospital, to professional ability and judgment, or to community need.
- 3.2-5 Administrative Officers. Individuals in administrative positions who are on the Medical Staff or who are seeking appointment to the Medical Staff are appointed and reappointed through the same procedure used for all other members of the Medical Staff.
- 3.2-6 “Employed Physicians”. Employed physicians are credentialed and evaluated in the same fashion as other s/physicians. Employed physicians shall be governed by these Bylaws and Rules and Regulations as well as pertinent policies and procedures of the Hospital.

3.3 Conditions and Duration of Appointment

- 3.3-1 Appointment Process. Initial appointment and reappointments to the Medical staff and the granting of privileges to Allied Health Care providers shall be made by the Governing Body. The Medical Staff in assessing the credentials of initial applicants and applicants for reappointment shall act only as the agents of the Governing Body and shall make recommendations to the Governing Body concerning the granting of Medical Staff membership or appointment as an Allied Health Care Provider and shall also recommend a delineation of specific privileges for each individual. The Governing Body shall act on appointments, reappointments, or the conditioning, suspension, or revocation of appointments after there has been a recommendation from the Medical Staff as provided in these Bylaws or after the Governing Body has, after notification to the Medical Staff, determined that the staff has failed to act in a timely manner. The Governing Body, in acting upon these recommendations, shall never be bound thereby and shall always exercise its independent discretion as the ultimate peer review body of the Hospital.
- 3.3-2 Forms and Applicant's Burden. Application shall be made on an application form to be furnished by the Hospital CEO, drafted with the approval of the Governing Body. The burden of providing complete and sufficient evidence properly to assess such an application shall always be on the applicant or re-applicant, and no consideration will be given to any application or reapplication which is materially incomplete. The time tables

for action upon applications and reapplications are set forth in these Bylaws under the procedures for application, but it shall be understood throughout these Bylaws that the specification of deadlines proceeding shall be goals subject to good faith compliance and that failure to comply with any such deadlines after good faith efforts have been made shall not give rise to any rights or causes of action deriving from these Bylaws.

3.3-3 Nature of Relationship. These Bylaws shall not be deemed as a contract of any kind. Applications for, the conditions of, and the duration of appointment to the Medical Staff or the granting of privileges as an Allied Health Care Provider shall not be deemed contractual in nature since the continuance of any such privileges at this Hospital is based solely upon a Practitioner's continued ability to justify the exercise of such privileges.

3.3-4 Probationary Period of Medical Staff Appointments. Initial appointment to the Medical Staff shall be for a probationary period of between twelve (12) and twenty four (24) months during which time the Practitioner shall be subject to close monitoring and supervision by the members of the Medical Staff and during which time the modification, alteration, or conditioning of his or her privileges will be subject to summary action. During this time, the Practitioner may not hold office or vote on Medical Staff issues, however, they may be appointed to Medical Staff committees, and be eligible to vote on those committees. Immediately following the initial twelve (12) months of probationary appointment, the Practitioner may apply for reappointment and a change in Medical Staff status to be effective until the next regularly scheduled time for evaluation of re-applications for membership and privileges. In the event the Credentials Committee concludes that it is not able to properly evaluate the capabilities of the Practitioner at the time the Practitioner applies for a change in Medical Staff status, the Credentials Committee may recommend that the probationary status be extended. In no event may a Practitioner's probationary state extend longer than their initial twenty four (24) month appointment. During the Probationary Period, all practitioners shall be subject to a period of Focused Professional Practice Evaluation (FPPE). The FPPE process for each shall be determined by the Medical Staff at the time the Practitioner is recommended to the Governing Body for appointment to the Medical Staff. The results of the FPPE shall be shared with the Credentials Committee. The Credentials Committee may recommend the continuation of existing privileges (no action), a continuation of the Focused Review, or Corrective Action based upon the results of the FPPE. The FPPE shall include relevant issues relating to the following competency principles:

- Patient care
- Medical/Clinical knowledge
- Practice based learning and improvement
- Interpersonal and communication skills
- Professionalism
- System-based practice

The Medical Staff shall determine relevant measures for all competency principles based upon the scope of each Practitioner's practices and privileges granted. The measures that may be used include, but are not limited to, the following:

- Patterns of operative and other clinical procedures and outcomes
- Patterns of blood and pharmaceutical usage
- Requests for tests
- Length of stay patterns
- Morbidity and mortality data
- Other relevant criteria as determined by the Medical Staff

3.3-5 Probationary Period of Allied Health Care Provider Appointments. Initial appointments as an Allied Health Care Provider shall be for a provisional period of twelve (12) months, during which time the initial appointee shall be subject to close monitoring and supervision by the physician sponsor and the members of the Medical Staff and during which time modification, alteration, or conditioning of his or her privileges will be subject to summary action. Allied Health Care Providers may not hold office, and are not eligible to vote. Immediately following this initial twelve (12) month probationary appointment, the Allied Health Care Provider may apply for reappointment and privileges as an Allied Health Care Provider to be effective until the next regularly scheduled time for evaluation of reapplications for membership and privileges. Thereafter, reappointment shall be for a period of not more than two (2) years. During the period of Probation, Allied Health Practitioners shall also be subject to a period of Focused Professional Practice Evaluation, as described in Section 3.3-4.

3.3-6 Federal Reporting Requirements. In satisfaction of the requirements of the Health Care Quality Improvement Act of 1986, the Hospital shall be required to report any payment under a policy of insurance, self-insurance, or otherwise in settlement of, or in satisfaction of a judgment in, a professional liability action or claim. Such information shall include the name of the physician or licensed health care Practitioner for whose benefit the payment was made, the amount of the payment, a description of the acts or omissions and injuries or illnesses upon which the action or claim was based, the name (if known) of any Hospital with which the physician or Practitioner is affiliated or associated, and such other information as may be required under the Act. This information will be reported as required by the Act to the Medical Licensing Board and the appropriate agency designated by the U.S. Department of Health and Human Services.

ARTICLE IV: CATEGORIES OF THE MEDICAL STAFF

Introduction – All s, irrespective of Medical Staff category, will be subject to Ongoing Professional Practice Evaluation (OPPE). The results of the OPPE shall be reported to the

Medical Staff at intervals that do not exceed twelve (12) months. The ongoing OPPE allows the organization to identify professional practice trends that impact on quality of care and patient safety. Such identification may require intervention by the Medical Staff. The criteria used in the OPPE may include the following:

- Review of operative and other clinical procedure(s) performed and their outcomes
- Pattern of blood and pharmaceutical usage
- Requests for tests and procedures
- Length of stay patterns
- Morbidity and mortality data
- Practitioner's use of consultants
- Other relevant criteria as determined by the Medical Staff

The Medical Staff shall determine relevant measures to be used in the OPPE. Based upon the results of the OPPE, the Medical Staff may determine that Focused Review should be initiated to further review any problems revealed, or may, in some instances, recommend Corrective Action.

Medical Staff members requesting new privileges will be subject to a period of Focused Review for the newly granted privileges. The Medical Staff shall determine the specific process of Focus Review at the time the new privileges are recommended for approval to the Governing Body.

- 4.1 The Medical Staff. The Medical Staff shall be subdivided into admitting physicians and co-admitting Practitioners. Each of those subcategories may be appointed to membership on the Medical Staff, active staff, courtesy staff, consulting staff, and honorary staff.
- 4.2 Active Medical Staff. The Active Medical Staff shall consist of physicians and dentists who regularly participate in the activities of the Hospital, who are located closely enough to the Hospital to provide continuous care to their patients, and who assume all the functions and responsibilities of membership on the active Medical Staff, including, where appropriate, emergency care and consultation assignments. Maintaining a practice within the service area of the Hospital means that a Practitioners must visit each of his or her patients on a daily basis and respond to patients needing attention at the Hospital within a medically reasonable period of time, twenty-four (24) hours per day seven (7) days per week. A physician may meet this obligation personally or by coverage by another physician who has equivalent privileges. Members of the Active Medical Staff shall be eligible to vote, to hold office, and to serve on Medical Staff committees, and shall be required to attend at least 50% of the regularly scheduled Medical Staff meetings and committee meetings (to which physician may be assigned).
- 4.3 Courtesy Medical Staff. The Courtesy Medical Staff shall consist of physicians and dentists qualified for staff membership, but who only occasionally admit or co-admit patients to the

Hospital, or who act only as consultants. Courtesy Medical Staff members shall not be eligible to vote or hold office in this Medical Staff organization. They shall be eligible for appointment to Medical Staff committees, and to participate in the educational programs of the staff and Hospital. Courtesy staff members who admit or co-admit more than twelve (12) patients in the Medical Staff Year must apply for a transfer to Active Staff membership. There is no limit on consultations performed by Courtesy staff members.

- 4.4 Consulting Medical Staff. The Consulting Medical Staff shall consist of physicians and dentists who are members of the active or associate medical staff of another hospital where he or she actively participates in patient care and meets the basic qualifications for membership on the Medical Staff of this Hospital as set forth in these Bylaws. Consulting staff members shall not be eligible to vote, to hold office, or to serve on standing Medical Staff committees, or to admit or co-admit patients to the Hospital.
- 4.5 Honorary Medical Staff. The Honorary Medical Staff shall consist of physicians and dentists who are not active in the Hospital, or who are honored by emeritus positions. These may be physicians and dentists who have retired from active Hospital practice, or who are of outstanding reputation, not necessarily residing in the community. Honorary staff members shall not be eligible to vote, to hold office or to serve on standing Medical Staff committees, or to admit or co-admit patients to the Hospital, treat patients, or to perform consultations in the Hospital.

ARTICLE V: PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

5.1 Application for Appointment.

5.1-1 Application Form. Applications for appointment to the Clinical Staff shall be in writing, and shall be submitted on forms prescribed by the Board after consultation with the Credentials Committee. These forms shall be obtained from the President or their designee. The application shall require detailed information concerning the applicant's professional qualifications including:

1. Names of at least two physicians or dentists, as appropriate, who have had extensive experience in observing and working with the applicant and who can provide adequate references pertaining to the applicant's professional competence and character;
2. Information as to previously successful or currently pending challenges to any licensure or registration (state or district, Drug Enforcement Administration) or the voluntary relinquishment of such licensure or registration;
3. Voluntary or involuntary termination of Medical staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at any other hospital

or health care facility. The submitted application shall include a copy of all of the applicant's current licenses to practice, as well as their narcotics license;

4. Information as to whether the applicant's membership in local, state, or national medical societies has ever been voluntarily or involuntarily suspended, surrendered, modified, or terminated or any currently pending challenges of such membership;
5. Information as to relevant training and experience;
6. Information as to the applicant's ability to perform the privileges requested;
7. Documentation evidencing that the applicant is currently qualified as a health care provider under Indiana Medical Malpractice Act;
8. Information concerning the applicant's malpractice experience including past and present complaints and/or judgment against the applicant;
9. A consent to the release of information from the applicant's present and past malpractice insurance carriers;
10. A request for the specific clinical privileges desired by the applicant; and
11. Such other information as the Board may require.

Information given in or attached to the application must be accurate and fairly represent the current level of the applicant's licensure, training, experience, capability and competence, and ability to perform the clinical privileges requested. Any significant misrepresentation, misstatement in, or omission from the application whether intentional or not, shall, of itself alone, constitute cause for automatic and immediate rejection of the application resulting in denial of appointment and clinical privileges. In the event that an appointment has been granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery may result in summary dismissal from the Clinical Staff.

Criminal background checks, data from the National Practitioner Data Bank, and lists of "excluded s" (Medicare and Medicaid) will be reviewed as part of the application process.

- 5.1-2 Duty to Obtain Information. Under the requirements of the Health Care Quality Improvement Act of 1986, the Hospital will request information from the designated agency on an applicant regarding professional liability actions or Professional Review Actions. The Hospital will also request from the designated agency, as required by the Act, information regarding professional liability actions or Professional Review Actions

at least once every two (2) years concerning any Practitioner in all categories of membership. The Hospital may also request information from the designated agency at any other time at its own discretion.

- 5.1-3 Applicant's Burden. The applicant will verify, from the primary source whenever feasible, information regarding the applicant's licensure, specific training, experience, and current competence. Nevertheless, the applicant shall have the burden of producing adequate information for the proper evaluation of his or her competence, character, ethics, physical, mental, and emotional health, and other qualifications, and for resolving any doubts about such qualifications.
- 5.1-4 Application Process. No action shall be taken upon any application or reapplication until it is deemed by the Hospital CEO to be materially complete. The completed application shall be submitted by the Hospital CEO to the Credentials Committee. The Hospital CEO shall collect the references and other materials deemed pertinent before transmittal to the Credentials Committee. If the Hospital CEO is unable to obtain any of the information which is pertinent, he shall notify the applicant, and the applicant shall have the burden of obtaining the required information.
- 5.1-5 Effect of Application. By applying for appointment to the Medical Staff or as an Allied Health Care Provider, each applicant thereby signifies his or her willingness to appear for interviews in regard to his or her application; authorizes the Hospital to consult with members of the Medical Staffs of other hospitals with which the applicant has been associated and with other hospitals with who may have information bearing on his or her competence, health, character, and ethical qualifications; consents to the Hospital's inspection of all records and documents that may be material to an evaluation of his or her professional qualifications, training, health, and competence to carry out the clinical privileges he or she requests, as well as of his or her moral and ethical qualifications for staff membership; authorizes all persons who may have such information to communicate it to the Governing Body, its agents or employees; releases from liability all representatives of the Hospital and members of the Medical Staff for their acts performed in good faith and without malice in connection with evaluating the applicant and his or her credentials; and releases from liability all individuals and organizations, including the Governing Body, its agents, and employees, who provide information to the Hospital in good faith and without malice concerning the applicant's competence, ethics, character, and other qualifications for staff appointment and clinical privileges, including otherwise privileged or confidential information.
- 5.1-6 Acknowledgment and Agreement. The application form shall include a statement that the applicant has received and read the Bylaws and Rules and Regulations of the Medical Staff, and that he or she agrees to be bound by the terms thereof during the application process and thereafter if he or she is granted membership and/or clinical privileges, and to be bound by the terms thereof without regard to whether or not he or she is granted membership and/or clinical privileges in all matters relating to consideration of his or her application.

5.2 Appointment Process

- 5.2-1 Credentials Committee Action. Within 60 (sixty) days after receipt of the completed application for membership on the Medical Staff or appointment as an Allied Health Care Provider, the Credentials Committee shall make a report of its investigation to the Medical Staff, including its recommendation that the Practitioner be appointed as a member of the Medical Staff or as an Allied Health Care Provider, that he or she be rejected for Medical Staff membership or appointment as an Allied Health Care Provider, or that his or her application be deferred for further consideration. All recommendations for appointment must also specifically delineate which clinical privileges are recommended to be granted. The granting of all initial privileges shall be probationary in nature.
- 5.2-2 Basis for Recommendations. Prior to making this report and recommendation, the Credentials Committee shall examine the evidence of the character, professional competence, qualifications and ethical standing of the , and shall determine, through information contained in references given by the and from other sources available to the Committee, whether the has established and meets all of the necessary qualifications for the category of staff membership and the clinical privileges requested by his or her including an evaluation of the applicant's physical and mental health. The Credentials Committee shall transmit to the Governing Body the completed application and all other documentation considered in arriving at its recommendation, subject to the applicant's right to request an ad hoc hearing and appeal concerning any denial of application or of specific privileges.
- 5.2-3 Recommendation to Defer. When the recommendation of the Credentials Committee is to defer the application for further consideration, it must be followed up within 60 (sixty) days with a subsequent recommendation for appointment with specified clinical privileges or for rejection of the application.
- 5.2-4 Adverse Recommendation. When the recommendation of the Credentials Committee is adverse to the Practitioner, or Physician Extender, either in respect to appointment or to specific requested clinical privileges, the Hospital CEO shall promptly notify the by certified mail, return receipt requested. No such adverse recommendation shall be forwarded to the Governing Board until after the has exercised, or has been deemed to have waived, his or her right to a hearing as provided in Article X of these Bylaws. If the Practitioner or Physician Extender waives or is deemed to have waived his or her right to a hearing, the report of the Credentials Committee shall be forwarded to the Governing Body for appropriate action. If the Practitioner elects to exercise his or her right to a hearing, all further proceedings shall be governed by Article X of these Bylaws.
- 5.2-5 Conflict of Resolution. Whenever the Governing Body's decision will be contrary to the recommendation of the Credentials Committee, the Governing Body shall submit the matter to the Joint Advisory Committee for review and recommendation and shall

consider such recommendation before making its final decision. The Governing Body shall, however, not be bound by any recommendation of the Joint Advisory Committee.

5.2-6 Governing Body's Action. At the next regular meeting or specially called meeting of the Governing Body after receipt of a favorable recommendation from the Credentials Committee, the Governing Body shall act on the matter. If the Governing Body's decision is adverse to the in respect to either appointment or clinical privileges, and if the Practitioner has not previously been afforded the right to a hearing, the Hospital CEO shall promptly notify him or her of such adverse decision by certified mail, return receipt requested, and such adverse recommendation shall be held in abeyance until the has exercised, or has been deemed to have waived his or her rights under Article X of these Bylaws, and until there has been a consideration of the matter by the Joint Advisory Committee of the Governing Body and the Medical Staff. The fact that the adverse decision is being held in abeyance shall not be deemed to confer privileges where none existed before or to provide any basis for the continuance of temporary privileges.

5.2-7 Governing Body's Final Decision. At its next regular or specially called meeting after all of the Practitioner's rights under Article X have been exhausted or waived, the Governing Body or its duly authorized committee shall act in the matter. The Governing Body's decision shall be conclusive, except that the Governing Body may refer the matter back to the Credentials Committee for specified further investigation, setting a deadline for action and specifying exactly what additional information is required. After receipt of such additional information, the Governing Body shall act in the matter.

5.2-8 Notice of Final Decision. When the Governing Body's decision is final, it shall send notice of such decision through the Hospital CEO to the applicant and the Credentials Committee. The notice to the applicant shall be by certified mail, return receipt requested.

5.3 Reappointment Process

5.3-1 Forms. All requests for reappointment to the Medical Staff or as an Allied Health Care Provider shall be submitted in writing on forms specified by the Hospital Governing Body. Applications for reappointment shall specify exactly which clinical privileges are being requested. No re-applicant will be granted privileges solely because he or she has exercised such privileges in the past at this Hospital or any other hospital.

5.3-2 FPPE and OPPE - The results of the FPPE for Probationary Staff members, OPPEs for any members of the Medical Staff, and any Focused Reviews conducted for any purpose shall be forwarded to the Credentials Committee and used for the review of all reappointment requests.

5.3-3 Credentials Committee Action. The Credentials Committee shall make an independent assessment of each and every privilege for which the applicant is applying and shall

submit a written report and recommendation to the Medical Staff and Governing Body. Prior to the writing of this report, the Credentials Committee may invite the applicant to appear before it to discuss specific privileges for which the applicant is reapplying and to solicit additional evidence as to continuing competence, training, and medical education. The Credentials Committee may also request and require the applicant to submit to appropriate physical and/or mental health evaluation and/or testing.

- 5.3-4 Adverse Recommendation. If after consultation with the applicant, the report of the Credentials Committee is adverse either in the matter of appointment to the Medical Staff or as an Allied Health Care Provider or the specific clinical privileges, the Hospital CEO shall notify the applicant by certified mail, return receipt requested, and the applicant shall exercise or waive his or her rights to a hearing and appeal as specified in Article X. Thereafter, the procedure to be followed on re-application shall be the same as specified above for initial applications.
- 5.3-5 Basis for Recommendation. Recommendations for reappointment, and the granting of privileges shall be based upon assessment of the particular candidate's proven continuing professional skill, evidence of continued licensure, demonstrated clinical judgment, level of performance, ethical conduct, attendance, participation and dedication to staff affairs, compliance with Hospital and Medical Staff Bylaws, Rules and Regulations, cooperation with other Hospital personnel, use of conferred privileges in an efficient manner consistent with the financial well being of the Hospital, relations with patients, colleagues, the public, the Governing Body, the applicant's physical and mental health, and the results of any FPPE and/or OPPE. Those who do not properly take advantage of conferred privileges will face possible removal of those privileges and/or denial of reappointment to the Medical Staff or as an Allied Health Care Provider.

ARTICLE VI: CLINICAL PRIVILEGES

6.1 Clinical Privileges Restricted

- 6.1-1 Nature of Clinical Privileges. Every Practitioner practicing at this Hospital by virtue of Medical Staff membership or as an Allied Health Care Provider shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted to him or her by the Governing Body, except as provided in these Bylaws for temporary privileges and emergency privileges.
- 6.1-2 Request for Clinical Privileges. Every initial application and reapplication shall include a specific request by the applicant or re-applicant for the privileges which he or she wishes to exercise. Except as provided above, no Practitioner may exercise any privilege at any time which has not specifically been conferred upon him or her. Practitioners may apply for additional privileges at any time during a Medical Staff Year by making a special application for additional privileges, which shall be handled as an initial application for privileges as set forth in Article V, including the initiation of a FPPE for any new privileges that may be awarded.

- 6.1-3 Special Conditions for Dental Privileges. Privileges granted to dentists shall be based upon their training, experience, and demonstrated competence and judgment. The scope and extent of surgical procedures that each dentist may perform shall be specifically delineated and granted in the same manner as other surgical privileges. All dental patients shall receive the same basis medical appraisal on admission as patients shall receive to other surgical services. A physician member of the Medical Staff shall be responsible for the initial history and physical examination and assessment of the patient's medical condition at the time of admission and shall be responsible for the care of any medical problems that may be present at the time of admission or that may arise during hospitalization. Dentist members of the Medical Staff may not admit or discharge patients without the concurrence and co-admission of a physician member of the Medical Staff. The dentist shall be responsible for recording on the patient's chart an admitting dental history and dental physical examination with detailed description of the examination and preoperative diagnosis, and complete operative report.
- 6.1-4 Responsibility of Co-Admitting Physician. A physician member of the Medical Staff who co-admits a patient with a dentist does not thereby accept responsibility for the dental care afforded to that patient. The responsibility of a co-admitting physician shall be to supervise and monitor the medical care of the patient other than the specific dental procedures which are to be performed.

6.2 Temporary Privileges

- 6.2-1 Circumstances. Upon receipt of a completed application for Medical Staff membership or for appointment as an Allied Health Care Provider, the Hospital CEO may, upon the basis of the information then available and which may reasonably be relied upon as to the competence and ethical standing of the applicant, and with the concurrence of the President of the Medical Staff, grant temporary admitting and clinical privileges to the applicant. Such temporary privileges will not ordinarily be afforded to an applicant who has not completed an application and/or who has not made every effort diligently to complete the application process prior to beginning practice in the community. (See - Section 6.3). Temporary privileges will not be granted for periods in excess of 120 days.
- 6.2-2 Care of Specific Patients. Temporary clinical privileges may also be granted by the Hospital CEO, for the care of a specific patient, to a Practitioner who is not applicant for membership in the same manner and upon the same conditions as set forth in the subparagraph A of this section 6.2, provided that the Hospital CEO shall first have determined the nature and extent of the Practitioner's privileges at other hospitals, shall have received recommendation from members of those hospital staffs and/or administrators to have specific knowledge of the Practitioner's qualifications and shall have obtained such Practitioner's signed acknowledgment that he or she has received and read copies of the Medical Staff's Bylaws, Rules and Regulations, and that he or she agrees to be bound by the terms thereof in all matters relating to his or her temporary clinical privileges. Such temporary privileges shall be granted and restricted to the extent determined by the CEO with the concurrence of the President of the Medical Staff.

- 6.2-3 Locum Tenens. Upon verification of the information contained with the Medical Staff application, the Hospital CEO and the President of the Medical Staff may grant temporary privileges to a physician serving as locum tenens for a member of the Medical Staff. The granting of privileges to a locum tenens shall be treated as other requests for temporary privileges, except that temporary privileges may be granted without submission of the application to the Governing Body.
- 6.2-4 Conditions and Terminations. Temporary clinical privileges are extended purely as a matter of grace, and confer upon the recipient no membership on the Medical staff or appointment as an Allied Health Care Provider and give rise to no rights whatsoever under these Bylaws including any rights to a hearing or appeal. Temporary clinical privileges may be suspended, modified, or revoked at any time by the Hospital CEO or by the Medical Staff President. Upon suspension and/or termination of temporary clinical privileges either by the Hospital CEO or by the Medical Staff President, the Medical Staff President shall assign a member of the Medical Staff to assess the condition of any patients then in the Hospital under the care of the Practitioner whose privileges have been suspended or terminated, and the Medical Staff President shall be authorized to provide or arrange for the provisions of alternate medical care to such patients and/or to discharge such patient from the Hospital.
- 6.3 Emergency Privileges. In the case of some natural catastrophe, local or national emergency, or other emergency which is a life-threatening situation where immediate life-saving action is demanded for patient survival, any Practitioner who is presently treating an emergency patient, or has initiated therapy, may continue such treatment within the scope of the 's license and be assisted to do everything possible to save the life of the patient, using every facility of the Hospital necessary, including the calling of any consultation necessary. Allowing such a Practitioner to render care to a patient shall not extend beyond the immediate need for such emergency care and shall not give rise to any rights under these Bylaws. See Medical Staff Rules and Regulations, Section 28.

ARTICLE VII: ALLIED HEALTH CARE PROVIDERS

- 7.1 Professionals Who May Qualify As Allied Health Care Providers. Qualifications for Allied Health Care Providers are set forth in Article III, Section 3.3. Such persons shall be governed by these Bylaws and shall be subject to the credentialing and peer review functions of the Medical Staff but shall not be considered members of the Medical Staff, shall have no vote in Medical Staff elections or deliberations, and shall not attend Medical Staff meetings or serve on any committees unless requested by the Medical Staff President. Since IU Health Blackford Hospital is organized and functions under a theory of medicine which is mutually intelligible by medical doctors, doctors of osteopathy and dentists but which is not congruent with the theory of chiropractic. Chiropractors shall not be considered for Medical Staff membership or for privileges as Allied Health Care Providers.

- 7.2 Medical Staff Sponsors. Since no Allied Health Care Provider may admit or co-admit patients to the Hospital, and no Allied Health Care Provider can provide services to a patient in the Hospital except on the order of a physician or dentist, with the exception of contracted services, applications for privileges as Allied Health Care Provider must contain the name of at least one (1) Medical Staff member who has agreed to supervise the quality of care of that Allied Health Care Provider within the Hospital. A physician sponsor, by signing such an application, is not obligated to request the services of that Allied Health Care Provider thereafter, but is obligated to supervise and review the quality of care being provided by that Allied Health Care Provider within the Hospital. Any reapplication by an Allied Health Care Provider must be accompanied by a review of the past two (2) year's performance by that health care provider written by the Medical Staff sponsor, on forms provided by the Hospital CEO.
- 7.3 Due Process Rights. Allied health care Practitioners are granted the same rights to due process in applications, corrective actions, hearings, and appeals as provided under these Bylaws for Medical Staff members.

VIII: OUTPATIENT DIAGNOSTIC PROCEDURES

- 8.1 Outpatient Diagnostic Procedures. Licensed Health Care Providers, including chiropractors, who are qualified under the Indiana Medical Malpractice Act (I.C. 16-9.5 et seq.) who are not members of the Medical Staff and/or who have no privileges as Allied Health Care Providers at IU Health Blackford Hospital may refer patients to the Hospital for the performance of outpatient diagnostic procedures within the scope of the Licensed Health Care Provider's license. In requesting the completion of tests/procedures, the Licensed Health Care Provider must provide evidence of relevant Indiana licensure, as well as name, address, registration number(s), and proof that he or she is a qualified health care provider under the Indiana Medical Malpractice Act. Such requests to refer patients shall be considered and approved or disapproved by the Hospital CEO.

ARTICLE IX: PROFESSIONAL REVIEW ACTION/CORRECTIVE ACTION

Please refer to the Corrective Action/Fair Hearing Plan as adopted by the Hospital Medical Staff and Board of Directors for procedures under this Article and the procedures and provisions of said Corrective Action/Fair Hearing Plan are hereby incorporated by reference into these Medical Staff Bylaws.

ARTICLE X: HEARING AND APPELLATE REVIEW PROCEDURE

Please refer to the Corrective Action/Fair Hearing Plan as adopted by the Hospital Medical Staff and Board of Directors for procedures under this Article and the procedures and provisions of said Corrective Action/Fair Hearing Plan are hereby incorporated by reference into these Medical Staff Bylaws.

ARTICLE XI: OFFICERS

11.1 Officers of the Medical Staff: The officers of the Medical Staff shall be:

- 1) President
- 2) Vice President
- 3) Secretary/Treasurer

11.2 Qualifications of Officers. Officers must be members of the active Medical Staff at the time of nomination and election, and must remain active staff members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

11.3 Election of Officers:

11.3-1 Election. Officers shall be elected at the last regular meeting of the Medical Staff in the year. Only members of the active Medical Staff shall be eligible to vote.

11.3-2 Voting. A majority vote of the members of the active Medical Staff is required for election to office.

11.4 Term of Office. All officers shall serve a one (1) year term coinciding with the Medical Staff Year immediately following the date of their election or until a successor is elected.

11.5 Vacancies in Office. Vacancies in office during the Medical Staff Year except for Medical Staff President shall be filled by the Medical Staff. If there is a vacancy in the office of the Medical Staff President, the Medical Staff Vice President shall serve out the remaining term. Any Officer of the Medical Staff may be removed at any regular or special meeting of the Medical Staff upon a two-thirds affirmative vote of the voting members of the Medical Staff.

11.6 Duties of Officers

11.6-1 Status of Officers in Credentialing Process. In dealing with the credentials of members of the Medical Staff, Allied Health Care Providers, Physician Extenders, or others, the officers and other members of the Medical Staff shall be operating solely as the agents of the Governing Body for the purposes of conducting such peer review.

11.6-2 President of Medical Staff. The Medical Staff President shall:

- a. Act in coordination and cooperation with the Hospital CEO in all matters of mutual concern within the Hospital as the chief representative of all Practitioners within the Hospital to the Governing Body;
- b. Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;

- c. Serve as ex-officio member on all other Medical Staff committees without vote unless otherwise appointed with vote pursuant to these Bylaws;
- d. Be responsible as the agent of the Governing Body of the Hospital for the enforcement of Medical Staff Bylaws, Rules and Regulations, for implementation of sanctions where those area indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a Practitioner;
- e. Appoint committee members to all standing, special, and multi-disciplinary Medical Staff committees;
- f. Represent the views, policies, needs, and grievances of the Medical Staff to the Governing Body and to the Hospital CEO;
- g. Receive and interpret the policies of the Governing Body to the Medical Staff, and report to the Governing Body on the performance and maintenance of quality of care within Hospital as the agent of the Governing Body;
- h. Be the spokesman for the Medical Staff in its external, professional and public relations, and in planning for the future.

11.6-3 Vice President of Medical Staff. In the absence of the Medical Staff President, the Medical Staff Vice President shall assume all the duties and have the authority of the Medical Staff President. He or she shall be a member of the Credentials Committee of the Medical Staff, and the Joint Advisory Committee. He or she shall automatically succeed the Medical Staff President when the latter fails to serve for any reason.

11.6-4 Secretary/Treasurer. The Secretary/Treasurer, or designee, shall keep accurate and complete minutes of all Medical Staff meetings, shall call Medical Staff meetings on order of the Medical Staff President, attend to all correspondence shall be responsible for collecting dues and disbursing them according to the directions of the Medical Staff, shall account for all expenditures, shall give an annual audit and perform such other duties as generally pertain to the office.

ARTICLE XII: COMMITTEES

12.1 Standing Medical Staff Committees and Sub-Committees. Committees of the Medical Staff shall be standing and special. All committees other than the executive shall be appointed by the President.

12.1-1 Executive Committee. The Executive Committee shall consist of officers of the Medical Staff. The duties of the Executive Committee shall be to coordinate the activities and general policies of the various departments, to act for the Staff, and to receive and act

upon reports of the Medical Records, Tissue, and such other committees and shall meet as needed. The duties of the Executive Committee, whenever possible, will be performed by the Medical Staff acting as a Committee of the Whole. The Medical Staff may, whenever it determines it appropriate, cease to function as a Committee of the Whole, delegating such duties to the Executive Committee.

12.1-2 Utilization Review Committee. The Utilization Review Committee shall consist of at least one member of the active Medical Staff appointed by the President of the Medical Staff. Ex-officio members will be appointed by the CEO and may include representatives from the Hospital Medical Records, Nursing Service, and Social Service.

Duties:

1. Utilization Review Studies. The Committee shall conduct utilization review studies designed to evaluate the appropriateness of admissions to the Hospital for lengths of stay, discharge practices, use of clinical and Hospital services, and all related factors in the Hospital which may contribute to the effective utilization of hospital and physician services. Specifically, it shall analyze how under-utilization and over-utilization of each of the Hospital's services affects the quality of patient care provided at the Hospital, shall study patterns of care and obtain criteria relating to average or normal lengths of stay by specific disease categories and shall evaluate systems of utilization review employing such criteria. It shall also discharge through, among other things, the accumulation of appropriate data on the availability of other suitable health care facilities and services outside the Hospital. The Committee shall communicate the results of its studies and other pertinent data to the Executive Committee and shall make recommendations for the optimum utilization of Hospital resources and facilities commensurate with quality patient care and safety and shall serve as a Peer Review Committee, as set forth in these Bylaws.
2. Written Utilization Plan. The Committee shall also formulate a written utilization review plan for the Hospital. Such plan, as approved by the Medical Staff, the CEO, and the Governing Body must be in effect at all times and must include the following elements:
 - a. The organization and composition of committees which shall be responsible for the monitoring and utilization review functions;
 - b. Frequency of meetings;
 - c. The types of records to be kept;
 - d. The method to be used in selecting cases on a sample or other basis;
 - e. The definition of what constitutes the period of extended duration;

- f. The relationship of the monitoring and utilization review plan to claims administration by a third party;
 - g. Arrangements for committee reports and their dissemination;
 - h. Responsibilities of the Hospital's administrative staff in support of utilization review.
3. Medical Records Function. Review and evaluate medical records and receive reports from unit medical records committees to determine that such records:
- a. Properly describe the condition and progress of the patient, the tests and therapy provided, the results thereof, and the identification of responsibility for all actions taken;
 - b. Are sufficiently complete at all times so as to facilitate continuity of care and communications among all those providing patient care services in the Hospital;
 - c. Meet standards of patient care usefulness and historical validity;
 - d. Assure the safe transfer of physician responsibility will take place if necessary;
 - e. Are adequate as medico-legal documents.

The Committee shall also review staff and Hospital policies, rules and regulations relating to medical records including medical records completion, forms, formats, filing, indexing, the use of microfilming, if applicable, storage and availability, and recommend methods of enforcement thereof and changes therein.

Meetings, Reports, and Recommendations:

1. The Utilization Review Committee shall meet no less than ten (10) times per year, shall maintain a permanent record of its findings, proceedings, and actions, and shall make a monthly report thereof to the Medical Staff and the CEO.
2. The Committee shall report (with or without recommendation) to the Credentials Committee and Medical Staff for its consideration and appropriate action any situation involving questions of clinical competency, patient care, and treatment or case management of any individual appointed to the Medical Staff.
3. The Committee shall report (with or without recommendation) to the Medical Staff for its consideration and appropriate action any situation involving questions of professional ethics, infraction of Hospital or Medical Staff Bylaws or Rules or unacceptable conduct on the part of any individual appointed to the Medical Staff.

12.1-3 Credentials Committee. The Credentials Committee shall consist of two individuals who are members of the Active Medical Staff. Members shall be appointed annually.

Duties:

The duties of the Credentials Committee shall be:

1. To review the credentials of all applicants, to make investigations of and interview applicants as may be necessary, and to make recommendations for appointment and delineation of clinical privileges in compliance with these Bylaws;
2. To make a report to the Medical Staff on each applicant for appointment and clinical privileges, including specific consideration of the recommendations for the departments in which such applicant requests privileges;
3. To review as questions arise all information available regarding the professional and clinical competence of persons currently appointed to the Medical Staff, their care and treatment of patients and case management, and as a result of such review to make recommendations to the Governing Body for granting, reduction or withdraw of promotions, privileges, reappointments, and changes in the assignment of appointees to the various departments;
4. To review reports on specific persons holding appointments to the Medical Staff that are referred by the Executive Committee or any other Medical Staff committee to the extent that those reports concern the clinical privileges of Medical Staff appointees and to make such recommendations as provided in these Bylaws;
5. In any instance where a member of the Credentials Committee has a conflict of interest in any matter involving an applicant or appointee to the staff which comes before the Credentials Committee, that member shall not participate in the discussion or voting on the matter and shall absent himself from the meeting during that time, although he may be asked and answer any questions concerning the matter before leaving;
6. To serve as a peer review committee, as set forth in these Bylaws.
7. To review all OPPE and FPPE reports and data.

The Chairman of the Credentials Committee, the Chairman's representative and/or such members of the committee as are deemed necessary shall be available to meet with the Governing Body or its applicable committees on the recommendations that the Credentials Committee may make, it being the purpose of these Bylaws to increase direct communication between the Governing Body and the Credentials Committee on all matters within the scope of the Credentials Committee's duties.

Meetings, Reports, and Recommendations:

1. The Credentials Committee shall meet as often as necessary to accomplish its duties, but not less than quarterly.

12.1-4 Joint Advisory Committee. The Joint Advisory Committee shall consist of two members of the Governing Body appointed by the President, two members of the Medical Staff, the CEO, and the Director of Nursing. The last two ex-officio members of this committee will be without power to vote. A chairman of the Joint Advisory Committee shall be appointed by the President of the Governing Body.

1. The Joint Advisory Committee shall meet when necessary, as determined by the President of the Medical Staff and the President of the Board of Directors.
2. The overall duties of this committee shall be to act in an advisory capacity to the Governing Body as follows:
 - a. To study all problems of misunderstanding or of a continuous nature which may arise from time to time among the personnel of departments and recommend solutions to the Governing Body;
 - b. To study methods and plans for the continuous improvement of the Hospital service, its relation to the community, the advancement in education, and a continuing development in the professional activities consistent with the general development in medical science;
 - c. In matters involving medico-administrative problems which fall within the province of the Governing Board and the active Medical Staff the Joint Advisory and the Governing Body.

12.1-5 Bylaws Committee. The Bylaws Committee shall consist of two persons appointed from the Active Medical Staff.

Duties:

The Bylaws Committee shall review the Bylaws of the Medical Staff at least annually and recommend amendments to the Executive Committee or the Committee of the Whole. In addition, the Committee shall receive and consider all recommendations for changes in these Bylaws by the Governing Body, the Joint Advisory Committee, the Executive Committee of the Medical Staff, the President of the Medical Staff, CEO, committees of the Medical Staff and any individual appointed to the Medical Staff.

Meetings, Reports, and Recommendations:

The Bylaws Committee shall meet as often as necessary to fulfill its duties, shall maintain a permanent record of its activities, and shall report its recommendations to the Executive Committee and the CEO.

12.1-6 Infection Control Committee. The Infection Control Committee shall consist of a Pathologist and at least one each from the Nursing Service and Hospital Management, as well as the Infection Control Nurse.

Duties:

The Infection Control Committee shall be responsible for the surveillance of inadvertent Hospital infection potentials, the review and analysis of actual infections, the promotion of a preventative and corrective action program designed to minimize infection hazards, and the supervision of infection control in all phases of the Hospital's activities, and may include:

1. Operating room, delivery rooms, recovery rooms, and special care units;
2. Sterilization procedures by heat, chemicals or otherwise;
3. Isolation procedures;
4. Prevention of cross-infection by anesthesia apparatus or inhalation therapy equipment;
5. Testing of Hospital personnel for carrier status;
6. Disposal of infectious material;
7. Required cultures of personnel or of the environment;
8. Antimicrobial susceptibility or resistance trend studies;
9. The relation of infection to length of stay;
10. Infections during hospitalization not reported in the final diagnosis, as referred by the Medical Records Committee;
11. Review of the prophylactic use of antibiotics for inpatients, outpatients, and emergency care patients, and establishment of criteria for therapeutic use of antibiotics;
12. Other situations as requested by the Executive Committee or other Medical or Hospital Committees, and;
13. Serve as a peer review committee, as set forth in these Bylaws.

Meetings, Reports, and Recommendations:

The Infection Control Committee shall meet quarterly, shall maintain a permanent record of its findings, proceedings and actions, and shall make a monthly report to the, Medical Staff, and the CEO.

- 12.1-7 Pharmacy & Therapeutics Committee – The activities of the Pharmacy & Therapeutics Committee shall be performed by the Indiana University Health Ball Memorial Hospital Pharmacy & Therapeutics Committee, with representation by one member of the IUH Blackford Hospital Active Staff appointed by the Medical Staff President, an IUH Blackford Hospital Pharmacist, and a representative from IUH Blackford Hospital Administration/Nursing. The activities of the Pharmacy & Therapeutics Committee shall be reported to the Medical Staff at least quarterly.

This Committee shall be responsible for the development and surveillance of all drug utilization policies and practices within the Hospital in order to assure optimum clinical results in a minimal potential for hazard. The Committee shall assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the Hospital.

- 12.1-8 Peer Review Committee: A committee comprised of the members of the Active Staff shall meet, at least quarterly, to review a representative sample of each =s cases. Any trends or patterns of problems identified during these case reviews will be referred to the Credentials Committee and the Medical Staff. Such information shall be considered during decisions relating to requests for and maintenance of clinical privileges. The Peer Review Committee shall participate in any FPPEs or OPPEs conducted.
- 12.1-9 Special Committees. These committees shall be appointed from time to time as may be required to carry out properly the duties of the Medical Staff. Such committees shall confine their work to the purpose for which they were appointed and shall report to the full Medical Staff. They shall not have power of action unless such is specifically granted by the motion which created the committee.
- 12.1-10 Committee of the Whole. If in the judgment of the Governing Body and active Medical Staff and number of members of the Medical Staff is not sufficient to organize committees set out in these Bylaws, the function of such committees shall be carried out, in-so-far as practicable, by the total membership acting as a committee of the whole, until such time as the membership of the Medical Staff is sufficient to provide an adequate number of physicians who are able and willing to serve on such committees.

The Committees of the Medical Staff have various responsibilities for the evaluation of the qualifications of professional health care providers, or of patient care rendered by

professional health care providers or of the merits of a complaint against a professional health care provider including a determination of recommendation concerning the complaint. In performing any such responsibilities, the Committee is intended to constitute a "peer review committee: within the meaning IND. CODE 34-4-12.6-1. and the committee, its members and its personnel shall conduct their activities accordingly.

12.2 Medical Staff Representation on Hospital Committees

12.2-1 Appointment to Hospital Committees. The Medical Staff President shall appoint one or more representatives to Hospital committees that are formed by the Governing Body or the Hospital CEO to oversee and make recommendations with respect to the clinical and patient related aspects of various Hospital departments and activities.

12.2-2 Clinical Responsibilities. The representatives of the Medical Staff appointed to the Hospital committees will assist in the Hospital departments with establishing criteria for the routine monitoring of the quality and appropriateness of care provided by that service. The representative will assist the Quality Assurance Committee in the audit and evaluation of areas within the department.

12.2-3 Administrative Responsibilities. The representative of the Medical Staff to the Hospital committees will assist the department in developing rules, regulations and policies which pertain to the care of the patients, and will assist the department in carrying out these policies, rules and regulations.

ARTICLE XIII. GENERAL PROVISIONS

13.1 Medical Staff Rules and Regulations. Subject to approval of the Governing Body, the Medical Staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within these Bylaws. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required by each Practitioner in the Hospital. Such rules and regulations shall be a part of these Bylaws and are hereby incorporated by reference, except that they may be amended or repealed at any regular meeting of the Medical Staff at which a quorum is present and without previous notice, or at any special meeting on notice, by two thirds (2/3) vote of those present and eligible to vote. Such changes shall become effective when approved by the Governing Body. To the extent the Rules and Regulations may conflict with these Bylaws the Bylaws will control.

13.2 Regular and Special Meetings. Regular meetings of the Medical Staff shall be held on a monthly basis on a date and time approved by the Medical Staff at least eight (8) monthly meetings shall be held each year. Special meetings of the Medical Staff may be called at any time by the Medical Staff President, President of the Governing Body, or by the majority of the active Medical Staff, or by a petition in writing of at least five (5) eligible voting members. No later than (5) working days prior to the meeting, notice shall be sent to the members of the Medical Staff which includes the stated purpose of the meeting. No business shall be transacted at any

special meeting except that stated in the meeting notice. The President of the Governing Body and the CEO shall be entitled to attend any regular or special meeting of the Medical Staff and may offer comments and discuss issues as presented in the meeting. However, neither the President of the Governing Body nor the CEO shall be entitled to vote on any issue coming before the Medical Staff at a regular or special meeting.

- 13.3 Construction of Terms and Headings. Words used in these Bylaws shall be read as the masculine or feminine gender, and as the singular or plural, as the context requires. The captions or headings in these Bylaws are for convenience only, and are not intended to limit or define the scope or effect of any provision of these Bylaws.
- 13.4 Quorum – One half of the Active Staff members shall constitute a quorum for a regular or special meeting of the Medical Staff (rounded up if the Active Staff membership consists of an odd number of members.)

ARTICLE IXV: ADOPTION AND AMENDMENT OF BYLAWS

- 14.1 Amendment. Any proposed amendment to these Bylaws shall be presented at a regular or special meeting for review by the Medical Staff. At the next regular meeting or a special meeting, the amendment shall be read and voted upon. A majority vote of the active Medical Staff is required for passage. Such amendments shall become effective when approved by the Governing Body.

ADOPTED by the Medical Staff and RECOMMENDED for approval to the Governing Body on January 31, 2013.

By: _____
President of the Medical Staff

Secretary of the Medical Staff

APPROVED by the Governing Body on January 31, 2013.

By: _____
Chairman of the Board of Directors

Assistant Secretary of the Board of Directors