



St. Ann's Medical Staff

Policy on

ALLIED HEALTH

PROFESSIONALS

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ARTICLE 1

GENERAL

1.1 Definitions

The following definitions apply to terms used in this Policy:

- (1) "ALLIED HEALTH PROFESSIONALS" ("AHPs") means individuals other than Medical Staff members who are authorized by law and by the Hospital to provide patient care services within the Hospital.
- (2) "BOARD" means the Board of Trustees of the Hospital, which has the overall responsibility for the Hospital, or its designated committee.
- (3) "CHIEF EXECUTIVE OFFICER" ("CEO") and/or "CHIEF OPERATING OFFICER" ("COO") means those individuals appointed by the Board to act on its behalf in the overall management of the Hospital.
- (4) "CLINICAL PRIVILEGES" means the authorization granted by the Board to render specific patient care services.
- (5) "DAYS" means calendar days.
- (6) "DENTIST" means a doctor of dental surgery ("D.D.S.") or doctor of dental medicine ("D.M.D.").
- (7) "HOSPITAL" means Mount Carmel St. Ann's Hospital of Columbus, Ohio, Inc.
- (8) "MEDICAL EXECUTIVE COMMITTEE" means the Executive Committee of the Medical Staff.
- (9) "MEDICAL STAFF" means all physicians, dentists, podiatrists, and psychologists who have been appointed to the Medical Staff by the Board.
- (10) "MEMBER" means any physician, dentist, podiatrist, and psychologist who has been granted Medical Staff appointment and clinical privileges by the Board to practice at the Hospital.
- (11) "NOTICE" means written communication by regular U.S. mail, e-mail, facsimile, Hospital mail, hand delivery, or posting on the Medical Staff website or bulletin board.

- (12) "PATIENT CONTACTS" includes any admission, consultation, procedure, response to emergency call, evaluation, treatment, or service performed in any facility operated by the Hospital or affiliate, including outpatient facilities.
- (13) "PHYSICIAN" includes both doctors of medicine ("M.D.s") and doctors of osteopathic medicine ("D.O.s").
- (14) "PODIATRIST" means a doctor of podiatric medicine ("D.P.M.").
- (15) "PSYCHOLOGIST" means an individual with a Ph.D. or Psy.D in psychology licensed by the State of Ohio.
- (16) "SPECIAL NOTICE" means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.
- (17) "VICE PRESIDENT FOR MEDICAL AFFAIRS" (or "VPMA") means the individual appointed by the Board to act as the chief medical officer of the Hospital.

1.2 Time Limits

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

1.3 Delegation of Functions

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

ARTICLE 2

SCOPE AND OVERVIEW OF POLICY

2.1 Scope of Policy:

This Policy addresses those Allied Health Professionals who are permitted to provide services at the Hospital. It sets forth the credentialing process and the general practice parameters for these individuals, as well as guidelines for determining the need for additional categories of Allied Health Professionals at the Hospital.

2.2 Categories of Allied Health Professionals:

Only those specific categories of Allied Health Professionals that have been approved by the Board of Trustees shall be permitted to practice at the Hospital. All such categories shall be classified as either "Licensed Independent Practitioners," "Licensed Dependent Practitioners," or "Dependent Practitioners," each having a slightly different relationship to the Hospital.

2.3 Licensed Independent Practitioners:

- (a) "Licensed Independent Practitioners" (hereinafter referred to as Level I practitioners) shall include all those Allied Health Professionals who are licensed or certified under state law, authorized to function independently in the Hospital, and granted clinical privileges. These individuals require no formal or direct supervision by a physician.
- (b) A current listing of the specific categories of Allied Health Professionals functioning in the Hospital as Level I practitioners is attached to this Policy as Appendix A. This Appendix may be modified or supplemented by action of the Board after receiving the recommendations of the Credentials and Medical Executive Committees, without the necessity of further amendment of this Policy.

2.4 Licensed Dependent Practitioners:

- (a) "Licensed Dependent Practitioners" (hereinafter referred to as Level II practitioners) shall include all those Allied Health Professionals who are licensed or certified under state law, are granted clinical privileges, and function in the Hospital under the supervision of, or in collaboration with, a physician(s) appointed to the Medical Staff. The supervising or collaborating physician(s) is responsible for the actions of the Level II practitioner in the Hospital.
- (b) A current listing of the specific categories of Allied Health Professionals functioning in the Hospital as Level II practitioners is attached to this Policy as Appendix B. This Appendix may be modified or supplemented by action of the

Board after receiving the recommendations of the Credentials and Medical Executive Committees, without the necessity of further amendment of this Policy.

2.5 Dependent Practitioners:

- (a) "Dependent Practitioners" (hereinafter referred to as Level III practitioners) shall include all those Allied Health Professionals who are permitted to practice in the Hospital only under the direct supervision of a physician(s) appointed to the Medical Staff and who function pursuant to a defined scope of practice. The supervising physician(s) is responsible for the actions of the Dependent Practitioner in the Hospital.
- (b) A current listing of the specific categories of Allied Health Professionals functioning in the Hospital as Level III practitioners is attached to this Policy as Appendix C. This Appendix may be modified or supplemented by action of the Board, after receiving the recommendations of the Credentials and Medical Executive Committees, without the necessity of further amendment of this Policy.

2.6 Additional Policies:

The Board shall adopt a separate policy for each category of Allied Health Professional that it approves to practice in the Hospital. These separate policies shall supplement this Policy and shall address the specific matters set forth in Section 3.2 of this Policy.

ARTICLE 3

GUIDELINES FOR DETERMINING THE NEED FOR NEW CATEGORIES OF ALLIED HEALTH PROFESSIONALS

3.1 Determination of Need:

Whenever an Allied Health Professional in a category that has not been approved by the Board requests permission to practice at the Hospital, the Board shall appoint the Credentials Committee to evaluate the need for that particular category of Allied Health Professional and to make a recommendation to the Board. As part of the process, the Allied Health Professional shall be invited to submit information about the nature of the proposed practice, why Hospital access is sought, and the potential benefits to the community by having such services available at the Hospital. If the Allied Health Professional is a dependent practitioner, the Credentials Committee may also obtain information from the supervising physician. The Credentials Committee may also consult with other experts, including those on the Medical Staff and those outside the Hospital, and may consider the following factors when making a recommendation to the Board as to the need for the services of this category of Allied Health Professionals:

- (a) the nature of the services that could be offered;
- (b) any state license or regulation which outlines the scope of practice for the Allied Health Professional;
- (c) any state "non-discrimination" or "any willing provider" laws that would apply to the Allied Health Professional;
- (d) the patient care objectives of the Hospital, including patient convenience;
- (e) how well the community's needs are currently being met and whether they could be better met if the services offered by the Allied Health Professional were provided by the Hospital or as part of its facilities;
- (f) the type of training that is necessary to perform the services that could be offered and whether there are individuals with more training currently providing those services;
- (g) the availability of supplies, equipment, and other necessary Hospital resources;
- (h) the need for and availability of trained staff to support the services that would be offered; and
- (i) the ability to appropriately supervise performance.

3.2 Development of Policy:

- (a) If the Credentials Committee recommends that there is a need for the particular category of Allied Health Professional at the Hospital, the Committee shall recommend:
 - (1) any specific qualifications and/or training that they must possess beyond those set forth in this Policy;
 - (2) a detailed description of their authorized scope of practice or clinical privileges;
 - (3) any specific conditions that apply to their functioning within the Hospital; and
 - (4) any supervision requirements, if applicable.
- (b) In developing such policies, the Credentials Committee shall consult the appropriate department chair(s) and applicable state law and may contact applicable professional societies or associations. The Credentials Committee may also recommend to the Board the number of Allied Health Professionals that are needed in a particular category.

ARTICLE 4

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

4.1 General Qualifications:

To be eligible to apply for initial and continued permission to practice at the Hospital, an Allied Health Professional must:

- (a) have a current, unrestricted license or certification to practice in Ohio and have never had a license or certification to practice revoked or suspended by any state licensing agency;
- (b) where applicable to their practice, have a current, unrestricted DEA registration and/or a Certificate to Prescribe;
- (c) be located (office and residence) close enough to fulfill his or her Allied Health Professional responsibilities and provide timely and continuous care for his or her patients in the Hospital consistent with the Policy on Response Time;
- (d) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital;
- (e) have never been, and are not currently, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program;
- (f) have never been convicted of Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil penalties for the same;
- (g) have never had clinical privileges or scope of practice denied, revoked, suspended, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct, and have never resigned or relinquished clinical privileges or scope of practice during an investigation or in exchange for not conducting an investigation;
- (h) have never been convicted of, or entered a plea of guilty or no contest to, any felony; or to any misdemeanor relating to controlled substances, illegal drugs, alcohol, insurance or health care fraud or abuse, or violence;
- (i) satisfy all additional eligibility qualifications relating to his or her specific area of practice that may be established by the Hospital;
- (j) if seeking to practice as a Level II or Level III practitioner, have a supervision agreement with a physician who is appointed to the Medical Staff; and

- (k) be able to document his or her:
 - (1) relevant training, experience, and current demonstrated clinical competence, and judgment;
 - (2) adherence to the ethics of his or her profession;
 - (3) good reputation and character;
 - (4) ability to perform, competently and safely, the scope of practice or clinical privileges requested;
 - (5) ability to work harmoniously with all members of the patient care team; and
 - (6) recognition of the importance of, and the willingness to support, the Hospital's and Medical Staff's commitment to quality care, and recognition that including interpersonal skill at collaboration, communication, and collegiality is essential for the provision of quality patient care.

4.2 Waiver of Criteria:

- (a) Any individual who does not satisfy one or more of the criteria outlined above may request that it be waived. The individual requesting the waiver bears the burden of demonstrating that his or her qualifications are equivalent to, or exceed, the criterion in question.
- (b) An application for appointment that does not satisfy an eligibility criterion will not be processed until the Board has determined that a waiver should be granted in accordance with this section.
- (c) A request for a waiver will be submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee may consider the specific qualifications of the individual in question, input from the relevant department chair, and the best interests of the Hospital and the communities it serves. Additionally, the Credentials Committee may, in its discretion, consider the application form and other information supplied by the applicant. The Credentials Committee's recommendation will be forwarded to the Medical Executive Committee. Any recommendation to grant a waiver must include the basis for such.
- (d) The Medical Executive Committee will review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the basis for such waiver.

- (e) The Board may grant waivers in exceptional cases after considering the findings of the Credentials Committee, Medical Executive Committee, or other committee designated by the Board, the specific qualifications of the individual in question, and the best interests of the Hospital and the communities it serves. The granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals.
- (f) No individual is entitled to a waiver or to a hearing if the Board determines not to grant a waiver. A determination that an individual is not entitled to a waiver is not a "denial" of appointment or clinical privileges. Rather, that individual is ineligible to request clinical privileges or scope of practice.

4.3 No Entitlement to Medical Staff Appointment:

With the exception of those psychologists who have opted to pursue Medical Staff appointment in accordance with the Medical Staff Credentials Policy, Allied Health Professionals shall not be appointed to the Medical Staff or entitled to the rights, privileges, and/or prerogatives of Medical Staff appointment.

4.4 Non-Discrimination Policy:

No individual shall be denied permission to practice at the Hospital on the basis of gender, race, creed, or national origin.

4.5 Ethical and Religious Directives:

All members shall abide by the terms of the Ethical and Religious Directives for Catholic Health Care Services promulgated by the National Conference of Catholic Bishops with respect to their practice at the Hospital. No activity prohibited by said directives shall be engaged in at the Hospital by any Allied Health Professional.

4.6 Assumption of Duties and Responsibilities:

As a condition of permission to practice at the Hospital, all Allied Health Professionals shall specifically agree to the following:

- (a) to provide continuous and timely care to all patients in the Hospital for whom the individual has responsibility;
- (b) to abide by all applicable bylaws, policies, rules and regulations of the Medical Staff and Hospital;
- (c) to accept committee assignments, participation in quality improvement and peer review activities, and such other reasonable duties and responsibilities as may be assigned;

- (d) to constructively participate in the development, review, and revision of clinical protocols and pathways pertinent to their medical specialties, including those related to national patient safety initiatives and core measures;
- (e) to comply with adopted protocols and pathways or document reasons for variance;
- (f) to provide, with or without request, new or updated information to the Credentials Committee, as it occurs, pertinent to any question on the application form;
- (g) to immediately submit to a blood and/or urine test if at least two Medical Staff leaders (or one Medical Staff leader and one member of the Administrative team) are concerned with the individual's ability to safely and competently care for patients;
- (h) to acknowledge that the individual has had an opportunity to read a copy of this Policy and any other applicable bylaws, policies, rules and regulations and agrees to be bound by them;
- (i) to appear for personal interviews in regard to an application for permission to practice as may be requested;
- (j) to refrain from illegal fee splitting or other illegal inducements relating to patient referral;
- (k) to refrain from assuming responsibility for diagnosis or care of hospitalized patients for which he or she is not qualified or without adequate supervision;
- (l) to refrain from deceiving patients as to the individual's status as an Allied Health Professional;
- (m) to seek consultation when appropriate;
- (n) to participate in the performance improvement and quality monitoring activities of the Hospital;
- (o) to complete, in a timely manner, the medical and other required records, containing all information required by the Hospital;
- (p) to perform all services and conduct himself/herself at all times in a cooperative and professional manner;
- (q) to satisfy applicable continuing education requirements;
- (r) to pay any applicable dues and assessments; and

- (s) that any misstatement in, or omission from, the application is grounds for the Hospital to stop processing the application. If permission to practice has been granted prior to the discovery of a misstatement or omission, the permission may be deemed to be automatically relinquished. In either situation, there shall be no entitlement to the procedural rights provided in this Policy.

4.7 Burden of Providing Information:

- (a) Allied Health Professionals seeking permission to practice shall have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications, and for resolving any doubts about such qualifications.
- (b) Allied Health Professionals seeking appointment have the burden of providing evidence that all the statements made and information given on the application are accurate and complete.
- (c) An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information verified from primary sources. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time. Any application that continues to be incomplete 60 days after the individual has been notified of the additional information required shall be deemed to be withdrawn.
- (d) It is the responsibility of the individual seeking permission to practice to provide a complete application, including adequate responses from references. An incomplete application will not be processed.

4.8 Application Form:

- (a) The application forms for both initial and renewed permission to practice as an Allied Health Professional shall require detailed information concerning the applicant's professional qualifications. The Allied Health Professional applications existing now and as may be revised are incorporated by reference and made a part of this Policy.
- (b) In addition to other information, the applications shall seek the following:
 - (1) information as to whether the applicant's clinical privileges, scope of practice, permission to practice, and/or affiliation has ever been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, reduced, subjected to probationary or other conditions, limited, terminated, or not renewed at any hospital or health care facility, or is currently being investigated or challenged;

- (2) information as to whether the applicant's license or certification to practice any profession in any state, Drug Enforcement Administration registration, or any state controlled substance license (if applicable) is or has ever been voluntarily or involuntarily relinquished, suspended, modified, terminated, restricted, or is currently being investigated or challenged;
 - (3) information concerning the applicant's professional liability litigation experience and/or any professional misconduct proceedings involving the applicant, in this state or any other state, whether such proceedings are closed or still pending, including the substance of the allegations of such proceedings or actions, the substance of the findings of such proceedings or actions, the ultimate disposition of any such proceedings or actions that have been closed, and any additional information concerning such proceedings or actions as the Credentials Committee, Medical Executive Committee or Board may deem appropriate;
 - (4) current information regarding the applicant's ability to perform, safely and competently, the scope of practice or clinical privileges requested and the duties of Allied Health Professionals; and
 - (5) a copy of a government-issued photo identification.
- (c) The applicant shall sign the application and certify that he or she is able to perform the scope of practice or clinical privileges requested and the responsibilities of Allied Health Professionals.

4.9 Grant of Immunity and Authorization to Obtain/Release Information:

By applying for permission to practice at the Hospital, Allied Health Professionals expressly accept the following conditions (i) during the processing and consideration of the application, whether or not permission to practice is granted, (ii) as a condition of continued permission to practice, if granted, (iii) should permission to practice be revoked, reduced, and/or suspended for reasons related to clinical competence or professional conduct, and (iv) with regard to any third-party inquiries received after the individual leaves about his or her tenure at the Hospital:

(a) Immunity:

To the fullest extent permitted by law, the Allied Health Professional releases from any and all liability, extends absolute immunity to, and agrees not to sue the Hospital, any member of the Medical Staff, their authorized representatives, and third parties who provide information for any matter relating to permission to practice, clinical privileges, scope of practice at the Hospital, or the individual's qualifications for the same. This immunity covers any actions, recommendations, reports, statements, communications, or disclosures involving the individual

which are made, taken, or received by the Hospital, its authorized agents, or third parties in the course of credentialing and peer review activities.

(b) Authorization to Obtain Information from Third Parties:

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

(c) Authorization to Release Information to Third Parties:

The Allied Health Professional also authorizes Hospital representatives to release information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their agents when information is requested in order to evaluate his or her professional qualifications for appointment, privileges, permission to practice, scope of practice, and/or participation status at the requesting organization/facility, and any license or regulatory matter.

(d) Procedural Rights:

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

(e) Legal Actions:

If, notwithstanding the provisions in this Section, an Allied Health Professional institutes legal action and does not prevail, he or she shall reimburse the Hospital and any of its authorized representatives named in the action for any and all costs incurred in defending such legal action, including reasonable attorney's fees.

ARTICLE 5

CREDENTIALING PROCEDURE

5.1 Request for Application:

- (a) Applications for permission to practice at the Hospital shall be in writing and shall be on forms approved by the Board upon recommendation by the Medical Executive Committee and Credentials Committee.
- (b) Any individual requesting an application for permission to practice at the Hospital shall be sent a letter that outlines the eligibility criteria for permission to practice, as well as any eligibility requirements that relate to the Allied Health Professional's specific area of practice, and the application form.
- (c) Allied Health Professionals who are in a category of practitioners that has not been approved by the Board for access to the Hospital shall be ineligible to receive an application. A determination of ineligibility does not entitle an Allied Health Professional to the procedural rights outlined in Article 8 of this Policy.

5.2 Initial Review of Application:

- (a) A completed application, with copies of all required documents, must be submitted to the Medical Staff Office within 30 days after receipt of the application if the Allied Health Professional desires further consideration. The application must be accompanied by the application processing fee, if one is required.
- (b) As a preliminary step, the application will be reviewed by the Medical Staff Office to determine that all questions have been answered and that the individual satisfies all threshold criteria. Individuals who fail to return completed applications or fail to meet the eligibility criteria set forth in Section 4.1(a-j) of this Policy will be notified that they are not eligible for permission to practice at the Hospital and that their application will not be processed. A determination of ineligibility does not entitle an Allied Health Professional to the procedural rights outlined in Article 8 of this Policy.
- (c) The Medical Staff Office shall oversee the process of gathering and verifying relevant information and confirming that all references and other information or materials deemed pertinent have been received.

5.3 Department Chair Procedure:

- (a) The Medical Staff Office shall transmit the complete application and all supporting materials to the appropriate department chair or the individual to whom the department chair has assigned this responsibility. Each chair shall prepare a written report regarding whether the applicant has satisfied all of the qualifications for permission to practice and the clinical privileges or scope of practice requested. As part of the process of making this report, the department chair has the right to meet with the applicant and the supervising physician (if applicable) to discuss any aspect of the application, qualifications, and requested scope of practice or clinical privileges. The department chair may also confer with experts within the department and outside of the department in preparing the report (e.g., other physicians, relevant Hospital department heads, nurse managers). In the event that the department chair or the individual to whom the department chair has assigned the responsibility is unavailable or unwilling to prepare a written report, the Chair of the Credentials Committee or the President of the Medical Staff shall appoint an individual to prepare the report.
- (b) The department chair may also recommend that an application raises no questions and should be processed in an expedited manner.
- (c) The department chair shall be available to the Credentials Committee, Medical Executive Committee, or the Board to answer any questions that may be raised with respect to that chair's report and findings.

5.4 Fast-Tracked Process:

- (a) If recommended by the relevant department chair, applications for initial permission to practice may be processed as set forth in this Section so long as they meet the following conditions:
 - (1) the applicant has not changed practice affiliations (groups or health systems) more than three times in the past 10 years;
 - (2) all reference evaluations are completed and received within a reasonable time of the initial request;
 - (3) all references contain only favorable evaluations and recommendations for the scope of practice or clinical privileges requested;
 - (4) the applicant's claims activity (including past malpractice claims, judgments and settlements) is reasonable in light of his or her area of practice and there has been no unusual pattern or excessive number of liability actions resulting in a judgment against the applicant;
 - (5) there are no current or previously successful challenges to licensure, certification, or registration;

- (6) there has been no involuntary suspension, termination, limitation, restriction, reduction, denial or loss of permission to practice, clinical privileges or scope of practice at any hospital or other entity; and
 - (7) there has been no investigation into and no disciplinary action taken relating to permission to practice, clinical privileges, or scope of practice at any hospital or other entity.
- (b) The Credentials Committee (or Chair acting on behalf of the Committee) shall review the report from the department chair. The Chair of the Credentials Committee shall examine evidence of the applicant's character, professional competence, qualifications, prior behavior, and ethical standing and shall determine whether the applicant has established and satisfied all of the necessary qualifications for permission to practice and the scope of practice or clinical privileges requested.
 - (c) The President of the Medical Staff shall review the report and recommendation made by the Chair of the Credentials Committee. If the President of the Medical Staff concurs with the recommendation, the recommendation shall be forwarded to the COO.
 - (d) The COO may grant the individual a temporary scope of practice or temporary clinical privileges, as applicable, for a period not to exceed 120 days.
 - (e) After determining that an applicant is otherwise qualified for permission to practice and the clinical privileges or scope of practice requested, the Chair of the Credentials Committee shall review the applicant's Confirmation of Ability to Perform Privileges/Scope of Practice Requested as noted on the application and addendum to determine if there is a question about the applicant's ability to perform the clinical privileges or scope of practice requested and the responsibilities of permission to practice. If there is no question, the temporary clinical privileges or scope of practice shall take effect. If there is a question, the application shall be referred to the full Credentials Committee.
 - (f) In the event the department chair, the Chair of the Credentials Committee, the President of the Medical Staff, or the COO has any questions about the applicant, the questions shall be noted and the matter shall be referred to the entire Credentials Committee for further action.
 - (g) A report regarding all applicants granted a temporary scope of practice or temporary clinical privileges shall be forwarded to the Credentials Committee for its information, and the application for clinical privileges/scope of practice shall be forwarded to the Medical Executive Committee for review and recommendation, and to the Board for final action.

5.5 Credentials Committee Procedure:

- (a) For all other applications, the Credentials Committee shall review the report from the appropriate department chair and the information contained in references given by the applicant and from other available sources. The Credentials Committee shall examine evidence of the applicant's character, professional competence, qualifications, prior behavior, and ethical standing and shall determine whether the applicant has established and satisfied all of the necessary qualifications for the clinical privileges or scope of practice requested.
- (b) The Credentials Committee may use the expertise of any individual on the Medical Staff or in the Hospital, or an outside consultant, if additional information is required regarding the applicant's qualifications. The Credentials Committee may also meet with the applicant and, when applicable, the supervising physician. The appropriate department chair may participate in this interview.
- (c) After determining that an applicant is otherwise qualified for permission to practice and the scope of practice or clinical privileges requested, the Credentials Committee shall review the applicant's Confirmation of Ability to Perform Privileges/Scope of Practice Requested as noted on the application and addendum to determine if there is any question about the applicant's ability to perform the scope of practice or privileges requested and the responsibilities of permission to practice. If so, the Credentials Committee may require the applicant to undergo a physical and/or mental examination by a physician(s) satisfactory to the Credentials Committee. The results of this examination shall be made available to the Committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall be considered an incomplete application and all processing of the application shall cease.
- (d) The Credentials Committee may recommend the imposition of specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring). The Credentials Committee may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of an individual's compliance with any conditions.

5.6 Medical Executive Committee Procedure:

- (a) At its next meeting, after receipt of the written findings and recommendation of the Credentials Committee (and/or its Chair), the Medical Executive Committee shall:
 - (1) adopt the findings and recommendations of the Credentials Committee (and/or its Chair) as its own; or

- (2) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the Medical Executive Committee; or
 - (3) set forth in its report and recommendation clear and convincing reasons, along with supporting information for its disagreement with the Credentials Committee's recommendation.
- (b) If the Medical Executive Committee's recommendation is favorable to the applicant, the Committee shall forward its recommendation to the Board, through the COO, including the findings and recommendation of the department chair and the Credentials Committee (and/or its Chair). The Medical Executive Committee's recommendation must specifically address the clinical privileges or scope of practice requested by the applicant, which may be qualified by any probationary or other conditions or restrictions relating to such clinical privileges or scope of practice.
- (c) If the Medical Executive Committee's recommendation would entitle the applicant to the procedural rights set forth in this Policy, the Medical Executive Committee shall forward its recommendation to the COO, who shall notify the applicant of the recommendation and his or her procedural rights. The COO shall then hold the Medical Executive Committee's recommendation until after the individual has completed or waived the procedural rights outlined in this Policy.

5.7 Board Action:

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

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

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

5.8 Renewal of Permission to Practice:

- (a) Permission to practice at the Hospital as an Allied Health Professional is a courtesy extended by the Board and, if granted, shall be for a period not to exceed two years. Renewal of clinical privileges or scope of practice shall be granted only upon submission of a completed renewal application.
- (b) Once an application for renewal of permission to practice has been completed and submitted to the Medical Staff Office, it shall be evaluated in the same manner and follow the same procedures outlined in this Policy regarding initial applications. However, applicants seeking renewed permission to practice are not eligible for the expedited review process and shall instead be processed through the full Credentials Committee and Medical Executive Committee.
- (c) As part of the process for renewal of clinical privileges for Level I and Level II practitioners, the following factors shall be considered:
 - (1) the competency of the practitioner as assessed by the appropriate department chair and documented on a biennial evaluation form;
 - (2) a recommendation from a peer; and
 - (3) use of the Hospital's facilities, taking into consideration practitioner-specific information concerning other individuals in the same or similar specialty.

- (d) As part of the process for renewal of a Level III practitioner's scope of practice, the **annual competency assessments** of the individual performed by the supervising physician(s) and the applicable Hospital department heads or nurse managers shall be considered. These evaluation forms, along with other reasonable indicators of continuing qualifications, shall be factors for the renewal of Level III practitioners' continued permission to practice.

- (e) Applicants seeking renewal of clinical privileges or scope of practice who are the subject of an adverse recommendation shall be entitled to the procedural rights outlined in Article 8 before the Board takes final action.

ARTICLE 6

CONDITIONS OF PRACTICE APPLICABLE TO LEVEL II AND LEVEL III PRACTITIONERS

6.1 Supervision by Supervising Physician:

- (a) Any activities permitted by the Board to be done at the Hospital by a Level II or Level III practitioner shall be done only under the supervision of the physician supervising that individual.
- (b) Level II or Level III practitioners may function in the Hospital only so long as (i) they are supervised by a physician currently appointed to the Medical Staff, and (ii) they have a current, written supervision agreement with that physician. In addition, should the Medical Staff appointment or clinical privileges of the staff physician supervising a Level II or Level III practitioner be revoked or terminated, the individual's permission to practice at the Hospital and clinical privileges or scope of practice shall be automatically relinquished (unless the individual will be supervised by another physician on the Medical Staff).
- (c) As a condition for permission to practice at the Hospital, each Level II or Level III practitioner and his/her supervising physician must submit a copy of their written Supervision Agreement or Standard Care Arrangement to the Hospital which must be verified by the Medical Staff Office.

This agreement must meet the requirements of all applicable state statutes and regulations, as well as any additional requirements of the Hospital. It is also the responsibility of the Level II or Level III practitioner and his/her supervising physician to provide the Hospital, in a timely manner, with any revisions or modifications that are made to the agreement.

6.2 Questions Regarding Authority or Activities of a Level II or Level III Practitioner:

- (a) Should any Medical Staff member or Hospital employee who is licensed or certified by the state have any question regarding the clinical competence or authority of a Level II or Level III practitioner either to act or to issue instructions outside the physical presence of the supervising physician in a particular instance, the Medical Staff member or Hospital employee shall have the right to require that the Level II or Level III practitioner's supervisor validate, either at the time or later, the instructions of the Level II or Level III practitioner. Any act or instruction of the Level II or Level III practitioner shall be delayed until such time as the staff member or Hospital employee can be certain that the act is clearly within the scope of the Level II or Level III practitioner's activities as permitted by the Board.

- (b) Any question regarding the clinical practice or professional conduct of a Level II or Level III practitioner shall be immediately reported to the President of the Medical Staff, the relevant department chair, or the COO, who shall undertake such action as may be appropriate under the circumstances. The individual to whom the concern has been reported shall also discuss the matter with the supervising physician.

6.3 Responsibilities of Supervising or Collaborating Physician:

- (a) The supervising or collaborating physician shall be responsible for the actions of the Level II or Level III practitioner in the Hospital.
- (b) The number of Level II or Level III practitioners acting under the supervision of, or in collaboration with, one physician, as well as the acts they may undertake, shall be consistent with applicable state statutes and regulations, the rules and regulations of the Medical Staff, and the policies of the Board.

ARTICLE 7

PEER REVIEW PROCEDURES FOR QUESTIONS INVOLVING ALLIED HEALTH PRACTITIONERS

7.1 Collegial Intervention:

- (a) As part of the Hospital's performance improvement and professional and peer review activities, this Policy encourages the use of collegial intervention and progressive steps by Medical Staff leaders and Hospital administration to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised. Collegial intervention efforts are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders.
- (b) Collegial efforts may include, but are not limited to, counseling, sharing of comparative data, monitoring, and additional training or education.

7.2 Administrative Suspension:

- (a) The President of the Medical Staff, the relevant department chair, the VPMA, and the COO shall each have the authority to impose an administrative suspension of all or any portion of the scope of practice or clinical privileges of any Allied Health Professional whenever a concern has been raised about such individual's clinical practice or conduct.
- (b) An administrative suspension shall become effective immediately upon imposition, shall immediately be reported in writing to the COO and the President of the Medical Staff, and shall remain in effect unless or until modified by the COO or the Medical Executive Committee.
- (c) Upon receipt of notice of the imposition of an administrative suspension, the COO and the President of the Medical Staff shall forward the matter to the full Medical Executive Committee, which shall review and consider the question(s) raised and thereafter make an appropriate recommendation to the Board. If the Medical Executive Committee's recommendation is to restrict or terminate the Allied Health Professional's scope of practice or clinical privileges, the individual and, when applicable, the supervising physician shall be entitled to the procedural rights outlined in Article 8 of this Policy before the Medical Executive Committee's recommendation is considered by the Board.

7.3 Automatic Relinquishment of Scope of Practice or Clinical Privileges:

An Allied Health Professional's clinical privileges or scope of practice shall be automatically relinquished, without entitlement to the procedural rights outlined in this Policy, in the following circumstances:

- (a) the Medical Staff appointment or clinical privileges of the staff physician supervising a Level II or Level III practitioner are revoked or terminate for any reason (unless the Level II or Level III practitioner will be supervised by another physician on the Medical Staff);
- (b) a Level II or Level III practitioner ceases to be supervised by a physician currently appointed to the Medical Staff for any reason (unless the Level II or Level III practitioner will be supervised by another physician on the Medical Staff);
- (c) an Allied Health Professional's license or certification expires, is revoked, or is suspended;
- (d) the Allied Health Professional no longer satisfies any of the threshold eligibility criteria set forth in Section 4.1 (a-j) or any additional threshold credentialing qualification set forth in the specific Hospital policy relating to his or her discipline;
- (e) the Allied Health Professional is indicted, convicted, or enters a plea of guilty or no contest pertaining to any felony, or any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) alcohol, (iv) Medicare, Medicaid, or insurance or health care fraud or abuse; or (v) violence against another;
- (f) the Allied Health Professional fails to provide information pertaining to his or her qualifications for the scope of practice or clinical privileges in response to a written request from the Medical Executive Committee, the COO, or any other committee authorized to request such information; or
- (g) a determination is made that there is no longer a need for the services that are being provided by the Allied Health Professional.

7.4 Leave of Absence:

- (a) An Allied Health Professional may request a leave of absence, for a period not to exceed a year, by submitting a written request to the COO. The COO will determine whether a request for a leave of absence shall be granted.
- (b) Except for maternity leaves, Allied Health Professionals must report to the COO or the VPMA any time they are away from patient care responsibilities for longer than 30 days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Under such circumstances, the COO, in consultation with the President of the Medical Staff and the VPMA, may trigger an automatic leave of absence.

- (c) Individuals requesting reinstatement shall submit a written summary of their professional activities during the leave, and any other information that may be requested by the Hospital at least 30 days prior to the conclusion of the leave of absence. If the leave of absence was for health reasons (except for maternity leaves), the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges or scope of practice requested.
- (d) Requests for reinstatement shall then be reviewed by the relevant department chair, the Chair of the Credentials Committee, the President of the Medical Staff, the VPMA, and the COO. If all these individuals make a favorable recommendation on reinstatement, the Allied Health Professional may immediately resume clinical practice at the Hospital. This determination shall then be forwarded to the Credentials Committee, the Medical Executive Committee, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee, Medical Executive Committee, and the Board for review and recommendation. If a request for reinstatement is not granted, for reasons related to clinical competence or professional conduct, the individual shall be entitled to the procedural rights set forth in Article 8 of this Policy.
- (e) The Credentials and Medical Executive Committees may recommend the imposition of specific conditions upon reinstatement from a leave of absence. The conditions may relate to behavior (i.e., code of conduct) or to clinical issues (i.e., general consultation requirements or proctoring).

ARTICLE 8

PROCEDURAL RIGHTS FOR ALLIED HEALTH PROFESSIONALS

8.1 General:

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

8.2 Procedural Rights for Employed Allied Health Professionals:

- (a) Except as provided in (b), any and all issues related to disciplinary matters involving Level I, Level II, or Level III practitioners who are employed by the Hospital shall be handled in accordance with applicable Human Resources grievance procedures and/or the terms of any applicable employment contract.
- (b) If the disciplinary action in question is recommended by the Medical Staff, the provisions of this Article 8 shall be followed and a report provided to Human Resources.

8.3 Procedural Rights for Level III Practitioners:

The procedural rights for Level III practitioners who are not employed by the Hospital shall be as follows:

- (a) In the event that a recommendation is made by the Medical Executive Committee that a Level III practitioner not be granted the scope of practice requested or that a scope of practice previously granted be restricted or terminated, the individual shall be notified of the recommendation. The notice shall include a specific statement of the reasons for the recommendation and shall advise the individual that he or she may request a meeting with the Medical Executive Committee before its recommendation is forwarded to the Board for final action.
- (b) If the Level III practitioner desires to request a meeting, he or she must make such request in writing and direct it to the COO within 30 days after receipt of the written notice of the adverse recommendation.
- (c) If a meeting is requested in a timely manner, it shall be scheduled to take place within a reasonable time frame. The meeting shall be informal and shall not be considered a hearing. The Level III practitioner and his or her employing or supervising physician shall both be permitted to attend and participate in the meeting. However, no counsel for either the Level III practitioner or the Medical Executive Committee shall be present.

- (d) Following this meeting, the Medical Executive Committee shall make its final recommendation to the Board.

8.4 Procedural Rights for Level I and Level II Practitioners:

- (a) In the event that a recommendation is made by the Medical Executive Committee that a non-Hospital employed Level I or Level II practitioner not be granted the clinical privileges requested, or that the clinical privileges previously granted be restricted or terminated, the practitioner shall be notified of the recommendation. The notice shall include the specific reasons for the recommendation and shall advise the individual that he or she may request a hearing before the adverse recommendation is transmitted to the Board for final action.
- (b) If the Level I or Level II practitioner desires to request a hearing, he or she must make such request in writing and direct it to the COO within 30 days after receipt of the written notice of the adverse recommendation.
- (c) If a request for a hearing is made in a timely manner, the COO, in conjunction with the President of the Medical Staff, shall appoint an Ad Hoc Committee composed of up to three individuals (including, but not limited to, individuals appointed to the Medical Staff, Allied Health Professionals, Hospital management, individuals not connected to the Hospital, or any combination of these individuals) and a Presiding Officer, who may be legal counsel to the Hospital. The Ad Hoc Committee shall not include anyone who previously participated in the recommendation, any relatives or practice partners of the Level I or Level II practitioner, or any competitors of the affected individual.
- (d) As an alternative to the Ad Hoc Committee described in paragraph (c) of this Section, the COO, in conjunction with the President of the Medical Staff, may instead appoint a Hearing Officer to perform the functions that would otherwise be carried out by the Ad Hoc Committee. The Hearing Officer shall preferably be an attorney at law. The Hearing Officer may not be in direct economic competition with the individual requesting the hearing and shall not act as a prosecuting officer or as an advocate to either side at the hearing. If the Hearing Officer is an attorney, he or she shall not represent clients who are in direct economic competition with the affected individual. In the event a Hearing Officer is appointed instead of an Ad Hoc Committee, all references in this Article to the Ad Hoc Committee shall be deemed to refer instead to the Hearing Officer, unless the context would clearly otherwise require.
- (e) The hearing shall be convened as soon as is practical, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to by the parties.

8.5 Hearing Process for Level I and Level II Practitioners:

- (a) At the hearing, a representative of the Medical Executive Committee shall first present the reasons for the recommendation. The Level I or Level II practitioner shall be invited to present information, both orally and in writing, to refute the reasons for the recommendation, subject to a determination by the Presiding Officer (or the Hearing Officer) that the information is relevant. The Presiding Officer (or the Hearing Officer) shall have the discretion to determine the amount of time allotted to the presentation by the representative of the Medical Executive Committee and the Level I or Level II practitioner.
- (b) The Level I or Level II practitioner shall not have the right to present other witnesses unless he or she can demonstrate to the satisfaction of the Presiding Officer (or the Hearing Officer) that the failure to permit witnesses to appear would be fundamentally unfair. In the event witnesses are allowed, the Presiding Officer (or the Hearing Officer) shall permit reasonable questioning of such witnesses.
- (c) Neither the Level I or Level II practitioner nor the Medical Executive Committee shall be represented by counsel at this hearing.
- (d) The affected practitioner shall have the burden of demonstrating that the recommendation of the Medical Executive Committee was arbitrary, capricious, or not supported by substantial evidence. The quality of care provided to patients and the smooth operation of the Hospital shall be the paramount considerations. Minutes of this proceeding shall be kept and shall be attached to the report and recommendation of the Ad Hoc Committee.

8.6 Ad Hoc Committee or Hearing Officer Report:

- (a) The Ad Hoc Committee (or the Hearing Officer) shall prepare a written report and recommendation within 30 days after the conclusion of the proceeding, and shall forward it along with all supporting information to the COO. The COO shall send a copy of the written report and recommendation, via certified mail, return receipt requested, to the Level I or Level II practitioner. A copy shall also be provided to the Medical Executive Committee.
- (b) Within ten days after receiving notice of the recommendation, either the Level I or Level II practitioner or the Medical Executive Committee may make a request for an appeal. The request must be in writing and must include a statement of the reasons for appeal, including the specific facts, which justify further review. The request shall be delivered to the COO either in person or by certified mail.
- (c) If a written request for appeal is not submitted within the ten-day time frame specified above, the recommendation and supporting information shall be forwarded by the COO to the Board for final action. If a timely request for appeal is submitted, the COO shall forward the report and recommendation, the supporting information, and the request for appeal to the Chair of the Board.

8.7 Appeals Process for Level I and Level II Practitioners:

- (a) The grounds for appeal shall be limited to the following assertions: (i) there was substantial failure to comply with this Policy and/or other applicable bylaws or policies of the Hospital or the Medical Staff and/or (ii) the recommendation was arbitrary, capricious, or not supported by evidence.
- (b) The Chair of the Board, or a committee of the Board appointed by the Chair, will consider the request for appeal and the record upon which the adverse recommendation was made. This review shall be conducted within 30 days after receiving the request for appeal.
- (c) The Level I or Level II practitioner and the Medical Executive Committee shall each have the right to present a written statement in support of its position on appeal.
- (d) At the sole discretion of the Chair of the Board or the committee appointed by the Chair, the Level I or Level II practitioner and a representative of the Medical Executive Committee may also appear personally to discuss their position. In that event, however, neither party shall be represented by counsel at the appeal.
- (e) Upon completion of the review, the Chair of the Board or the committee appointed by the Chair shall provide a report and recommendation to the full Board for action. The Chair (or the committee) may also refer the matter to any committee or individual deemed appropriate for further review and recommendation to the full Board. The Board shall then make its final decision based upon the Board's ultimate legal responsibility to grant privileges and to authorize the performance of clinical activities at the Hospital.

ARTICLE 9

HOSPITAL EMPLOYEES

- (a) A request for clinical privileges or scope of practice, on an initial basis or for renewal, submitted by an Allied Health Professional who is seeking employment or who is employed by the Hospital will be processed in accordance with the terms of Article 5 of this Policy. The findings of the Board regarding each Allied Health Professional's qualifications will be forwarded to Hospital management personnel or Human Resources (as appropriate) to assist the Hospital in making employment decisions.
- (b) Except as provided in paragraph (c) below, any disciplinary concern or action with respect to an employed Allied Health Professional will be governed by the Hospital's employment policies and manuals and the terms of the individual's employment relationship and/or written contract. If an Allied Health Professional's employment is terminated by the Hospital for any reason, the individual's permission to practice in the Hospital will automatically expire without any procedural rights set forth in this Policy.
- (c) If a concern about an employed Allied Health Professional's clinical competence or conduct originates with the Medical Staff, the concern will be reviewed and addressed in accordance with Articles 7 and 8 of this Policy, after which a report will be provided to Human Resources.
- (d) Except as otherwise provided above, to the extent that the Hospital's employment policies or manuals, or the terms of any applicable employment contract, conflict with this Policy, the employment policies, manuals, and descriptions and terms of the individual's employment relationship and/or written contract will apply.

ARTICLE 10

AMENDMENTS

This Policy may be amended by a majority vote of the members of the Medical Executive Committee present and voting at any meeting of that committee where a quorum exists, provided that the written recommendations of the Credentials Committee concerning the proposed amendments shall have first been received and reviewed by the Medical Executive Committee. Notice of all proposed amendments shall be made available to the voting members of the Medical Staff at least 14 days prior to the Medical Executive Committee meeting and any member of the Medical Staff may submit written comments to the Medical Executive Committee. No amendment shall be effective unless and until it has been approved by the Board.

ARTICLE 11

ADOPTION

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

Adopted by the Medical Staff: _____ 4/13/2009 _____

Approved by the Board: _____ 4/27/2009 _____

APPENDIX A

Those individuals currently practicing as Level I practitioners at the Hospital are as follows:

Audiologists

Psychologists

APPENDIX B

Those individuals currently practicing as Level II practitioners at the Hospital are as follows:

Certified Nurse Midwives

Certified Nurse Practitioners

- Emergency Department
- Internal Medicine
- Neonatal Intensive Care
- Orthopedic, General Surgery, OB/GYN

Certified Registered Nurse Anesthetists

Certified Nurse Specialists

- Registered Nurse Mental Health Specialists

Physician Assistants

- Internal Medicine (including Cardiology)
- Emergency Medicine
- Orthopedic, General Surgery

APPENDIX C

Those individuals currently practicing as Level III practitioners at the Hospital are as follows:

Dental Assistants

Equipment Technicians

Exercise Physiologist

Licensed Practical Nurses

Medical Assistants

Physician Clerical Office Staff

Operating Room Technicians

Pathology Assistants

Privately Employed Registered Nurses

Registered Nurse First Assistants

Surgical Assistants

Surgical Technicians