Medical Staff Bylaws

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ARTICLE I NAME

1.1 NAME

The name of this organization shall be the Medical Staff of Memorial Hospital of Carbon County.

ARTICLE II PURPOSES AND RESPONSIBILITIES

2.1 PURPOSES

The purposes of the Medical Staff are:

(a) To be the formal organizational structure through which the benefits of membership on the staff may be obtained by individual practitioners and to ensure that the obligations of medical staff membership may be fulfilled.

(b) To serve as the primary means for accountability to the Board of Trustees for the quality and appropriateness of the professional performance and ethical conduct of its members and to strive toward ensuring that the patient care in the Hospital and its clinics is consistently maintained at the level of quality and efficiency achievable by the state of the healing arts and the resources locally available.

(c) To provide a means through which the Medical Staff may participate in the Hospital's policy-making and planning process.

(d) To support research and educational activities in the interest of improving patient care, the skills of the persons providing health services, and the promotion of the general health of the community.

2.2 RESPONSIBILITIES

2.2-1 Quality and Appropriateness Accountability

Accounting for the quality and appropriateness of patient care rendered by all practitioners and allied health professionals authorized to practice in the Hospital and its clinics through the following measures:

(a) A credentials program, including mechanisms for appointment and reappointment, and the delineation of Clinical Privileges to be exercised or of specified services to be performed with the verified credentials and current demonstrated performance of the applicant, staff member or allied health professional.

Approved by Medical Staff: 11.14.23
Approved by Board of Trustees: 12.7.23

(b) A continuing education program fashioned, at least in part, on the needs demonstrated by the quality/utilization management program.

(c) A utilization review program to evaluate inpatient medical and health services based upon patient specific determinations of individual medical needs.

(d) An organizational structure that allows continuous monitoring and evaluation of patient care practices.

(e) A quality assessment procedure that allows a valid and reliable review of the quality of patient care.

2.2-2 Responsibilities to the Board of Trustees

(a) Consulting with and making recommendations to the Board of Trustees including actions with respect to appointments, reappointments, staff category, Clinical Privileges, and corrective action.

(b) Accounting to the Board of Trustees for the quality, appropriateness and efficiency, and safety of patient care rendered to patients in the Hospital and its clinics through regular reports and recommendations concerning the implementation, operation and results of the quality/utilization management program, review of applicable hospital policies and procedures and making recommendations to the Board of Trustees with regard to the same.

2.2-3 Corrective Action

Initiating and pursuing corrective action with respect to Medical Staff members and allied health professionals when warranted.

2.2-4 Compliance with Medical Staff and Hospital Policies

Developing, administering, and seeking compliance with these bylaws, the rules and regulations of the staff, and other Hospital policies.

2.2-5 Meeting Community Needs

Assisting to identify community health needs and to set appropriate institutional goals and implement programs to meet those needs.

2.2-6 Hospital Accreditation Needs

Actively cooperating with hospital accreditation activities and assisting the Hospital in maintaining accreditation.

2.2-7 Exercise of Authority

Exercising the authority granted by these bylaws as necessary to adequately fulfill the foregoing responsibilities.

2.2-8 Priority of Bylaws of the Board of Trustees

The Board of Trustees has delegated the foregoing rights and responsibilities to the Medical Staff in accordance with the Bylaws of the Board of Trustees reserving the authority to take any direct action that is appropriate with respect to any individual appointed to the Medical Staff. Actions taken by the Board of Trustees may, but need not, follow the procedures outlined in these bylaws. The authority and rights granted under these bylaws shall be subordinate to the rights, powers and authority of the Board of Trustees as set forth in the Bylaws of the Board of Trustees.

ARTICLE III DEFINITIONS

ALLIED HEALTH PROFESSIONAL or "AHP" means an individual other than a physician who has been licensed or certified by the appropriate licensing or certified agency(s) who desires to provide professional services in the Hospital, and who has been approved by the Board of Trustees to provide such services at the Hospital. (*see also*, 5.7)

AUTHORIZED REPRESENTATIVE or **HOSPITAL'S AUTHORIZED REPRESENTATIVE** means the individual designated by the Hospital and approved by the Board of Trustees to provide information to, and request information from, the National Practitioner Data Bank according to the terms of these bylaws.

CHIEF EXECUTIVE OFFICER or **CEO** means the individual appointed by the Board of Trustees to act on its behalf in the overall management of the Hospital.

CHIEF OF STAFF or **CHIEF OF THE MEDICAL STAFF** means the chief officer of the Medical Staff elected by members of the Medical Staff.

CLINICAL PRIVILEGES or **PRIVILEGES** means the permission granted to Medical Staff members to provide patient care and access to those Hospital resources (including equipment, facilities and Hospital personnel), which are necessary to effectively exercise those Privileges.

CORRECTIVE ACTION shall include any action recommended by the Medical Executive Committee and imposed by the Board of Trustees which results or will result in:

a. denial of Medical Staff membership;

b. denial of requested advancement in Medical Staff membership status, or category;

c. denial of Medical Staff reappointment;

d. change in Medical Staff category which results in a loss of prerogatives or in Clinical Privileges;

e. suspension of Medical Staff membership;

f. revocation of Medical Staff membership;

g. denial of requested Clinical Privileges;

h. involuntary reduction of current Clinical Privileges

i. suspension of Clinical Privileges;

j. termination of all Clinical Privileges;

k. involuntary imposition of significant consultation requirements.

CORRECTIVE ACTION shall not include:

a. appointment of an Investigative Committee;

b. the performance of an investigation into any matter;

c. the formulation and presentation of any preliminary report of any Investigation Committee to the Medical Executive Committee or CEO of the Hospital;

d. the making of a request or issuance of a directive to an applicant or Medical Staff member to appear at an interview or conference before the Credentials Committee, any Ad Hoc Investigation Committee, the Peer Review Committee, the Medical Executive Committee, the Board of Trustees, or the CEO of the hospital in connection with any investigation prior to a proposed adverse recommendation or action;

e. the denial of or refusal to accept an application for initial appointment or reappointment to the Medical Staff where the application is incomplete or where the application is not accepted because the Hospital has closed a department or exclusive contract in the area in which the applicant or Medical Staff member is requesting clinical privileges;

f. the denial or revocation of temporary privileges;

g. the automatic suspension or limitation of clinical privileges under Section 8.2 of the Medical Staff bylaws;

h. the imposition of supervision or observation on a Medical Staff member which supervision or observation does not restrict the clinical privileges of the Medical Staff member or the delivery of professional services to patients;

i. the issuance of a letter of warning, admonition or reprimand;

j. the following changes in Medical Staff category: (i) a change from active staff to courtesy staff for failure to live close enough to Hospital or its clinics or failure to regularly admit or care for patients in the Hospital or its clinics; (ii) a change to retired staff; or (iii) any other change in category resulting from the failure of a Medical Staff member to meet the criteria for a specific category;

k. concurrent or retrospective proctoring that does not restrict the clinical privileges of any individual member or the delivery of professional services to patients;

l. any recommendation or action not "adversely affecting" (as such term is defined in Section 431(1) of the Health Care Quality Improvement Act) any Medical Staff member;

m. corrective counseling;

n. imposition of requirement for physical or mental exam;

o. Involuntarily imposed Leave of Absence necessitated as a result of lapse of professional liability insurance.

EX-OFFICIO means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.

FAIR HEARING or HEARING means the procedure and safeguards set forth in Article IX.

FEDERAL HEALTH CARE PROGRAM means any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government or a State health care program (with the exception of the Federal Employees Health Benefits Programs). The most significant Federal health care programs are, but are not limited to, Medicare,

Medicaid, Blue Cross Federal Employee Program (FEP)/Tricare/Champus and the Veterans programs.

GOOD STANDING means the Medical Staff member has met committee requirements during the previous Medical Staff year, is not in arrears in dues payment, is not under suspension of Medical Staff appointment and has had three or less medical record suspensions during the previous Medical Staff year.

HOSPITAL means Memorial Hospital of Carbon County and its clinics.

INELIGIBLE PERSON mean any individual who: (1) is currently excluded, suspended, debarred or ineligible to participate in any Federal health care program; or (2) has been convicted of a criminal offense related to the provision of healthcare items or services and has not been reinstated in a Federal health care program after a period of exclusion, suspension, debarment or ineligibility.

INVESTIGATION means a process specifically instigated by the Medical Executive committee or Board of Trustees to determine the validity of a concern or complaint raised against a member of the Medical Staff.

MEDICAL EXECUTIVE COMMITTEE means the executive committee of the Medical Staff that shall constitute the governing body of the Medical Staff as described in these bylaws.

MEDICAL STAFF means those practitioners who have been granted recognition as members of the medical staff pursuant to the terms of these bylaws.

MEDICAL STAFF COORDINATOR means the Hospital designee for maintenance of Medical Staff records.

MEDICAL STAFF YEAR means the period from July 1 through June 30.

MEMBER means, unless otherwise expressly limited, any practitioner holding a current license to practice within the scope of that license, who is a member of the Medical Staff.

PHYSICIAN means an individual with an MD, DO or equivalent foreign medical school degree, licensed to practice in Wyoming applying for or exercising Clinical Privileges at the Hospital.

PRACTITIONER means, unless otherwise expressly limited, any appropriately licensed physician or individual applying for or exercising Clinical Privileges in this Hospital.

PREROGATIVE means a participatory right granted, by virtue of staff category or otherwise, to a staff member and exercisable subject to the conditions imposed in these bylaws and in other Hospital and Medical Staff policies approved by the Board of Trustees.

PROFESSIONALLY ASSOCIATED means affiliated by means of participation as a partner in, current shareholder member of, or employee of, a medical practice or entity, including, but not limited to, a partnership, professional corporation, or medical group practice.

SPECIAL NOTICE means written notification sent by certified mail, return receipt requested, or hand delivered to the addressee.

UNASSIGNED PATIENT means any patient admitted to the hospital through the emergency room or otherwise who has no regularly established relationship with a local physician.

ARTICLE IV MEMBERSHIP

4.1 NATURE OF MEMBERSHIP

Membership on the Medical Staff of the Hospital is a privilege, which shall be extended only to professionally competent Practitioners who continuously meet the qualifications, standards and requirements set forth in these bylaws. Appointment to and membership on the staff shall confer on the appointee or member only such Clinical Privileges and prerogatives as have been granted by the Board of Trustees in accordance with these bylaws, and shall include Medical Staff category, and any service area assignments, if applicable.

4.2 QUALIFICATIONS FOR MEMBERSHIP

4.2-1 General Qualifications

Only Practitioners deemed to possess basic qualifications for membership in the Medical Staff shall be granted Medical Staff Privileges. Practitioners may be granted membership, who:

(a) document their (1) current licensure in the State of Wyoming, (2) adequate experience, education, and training, (3) current professional competence, (4) good judgment, and (5) current adequate physical and mental health status, so as to demonstrate to the satisfaction of the Medical Staff that they are professionally and ethically competent and that patients treated by them can reasonably expect to receive quality medical care;

(b) are determined (1) to adhere to the ethics of their respective professions, (2) to be able to work cooperatively with others so as not to adversely affect patient care, (3) to keep as confidential, as required by law, all information or records received in the practitioner-patient relationship, and (4) to be willing to participate in and properly execute those responsibilities as determined by the Medical Staff;

(c) maintain in force continuous and uninterrupted professional liability insurance in not less than the minimum amounts, if any, as may be determined by the Board of Trustees. If professional liability insurance is obtained on a claims-made basis, the member shall be required to purchase "tail" insurance or its equivalent, as necessary, in order to prevent a lapse in coverage and shall provide evidence of such coverage to the Hospital.

(d) A verification that Practitioner is not currently an ineligible person and shall not become an ineligible person and shall specifically agree to provide to the Medical Staff with or without request, any new or updated information that is pertinent to the individual's professional qualifications, current DEA registration, or any question on the application form, including but not limited to any change in Ineligible Person status, any change in the sanctions imposed or recommended by the Federal Department of Health and Human Services or any State.

4.2-2 Particular Qualifications

(a) Physicians. An applicant for physician membership in the medical staff, except for the honorary staff, must hold an MD or DO degree or their equivalent, an unsuspended license to practice medicine in the State of Wyoming, a current Wyoming Controlled Dangerous Substance Registration, and a current DEA registration issued with a Wyoming address or be able to transfer registration to Wyoming before practicing at the Hospital. For the purpose of this Section, "or their equivalent" shall mean any foreign medical degree recognized by MD and DO medical licensing boards for Wyoming.

(b) Podiatrists. An applicant for podiatric membership on the medical staff must hold a DPM degree and a valid, current, and unrestricted certificate to practice podiatry issued by the applicable licensing board for Wyoming.

(c) Dentists: An applicant for dentist membership on the medical staff must hold a DDS or DMD degree and a valid, current, and unrestricted certificate to practice dentistry issued by the applicable licensing board for Wyoming.

(d) Allied Health Staff: An applicant for Allied Health Staff including, but not limited to, physician assistants, advanced practice registered nurses, CRNAs and nurse practitioners, must hold an unsuspended license to practice in the

State of Wyoming, a current Wyoming Controlled Substance Registration, and a current DEA registration issued in connection with a Wyoming address or be able to transfer registration to Wyoming before practicing at the Hospital. Licensed professional counselors, licensed clinical social workers, and optometrists must hold a current license, certificate or other valid credential as required by the State of Wyoming.

4.3 EFFECT OF OTHER AFFILIATIONS

No person shall be entitled to membership in the Medical Staff merely because that person holds a certain degree, is licensed to practice in Wyoming or in any other state, is a member of any professional organization, is certified by any clinical Board, or because such person had, or presently has, staff membership or Privileges at another health care facility.

4.4 NONDISCRIMINATION

No aspect of Medical Staff membership or particular Clinical Privileges shall be denied on the basis of sex, race, age, creed, color, sexual orientation, religion, national origin, or physical or mental impairment that does not prevent the practitioner from performing the essential elements of Medical Staff membership.

4.5 HEALTH STATUS

When the Credentials Committee, Medical Executive Committee, Board of Trustees or CEO has reason to believe that the physical and/or mental health status of a practitioner may be impaired, the practitioner shall be required to submit to an evaluation of physical and/or mental health status by a practitioner or practitioners designated by the Medical Executive Committee and acceptable to the practitioner as a prerequisite to the maintenance of member's current staff appointment or the exercise of previously granted Clinical Privileges, for further consideration of practitioners application for Medical Staff reappointment, or for initial Medical Staff appointment.

4.6 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

The ongoing responsibilities of each member of the Medical Staff include:

(a) providing patients with the quality of care meeting the professional standards of the Medical Staff of this Hospital;

(b) abiding by the Medical Staff bylaws, Medical Staff rules and regulations, and Hospital policies;

(c) executing in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of Medical Staff membership, including committee assignments;

(d) promptly notifying the Medical Executive Committee of the revocation, suspension, or a lapse of member's professional license or the imposition of terms of probation or limitation of practice by any state licensing agency or loss or restriction, whether voluntary or involuntary, of Privileges at any hospital or other health care institution or of any adverse malpractice judgment or settlement or of the commencement of a formal investigation or the filing of charges, by the Department of Health and Human Services, or any law enforcement agency or health regulatory agency of the United States or any other state, or the cancellation or restriction of member's professional liability coverage or the revocation, suspension or voluntary relinquishment or lapse of member's DEA certification;

(e) preparing and completing in a timely fashion medical records for all the patients to whom the member provides care in the Hospital according to the Medical Staff Rules and Regulations;

(f) preparing and completing a History and Physical Examination ("H&P") prior to surgery for all patients to whom the member provides care in the Hospital;

(g) abiding by the lawful ethical principles of the member's professional association;

(h) aiding in any Medical Staff-approved educational programs;

(i) working cooperatively with members, nurses, Hospital administration, the Board of Trustees, and others;

(j) making appropriate arrangements for coverage of that member's patients as determined by the Medical Staff;

(k) refusing to engage in improper inducements for patient referral;

(l) participating in continuing education programs as determined by the Medical Staff;

(m) participating in consultation panels as may be required by the Medical Staff or the Hospital;

(n) executing such other staff obligations as may be established from time to time by the Medical Staff or Medical Executive Committee; and

(o) providing information to the Medical Staff on an accused practitioner regarding any matter under an investigation pursuant to paragraph 8.1-3, and those which are the subject of a hearing pursuant to Article IX.

4.7 HARASSMENT PROHIBITED

Harassment by a Medical Staff member against any individual (including, but not limited to, another Medical Staff member, hospital employee or patient) on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex or sexual orientation shall not be tolerated. All allegations of harassment shall be immediately investigated by the Board of Trustees or the Medical Executive Committee and may result in corrective action, including, but not limited to, verbal or written reprimand(s) up to and including termination of Medical Staff Privileges or membership in accordance with Hospital policy, as warranted by the facts.

4.8 DISRUPTIVE CONDUCT

INTENTIONALLY OMITTED. See, Medical Staff Policy No. 603-08.

ARTICLE V CATEGORIES OF MEMBERSHIP

5.1 CATEGORIES

The Medical Staff shall be divided into Active, Courtesy, Telemedicine, Locum Tenens, and Allied Health Professional categories.

5.2 ACTIVE STAFF

5.2-1 Qualifications

The active staff shall consist of practitioners each of whom:

(a) Meets the basic qualifications set forth in Section 4.2-1;

(b) Have offices or residences which, in the opinion of the Medical Executive Committee, are located closely enough to the Hospital to provide appropriate continuity of quality care to patients;

(c) Participate in the medical treatment of a minimum of thirty-six (36) patients treated within the Hospital or, alternatively, one thousand five hundred (1,500) patient visits in the clinic, during the three-year appointment period ("minimum case criteria"). If at the time of reappointment the minimum case criteria is not met, then the medical staff may provide the member with an opportunity to request an appointment to the Courtesy Staff or change the member's status to

Courtesy at the time of reappointment. Such change in medical staff category does not constitute a reduction or limitation of privileges and thus is not reportable to the NPDB or require the member to report this category change when making application or reapplication to the Hospital. The minimum case criteria requirements set forth herein may be waived by the Board of Trustees upon the recommendation of the Executive Committee.

(d) Except for good cause shown as determined by the Medical Staff, have satisfactorily completed their designated term in the provisional status; and

(e) Unless otherwise waived by the Board of Trustees, upon recommendation of the Executive Committee, are board certified or board eligible as recognized by an American Board of Medical Specialties member board.

(f) Subcategory of Active Staff: "Active Administrative Staff" is defined as a nonclinical member of the Active Staff. Responsibilities of Active Administrative Staff include, but are not limited to, participating in committees of the Medical Staff as assigned by the Chief of Staff, aid in the organization of committee assignments assigned by the Chief of Staff, and service as the Committee liaison with the Board of Trustees and the CEO of MHCC.

5.2-2 Prerogatives

The prerogatives of an active staff member shall be to:

(a) admit patients to the Hospital according to member's Privileges;

(b) exercise such Clinical Privileges as are granted to members pursuant to Article VII;

(c) vote on all matters presented at general and special meetings of the Medical Staff, and committees on which member serves;

(d) hold office in the staff organization and committees on which member serves.

5.2-3 Responsibilities

Each member of the active category shall:

(a) meet the basic responsibilities set forth in Section 4.6.

(b) retain responsibility within member's area of professional competence for the care and supervision of each patient in the Hospital for whom member is providing services or arrange a suitable alternative for such care and supervision.

(c) actively participate in quality/utilization management activities required of the staff, in supervising provisional appointees of member's same profession, and in executing such other staff functions as may from time to time be required.

(d) accept appointment to, and serve on, committees to which the member has been appointed.

(e) satisfy the requirements set forth in Section 13.7 for attendance at meetings of the staff and committees on which member serves.

(f) pay dues and assessments as determined by the Medical Staff.

(g) as needed or required, participate in on call coverage on a prorate basis with other members of the Medical Staff exercising privileges within the members area of professional competence to provide care and supervision of each patient admitted to the Hospital. When needed, on call coverage shall be divided equally, as near as possible, between all members of the Medical Staff practicing within all areas of professional competence provided by the hospital. Areas of professional competence offered by the Hospital shall be determined by the Medical Executive Committee and shall include at a minimum:

1. Emergency Medicine;

2. Family Practice; and

3. Obstetrics.

Medical Staff members are obligated to work out a reasonable, shared unassigned patient call system which will provide for 24 hours per day, seven days per week, 365 days per year on call coverage for each area of professional competence offered by the Hospital. If members are unable to agree on such a schedule, the Medical Executive Committee shall provide a schedule for the members. Any schedule provided by the Medical Executive Committee shall be binding and failure to adhere to such schedule shall be grounds for imposition of corrective action pursuant to these bylaws.

5.3 COURTESY STAFF

5.3-1 Qualifications

The courtesy staff shall consist of practitioners each of whom:

(a) meets the basic qualifications set forth in Section 4.2-1;

(b) do not regularly care for or are not regularly involved in Medical Staff functions as determined by the Medical Executive Committee;

(c) Unless otherwise waived by the Board of Trustees, and upon the recommendation of the Executive Committee, are board certified or board eligible as recognized by an American Board of Medical Specialties member board.

5.3-2 Limitation

Courtesy staff members who regularly care for or admit patients to the Hospital, as determined by the Medical Executive Committee, shall be obligated to seek appointment to the active Medical Staff. Any staff member who admits and cares for more than thirty-six (36) patients shall be deemed to be regularly caring for and admitting patients to the Hospital.

5.3-3 Prerogatives

The prerogatives of a courtesy staff member shall be to:

(a) follow member's own patients in the Hospital and to provide medical consultation upon request of the attending practitioner.

(b) attend medical staff meetings and any staff or Hospital education programs.

(c) serve as a member of committees.

Courtesy category members shall not be eligible to vote, except when serving as a member of a committee, or to hold office in this Medical Staff organization.

5.3-4 Responsibilities

The responsibilities of a courtesy category member shall be to:

(a) execute the basic responsibilities specified in Section 4.6.

(b) pay dues and assessments as determined by the Medical Staff.

(c) provide care to a sufficient number of patients within the Hospital during each three-year appointment period so that the medical staff can evaluate clinical competency at the time of reappointment or provide proof of continued competency at the time of reappointment to the medical staff to include appropriate data associated with the quality of professional practice. A minimum requirement for number of patients to be seen is not defined for the Courtesy Staff.

(d) all visiting specialists that provide care in the Hospital's visiting specialist clinic(s) shall apply for hospital privileges at minimum in the "courtesy" staff designation. Application for such privileges, and the granting of the same, shall be in accordance with these bylaws.

5.4 TELEMEDICINE STAFF

5.4-1 Qualifications

The telemedicine staff shall consist of specialists in various categories of care who shall act in an auxiliary capacity to the Active Staff in the management of patients, each of whom:

(a) meets the basic qualifications set forth in Section 4.2-1;

(b) Unless otherwise waived by the Board of Trustees, and upon the recommendation of the Executive Committee, are board certified or board eligible as recognized by an American Board of Medical Specialties member board.

5.4-2 Limitation

Telemedicine Staff members shall not be eligible to admit patients. Members of the Telemedicine Staff shall participate on the Executive Committee and other medical staff committees as deemed necessary.

5.4-3 Prerogatives

The prerogatives of a telemedicine staff member shall be to:

(a) to provide medical consultation upon request of the attending practitioner.

(b) attend medical staff meetings and any staff or Hospital education programs as needed.

(c) serve as a member of committees as needed.

Telemedicine Staff members shall not be eligible to hold office or to vote, except when serving as a member of a committee, or to hold office in this Medical Staff organization.

5.4-4 Responsibilities

The responsibilities of a Telemedicine Staff member shall be to:

(a) execute the basic responsibilities specified in Section 4.6.

(b) pay dues and assessments as determined by the Medical Staff.

5.5 LIMITATIONS AND EXCEPTIONS TO STAFF CATEGORY PREROGATIVES

The prerogatives set forth under each membership category are general in nature and may be subject to limitation by special conditions attached to a particular membership, by other sections of these bylaws and by the Medical Staff rules and regulations.

5.6 MODIFICATION OF MEMBERSHIP

On its own, upon recommendation of a Medical Staff Committee, or pursuant to a request by a member under Section 6.8, the Medical Executive Committee may recommend a change in the Medical Staff category of a member consistent with the requirements of these bylaws.

5.7 ALLIED HEALTH PROFESSIONALS

The Medical Staff may recommend to the Board of Trustees the granting of Clinical Privileges to allied health professionals, namely, physician assistants, advanced practice registered nurses, CRNAs, nurse practitioners, licensed professional counselors, licensed clinical social workers, and optometrists based upon investigation and evaluation of the education, training, experience and demonstrated ability and judgment of individuals requesting Privileges as allied health professionals, according to procedures established in the rules and regulations of the Medical Staff.

5.7-1 Eligible Allied Health Professionals

Eligibility to provide patient care services in the Hospital or its clinics is based on the Allied Health Professional's licensure and scope of practice and will be limited to Allied Health Professionals who are:

(r) directly employed by the Hospital to provide patient care services; or

(s) employees of any organization under contract with the Hospital; or

(t) employees or contractors of any physicians on the Medical Staff and who will provide patient care services in the Hospital or Hospital's clinic.

(u) or others as recommended by the Medical Executive Committee and approved by MHCC Board of Trustees.

5.7-2 Qualifications

Allied Health Professionals, who satisfy one of the eligibility requirements set forth in Section 5.7-1, will each:

(a) hold a current license, certificate, or other valid credential as required by the State of Wyoming;

(b) document their experience, background, training, ability, physical health status, and upon request of the credentials committee, mental health status with sufficient adequacy to demonstrate that any patient treated by them will receive care of the generally recognized professional level of quality and efficiency and that they are qualified to provide a needed service within the Hospital or its clinics; and

(c) Participate in the medical treatment of a minimum of thirty-six (36) patients within the Hospital or, alternatively, one hundred fifty (150) patient visits in the clinic during the three-year appointment period ("minimum case criteria"). The minimum case criteria requirements set forth herein may be waived by the Board of Trustees upon the recommendation of the Executive Committee.

(d) Adhere strictly to the ethics of their respective professions as applicable and work cooperatively with others as determined on the basis of documented references.

Where appropriate, the Credentials Committee, in consultation with the CEO and the Board of Trustees, may establish additional qualifications required of members of any particular category of Allied Health Professionals, provided that such qualifications are not founded on an arbitrary or discriminatory basis and are in conformance with applicable laws, rules and regulations.

5.7-3 Application Procedure

Each person who claims to be an Allied Health Professional and who makes a written request to enter the process for application as an AHP at the Hospital, shall be provided with an AHP application form. Any AHP who has submitted information consistent with the basic qualifications set forth in Sections 5.7-1 and 5.7-2 shall be eligible for Clinical Privileges as an AHP at the Hospital. Each AHP's application will be processed and evaluated in accordance with the procedures of Section 6.7 and 6.8 applicable to the Medical Staff, except that AHP applicants shall not be entitled to procedural rights as provided in Article IX.

5.7-4 Specification of Responsibilities

(a) An AHP is subject to the same general qualifications, responsibilities, and conditions as members of the Medical Staff, as set forth in Sections 4.2-1, 4.5, 4.6 and 4.7.

(b) The Medical Executive Committee and Hospital's CEO, with input from the Chief of Staff, shall approve specific written guidelines, or protocols, for the performance of services to be provided by each discipline practiced by the AHP. For each category of AHP, such guidelines must include, without limitation:

(i) specification of the classes of patients that may be treated;

(ii) description of the service to be provided and procedures to be performed; and

(iii) definition of the degree of assistance that may be provided to a practitioner regarding the treatment of patients at Hospital or its clinics and any limitations thereon, including the degrees of practitioner supervision required for each service.

5.7-5 Prerogatives and Limitations

The prerogatives and limitations of Allied Health Professionals shall be to:

(a) Provide specified patient care services based on licensure and scope of practice, except as otherwise expressly provided by the Credentials Committee or the Medical Executive Committee.

(b) Write orders only to the extent established by the Medical Staff but not beyond the scope of the Allied Health Professional's licensure, certificate, or other legal credentials and scope of practice.

(c) Serve on Medical Staff, and other committees as appointed by the Chief of Staff.

(d) Attend staff, Hospital, and in-service educational programs and clinical meetings related to AHP's discipline as required by member's certification boards.

(e) Exercise such other prerogatives as the Credentials Committee may establish as a specific category of allied health professionals, or Allied Health Professionals in general.

A recommendation by or on behalf of the Medical Staff to not grant Privileges to an applicant for Privileges as an allied health professional, or to suspend, to terminate, or to discontinue such Privileges, or such a decision by the Board of Trustees, shall not give rise to any procedural rights set forth in Article IX, unless otherwise specifically provided in the rules and regulations of the Medical Staff. Allied Health professionals shall be given limited procedural rights, including written notice of any final action on the application, and any reason for denial or restriction of the privileges requested. Additionally, if the privileges of an allied health professional are modified or revoked, the allied health professional will be provided, at a minimum, written reasons for the modification or revocation of privileges, and a mechanism for appeal to the Board of Trustees.

5.7-6 Responsibilities

The responsibilities of each Allied Health Professional shall be to:

(a) Meet the same basic responsibilities as members of the Medical Staff set forth in Section 4.6;

(b) Retain appropriate responsibility within AHP's area of professional competence for the care and supervision of each patient in the Hospital or at Hospital's clinic for whom AHP is providing services, or alert the principal attending practitioner of the need to arrange a suitable alternative for such care and supervision;

(c) Participate as appropriate in the quality improvement program activities required of the Medical Staff; and

(d) Execute such other Medical Staff functions as may be required from time to time by the Chief of Staff or Medical Executive Committee.

5.8 LOCUM TENENS STAFF

5.8-1 Qualifications

The Locum Tenens Staff shall consist of practitioners each of whom:

(a) meets the basic qualifications set forth in Section 4.2-1 and, if applicable, Section 4.2-2.

(b) be serving as temporary replacement for an existing position on the Medical Staff or Allied Health Professional.

5.8-2 Prerogatives

The prerogatives of a Locum Tenens Staff member shall:

(a) exercise such prerogatives granted to the Locum Tenens Staff member as specifically authorized in writing by the Chief Executive Officer and Chief of Staff pursuant to Section 5.4-1 and consistent with the Locum Tenens Staff member's training, experience, scope of practice and licensure.

(b) exercise such Clinical Privileges granted to the Locum Tenens Staff member pursuant to Article VII.

5.8-3 Responsibilities

Each Locum Tenens Staff member shall:

(a) meet the basic responsibility set forth in Section 4.6.

(b) retain responsibility within member's area of professional competence for the care and supervision of each patient in the Hospital or its clinics for whom member is providing services, or arrange a suitable alternative for such care and supervision.

(c) actively participate in quality/utilization management activities required of the staff, in supervising provisional appointees of member's same profession, and in executing such other staff functions as may from time to time be required.

(d) as needed or required, participate in on call coverage on a prorate basis with other members of the Medical Staff exercising privileges within the members area of professional competence to provide care and supervision of each patient admitted to the Hospital or treated at Hospital's clinics. On call coverage shall be divided equally, as near as possible, between all members of the Medical Staff practicing within all areas of professional competence provided by the hospital.

5.8-4 Special Credentialing Considerations for Locum Tenens

Upon receipt of an application for Locum Tenens Medical Staff membership or Locum Tenens Allied Health Professional status from a licensed practitioner, the Chief Executive Officer may, with the concurrence of the Chief of Staff, grant such Clinical Privileges as agreed by the Chief Executive Office and Chief of Staff to the Locum Tenens Staff member. A letter, signed by the Chief Executive Officer and Chief of Staff, outlining the status and specific Clinical Privileges granted will be sent to the Locum Tenens Staff member and maintained permanently at the Hospital. Specific dates for Locum Tenens Staff members shall be designated in this letter. All appointments as a Locum Tenens Staff member will be reported to the Medical Staff and Board at their next scheduled meeting. Should the Chief Executive Officer and Chief of Staff choose to grant clinical privileges in the manner set forth above, the Chief Executive Officer and/or Chief of Staff shall verify the following information prior to granting the requested privileges:

(a) Applicant's current, and valid, Wyoming Licensure;

(b) Training;

(c) References;

(d) Proof of Insurance;

(e) National Practitioner's Databank Inquiry;

Should the Chief Executive Officer not choose to exercise the special credentialing considerations as set forth in this Section 5.8-4, applications for Locum Tenens status shall be made, considered, and/or granted or denied in accordance with these bylaws.

ARTICLE VI PROCESS FOR APPOINTMENT AND REAPPOINTMENT

6.1 PRE-APPLICATION PROCESS

INTENTIONALLY OMITTED. *See*, Medical Staff Policy No. 603-02.

6.2 GENERAL PROCEDURE

Appointment to the Medical Staff is a privilege which shall be extended only to professionally competent individuals who continuously meet the qualifications, standards, and requirements set forth in these bylaws and in the policies adopted by the Hospital. Appointment to the Medical Staff shall confer on the appointee only such Clinical Privileges as have been granted in accordance with these bylaws.

Except as otherwise specified herein, no person shall exercise Clinical Privileges in the Hospital unless and until:

(a) that person applies for and receives appointment to the Medical Staff, or

(b) is granted temporary Privileges as set forth in these bylaws, or

(c) with respect to Allied Health Practitioners, has been granted Privileges pursuant to these bylaws and/or applicable Medical Staff policies.

6.3 BURDEN OF PRODUCING INFORMATION

In connection with all applications for appointment, reappointment, advancement, or transfer, the applicant shall have the burden of producing information for an adequate evaluation of the applicant's qualifications and suitability for the Clinical Privileges and staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. The applicant's failure to sustain this burden shall be grounds for denial of the application. To the extent consistent with law, this burden may include submission to a medical or psychological examination, at the applicant's expense, if deemed appropriate by the Medical Executive Committee, which may select the examining physician.

6.4 COMPLIANCE WITH MEDICAL STAFF RULES

By applying to the Medical Staff for appointment or reappointment the applicant acknowledges responsibility to first review these bylaws and Medical Staff rules, regulations and policies, and agrees that throughout any period of membership that applicant will comply with the responsibilities of Medical Staff membership and with the bylaws, rules and regulations and policies of the Medical Staff as they exist and as they may be modified from time to time.

6.5 DURATION OF PROVISIONAL APPOINTMENT AND REAPPOINTMENT

Except as otherwise provided in these bylaws, initial appointments to the Medical Staff shall be provisional appointments for a period of one (1) year. Reappointments shall be for any period of time, or up to three (3) years. During the provisional period, the practitioner must demonstrate all of the qualifications, may exercise all of the prerogatives granted to him/her, must fulfill all of the obligations of his/her staff category, and must have participated in the treatment of a sufficient number of patients so that his/her competence can be evaluated.

Upon conclusion of the provisional period, the Credentialing Committee will complete an evaluation of the practitioner, based on the practitioner's professional performance, judgment and technical skills. A summary of the evaluation shall be provided to the Medical Executive Committee to make recommendation to the Board of Trustees concerning advancement from provisional to regular status.

If at the time of reappointment, the minimum case criteria for the Active Staff category is not met, then the medical staff may provide the member with an opportunity to request an appointment to the Courtesy Staff or change the member's status to Courtesy at the time of reappointment. Such change in medical staff category does not constitute a reduction or limitation of privileges and thus is not reportable to the NPDB or requires the member to report this category change when making application or reapplication to this or another facility.

Failure to advance an appointee from provisional to full, unrestricted, regular status shall be deemed termination of his/her staff appointment after initial appointment period.

Upon satisfactory conclusion of the provisional period, the appointee shall be placed in the appropriate reappointment cycle.

6.6 APPLICATION FOR INITIAL APPOINTMENT

INTENTIONALLY OMITTED. *See*, Medical Staff Policy No. 603-02.

6.7 EFFECT OF APPLICATION

By applying for appointment to the Medical Staff, the applicant:

(a) pledges to provide for continuous quality care to applicant's patients in the Hospital or Hospital's clinics;

(b) signifies willingness to appear for interviews in regard to applicant's application;

(c) acknowledges responsibility for timely payment of Medical Staff dues, if a requirement then exists;

(d) pledges to maintain an ethical practice, including refraining from illegal inducements for patient referral, providing for the continuous care of the applicant's patients, seeking consultation whenever necessary, and refraining from delegating patient care responsibility to non-qualified or inadequately supervised practitioners;

(e) pledges to be bound by the Medical Staff and Hospital bylaws, policies, rules and regulations;

(f) authorizes Hospital Representatives to consult with others who have been associated with applicant and/or who may have information bearing on applicant's competence and qualifications and to solicit and act upon information, including otherwise privileged or confidential information, provided by third parties bearing on applicant's competence and qualifications and agrees that any information so provided shall not be required to be disclosed to applicant if the third party providing such information does so on the condition that it be kept confidential;

(g) consents to the inspection by Hospital Representatives of all records and documents that may be material to an evaluation of applicant's personal and professional qualifications, health status pertinent to performance of professional duties and ability to carry out the Clinical Privileges requested, as well as of applicant's professional ethical qualifications for staff membership;

(h) authorizes the Hospital to release confidential information, including peer review and/or quality assurance information, obtained from or about the Medical Staff member to other requesting healthcare facilities for the purpose of credentialing activities;

(i) releases from any liability the Hospital and all Hospital Representatives may have for their acts performed in connection with evaluation of the applicant and applicant's credentials;

(j) releases from all liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to Hospital Representatives concerning the applicant's ability, professional ethics, character, physical and mental health, emotional stability, and other qualifications for staff appointment and Clinical Privileges;

(k) agrees that any lawsuit brought by the applicant against an individual, or organization, providing information to a Hospital Representative, or that any such lawsuit brought against a Hospital Representative, shall be brought in a state or federal court in Wyoming.

(l) agrees to promptly report to the Hospital's CEO or Chief of Staff any changes in applicant's physical or mental health that could impair applicant's ability to practice the Privileges granted; any changes in applicant's staff membership or Privileges at any other healthcare facility; any investigation or accusation with regard to applicant's state license or controlled substance registration certificate(s); or any adverse changes in applicant's professional liability insurance coverage.

For purposes of this Section, the term "Hospital Representative" includes the Hospital's Board of Trustees ("Board of Trustees"), its directors and committees; the Chief of Staff, the Hospital's Chief Executive Officer, all Medical Staff members, and committees

which have responsibility for collecting or evaluating the applicant's credentials or acting upon applicant's applications; and any authorized representative of any of the foregoing.

6.8 PROCESSING THE APPLICATION

6.8-1 Transmittal for Evaluation

INTENTIONALLY OMITTED. *See*, Medical Staff Policy No. 603-01 and 603-02.

6.8-2 Action by Chief of Staff

INTENTIONALLY OMITTED. *See*, Medical Staff Policy No. 603-02.

6.8-3 Action by Credentials Committee

INTENTIONALLY OMITTED. *See*, Medical Staff Policy No. 603-02.

6.8-4 Action by Medical Executive Committee

INTENTIONALLY OMITTED. *See*, Medical Staff Policy No. 603-02.

6.8-5 Action by Board of Trustees

INTENTIONALLY OMITTED. *See*, Medical Staff Policy No. 603-02.

6.8-6 Notice of Final Decision

Notice of the final decision shall be given in writing to the Chief of Staff, the Medical Executive Committee and the Credentials Committee, the applicant, and the Hospital CEO.

A decision and notice to appoint or reappoint shall include:

(a) the staff category to which the applicant is appointed;

(b) the Clinical Privileges granted; and

(c) any special conditions attached to the appointment.

6.8-7 Reapplication after Adverse Appointment Decision

An applicant who has received a final adverse decision regarding appointment shall not be eligible to reapply to the Medical Staff for a period of six (6) months. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as may be required to demonstrate that the basis for the earlier adverse action no longer exists.

6.8-8 Timeframes for Action on Application

Complete applications are to be acted on within a reasonable period of time. Applications for staff appointments shall be considered in a timely manner by all persons and committees required by these bylaws to act thereon. While special or unusual circumstances may constitute good cause and warrant exceptions, the following maximum time periods provide a guideline for routine processing of applications:

(a) evaluation, review, and verification of application and all supporting documents by the Medical Staff office: thirty (30) days from receipt of complete application and all necessary documentation;

(b) review and recommendation by credentials committee: thirty (30) days after receipt of all necessary documentation;

(c) review by the Medical Executive Committee: thirty (30) days after review by the credentials committee;

(d) review and recommendation by Board of Trustees: thirty (30) days after receipt of all necessary documentation from the Medical Executive committee; and

(e) final action: one hundred twenty (120) days after receipt of all necessary documentation by the Medical Staff office or fourteen (14) days after conclusion of hearings.

6.9 REAPPOINTMENT AND REQUESTS FOR MODIFICATIONS OF STAFF STATUS OR PRIVILEGES

6.9-1 Application for Reappointment and/or Modifications

At least one hundred twenty (120) days prior to the expiration date of the current staff appointment, a reapplication form developed by the Medical Executive Committee shall be emailed to the applicant through credentialing software. If an application for reappointment is not received at least sixty (60) days prior to the expiration date, written notice shall be promptly sent to the applicant advising that the application has not been received. At least forty-five (45) days prior to the expiration date, each Medical Staff member shall submit to the credentials committee the completed application form for renewal of appointment to the staff for the coming year, and for renewal or modification of Clinical Privileges. The reapplication form shall include all information necessary to update and evaluate the qualifications of the applicant including, but not limited to, the

matters set forth in the applicant's initial application, as well as peer review and quality of care indicators. Upon receipt of the application, the information shall be processed as set forth commencing at Section 6.8 and relevant Medical Staff policies.

A Medical Staff member who seeks a change in Medical Staff status or modification of Clinical Privileges may submit such a request at any time upon a form developed by the Medical Executive Committee, except that such application may not be filed within one hundred eighty (180) days of the time a similar request has been denied.

6.9-2 Effect of Application for Reappointment and/or Modifications

The effect of an application for reappointment or modification of staff status or Privileges is the same as that set forth in Section 6.6 and applicable Medical Staff policies.

6.9-3 Standards and Procedure for Review of Application for Reappointment and/or Modifications

When a staff member submits the first application for reappointment, and every three (3) years thereafter, or when the member submits an application for modification of staff status or Clinical Privileges, the member shall be subject to an in-depth review generally following the procedures set forth in Sections 6.7(a) through 6.7(l) and applicable Medical Staff policies.

6.9-5 Failure to File Reappointment Application

Failure without good cause to timely file a completed application for reappointment shall result in the automatic suspension of the member's admitting privileges and expiration of other practice privileges and prerogatives at the end of the current staff appointment, unless otherwise recommended by the Medical Executive Committee and with the approval of the Board of Trustees. If the member fails to submit a completed application for reappointment prior to the expiration of member's staff appointment, the member shall be deemed to have resigned membership in the Medical Staff. In the event membership terminates for the reasons set forth herein, the procedures set forth in Article IX shall not apply.

6.10 LEAVE OF ABSENCE

6.10-1 Voluntary Leave of Absence

INTENTIONALLY OMITTED. *See*, Medical Staff Policy No. 603-03.

6.10-2 Medical Leave of Absence

INTENTIONALLY OMITTED. *See*, Medical Staff Policy No. 603-03.

6.10-3 Military Leave of Absence

INTENTIONALLY OMITTED. *See*, Medical Staff Policy No. 603-03.

ARTICLE VII DETERMINATION OF CLINICAL PRIVILEGES

7.1 EXERCISE OF PRIVILEGES

Every practitioner or allied health professional providing direct clinical services at the Hospital or its clinics by virtue of Medical Staff membership or otherwise shall, in connection with such practice and except as provided in Section 7.4, be entitled to exercise only those Clinical Privileges or provide patient care services as are specifically granted pursuant to the provisions of these Medical Staff bylaws and the Medical Staff rules and regulations.

7.2 DELINEATION OF PRIVILEGES IN GENERAL

7.2-1 Requests

Each application for appointment and reappointment to the Medical Staff must contain a request for the Clinical Privileges desired by the applicant. A request by a staff member pursuant to Section 6.8 for a modification of Privileges must be supported by documentation of training and/or experience supportive of the request.

7.2-2 Basis for Privileges Determination

Requests for Clinical Privileges shall be evaluated on the basis of the practitioner's education, training, scope of practice, experience, and demonstrated competence and judgment. The basis for Privileges determinations to be made in connection with periodic reappointment or otherwise shall include observed clinical performance, whether the frequency of exercise of Clinical Privileges is sufficient to indicate current proficiency, and the documented results of the quality/utilization management program and other quality maintenance activities required by these bylaws; accreditation standards and state and federal regulation to be conducted at the Hospital. Privileges determinations may also be based on pertinent information concerning clinical performance obtained from other sources including, but not limited to, other health care facilities where a practitioner exercises Clinical Privileges. This information shall be added to and maintained in the credentialing file established for a staff member.

7.2-3 Procedure

All requests for Clinical Privileges shall be determined by the Board of Trustees in accordance with the procedures outlined in Article VI, and applicable Medical Staff and Hospital policies.

7.3 TEMPORARY PRIVILEGES

7.3 -1 Circumstances

Upon the written concurrence of the Chief of the Medical Staff and the Hospital's CEO, temporary Privileges may be granted for a period of one hundred twenty (120) days in the following circumstances:

(a) Urgent Patient Care Need - To fulfill an urgent patient care need that, in the opinion of the Chief of Staff (or in the Chief's absence, the active attending physician), identifies the need for an immediate authorization to practice, for a limited period of time, after a credentials file is complete and is reviewed by the Chief of Staff and CEO.

(b) Pendency of Application - To an applicant awaiting final Medical Executive Committee and Board approval. The applicant must have: no challenges to his/her licensure or DEA registration, not been involuntarily terminated from the medical staff at another institution, and have no history of limited, reduced, denied, or lost Clinical Privileges at another institution.

7.3-2 Conditions

Temporary Privileges shall be granted only when the information available reasonably supports a favorable determination regarding the requesting practitioner's qualifications, ability and judgment to exercise the Privileges requested, and only after the practitioner has provided evidence of professional liability insurance in an amount satisfactory to the Chief of Staff, and as required by the Board of Trustees. Special requirements of consultation and reporting may be imposed by the Chief of Staff responsible for supervision of a practitioner granted temporary Privileges. Before temporary Privileges are granted, the practitioner must acknowledge in writing that practitioner has received and read the Medical Staff bylaws, rules and regulations and that practitioner agrees to be bound by the terms thereof in all matters relating to practitioner's temporary Privileges.

7.3 -3 Termination

The Chief of Staff may terminate any or all of such practitioner's temporary Privileges, provided that where the life or well-being of a patient is determined to be endangered by continued treatment by the practitioner, the termination may be effected by any person entitled to impose summary suspensions under Sections 8.1 and 8.2. In the event of any such termination, the practitioner's patients then in the Hospital or Hospital's clinics shall be assigned to another practitioner by the Chief of Staff. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner. The terminated practitioner shall confer with the substitute practitioner to the extent necessary to safeguard the patient.

7.3-4 Rights of the Practitioner

A practitioner shall not be entitled to the procedural rights afforded by Article IX because of practitioner's inability to obtain temporary Privileges or because of any termination, modification, or suspension of temporary Privileges.

7.4 EMERGENCY PRIVILEGES

For the purposes of this Section, an "emergency" is defined as a condition in which serious or permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger. In the case of an emergency, any practitioner, to the degree permitted by his or her license, scope of practice, staff status or Clinical Privileges, shall be permitted to do, and shall be assisted by Hospital personnel in doing everything possible to save the life of a patient or to save a patient from serious harm. A practitioner utilizing emergency Privileges shall promptly provide to the Medical Executive Committee in writing a statement explaining the circumstances giving rise to the emergency.

7.5 DISASTER PRIVILEGES

Disaster privileges may be granted when the emergency management plan has been activated and the Hospital is unable to handle the immediate patient needs due to the disaster. The CEO or Chief of Staff or their designee(s) has the option to grant disaster privileges, based on the following requirements: 1) The Medical Staff authorizes that the CEO, Chief of Staff or during a disaster, the CEO's designee may grant such privileges for the period limited to the activation of the emergency management plan; 2) The responsibilities of the person granted privileges are limited to his/her legal authority to act within their license and specialty to provide care during a disaster period; 3) A list will be maintained by Administration or designee as to the person being granted disaster privileges, a copy of their driver's license or available a copy of their license to practice issued by a state, federal or regulatory agency, current picture Hospital ID, identification that the individual is a member of a Disaster Medical Assistance Team (DMAT), or an identification that the individual has been granted authority to render patient care, treatment and services in disaster circumstances by an agency of the government, may be presented for later verification as soon as the situation is under control. The verification process is identical to that used for new applicants to the Medical Staff; and 4) At least one member of either the Hospital staff and/or Medical Staff must verify the knowledge that the practitioner being granted privileges is in fact familiar to them and is eligible to practice in the professional status presented.

ARTICLE VIII PROCESS FOR CORRECTIVE ACTION

8.1 CORRECTIVE ACTION

8.1-1 Criteria for Initiation

Any person may provide information to the Medical Staff about the conduct, performance, or competence of any of its members. When reliable information indicates a member may have exhibited acts, demeanor, or conduct reasonably likely to be (1) detrimental to patient safety or to the delivery of quality patient care within the Hospital or its clinics; (2) unethical; (3) contrary to the Medical Staff bylaws and rules or regulations or Hospital bylaws or policies; or (4) below applicable professional standards, a request for an investigation or action against such member may be initiated by the Board of Trustees, Chief of Staff, CEO, or the Medical Executive Committee.

8.1-2 Initiation

A request for an investigation must be in writing, submitted to the Board of Trustees or Medical Executive Committee, and supported by reference to specific activities or conduct alleged. If the Board of Trustees or Medical Executive Committee initiates the request, it shall make an appropriate recording of the reasons.

8.1-3 Investigation

If the Board of Trustees or Medical Executive Committee determines an investigation is warranted, it shall direct an investigation to be undertaken. The Medical Executive Committee may conduct the investigation itself, or may assign the task to an appropriate Medical Staff officer, a standing, or ad hoc committee of the Medical Staff. The Board of Trustees or Medical Executive Committee, in its discretion, may appoint practitioners who are not members of the Medical Staff as appointed agents of the Committee(s) for the sole purpose of serving on a standing or ad hoc committee, and not for the purpose of granting these practitioners temporary Clinical Privileges under Section 7.3, should circumstances warrant. If the investigation is delegated to an officer or committee other than the Medical Executive Committee, such officer or committee shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the Medical Executive Committee as soon as practicable. The report may include recommendations for appropriate corrective action. The member shall be notified that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The individual or body investigating the matter may, but is not obligated to, conduct interviews with persons involved; however, such investigation shall not constitute a "hearing" as that term is used in Article IX, nor shall the procedural rules with respect to hearings or appeals apply. Despite the status of any investigation, at all times the Medical Executive Committee shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process, or other action.

8.1-4 Medical Executive Action

As soon as practicable after the conclusion of the investigation, the Medical Executive Committee shall take action, which may include, without limitation:

(a) determining no corrective action be taken and, if the executive committee determines there was no credible evidence for the complaint in the first instance, removing any adverse information from the member's file;

(b) deferring action for a reasonable time where circumstances warrant;

(c) issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude the Chief of Staff from issuing informal written or verbal warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected member may make a written response, which shall be placed in the member's file;

(d) recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of Clinical Privileges, including, without limitation, requirements for co-admission, mandatory consultation, or monitoring;

(e) recommending reduction, modification, suspension or revocation of Clinical Privileges;

(f) recommending reductions of membership status or limitation of any prerogatives directly related to the member's delivery of patient care;

(g) recommending suspension, revocation or probation of Medical Staff membership; and

(h) taking other actions deemed appropriate under the circumstances.

8.1-5 Subsequent Action

(a) If corrective action as set forth in Section 9.2(a)-(k) is recommended by the Medical Executive Committee, that recommendation shall be transmitted to the Board of Trustees.

(b) So long as the recommendation is supported by credible evidence the recommendation of the Medical Executive Committee shall be adopted by the Board of Trustees as final action unless the member requests a hearing, in which case the final decision shall be determined as set forth in Article IX.

8.1-6 Initiation by Board of Trustees

If the Medical Executive Committee fails to investigate or take disciplinary action, contrary to the weight of the evidence, the Board of Trustees may direct the Medical Executive Committee to initiate investigation or disciplinary action, but only after consultation with the Medical Executive Committee. The Board of Trustees' request for Medical Staff action shall be in writing and shall set forth the basis for the request. If the Medical Executive Committee fails to take action in response to that Board of

Trustees' direction, the Board of Trustees may initiate corrective action after written notice to the Medical Executive Committee, but this corrective action must comply with Articles VIII and IX of these Medical Staff bylaws.

8.2 SUMMARY RESTRICTION OR SUSPENSION

8.2-1 Criteria for Initiation

Whenever a Medical Staff member's conduct appears to require that immediate action be taken to protect the life or well-being of patient(s) or to reduce a substantial and imminent likelihood of significant impairment of the life, health, safety of any patient, prospective patient, or other person, the Chief of Staff, the Chief Executive Officer or the Medical Executive Committee, may summarily restrict or suspend the Medical Staff membership or Clinical Privileges of such member. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the person or body responsible shall promptly give written notice to the Board of Trustees, the Medical Executive Committee, and the Hospital's Chief Executive Officer. In addition, the affected Medical Staff member shall be provided with a written notice of the action which notice fully complies with the requirements of Section 8.2-2 below. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the member's patients shall be promptly assigned to another member by the Chief of Staff, considering where feasible, the wishes of the patient in the choice of a substitute member.

8.2-2 Written Notice of Summary Suspension

Within one (1) working day of imposition of a summary suspension, the affected Medical Staff member shall be provided with written notice of such suspension. This initial written notice shall include a statement of facts demonstrating that the suspension was necessary because failure to suspend or restrict the practitioner's Privileges summarily could reasonably result in an imminent danger to the health of an individual. The statement of facts provided in this initial notice shall also include a summary of particular incidents giving rise to the assessment of imminent danger. This initial notice shall not substitute for, but is in addition to, the notice required under Section 9.3-1 (which applies in all cases where the Medical Executive Committee does not terminate the summary suspension in a timely manner). The notice under Section 9.3-1 may supplement the initial notice provided under this Section, by including any additional relevant facts supporting the need for summary suspension or other corrective action.

8.2-3 Medical Executive Committee Action

Within one (1) week after such summary restriction or suspension has been imposed, a meeting of the Medical Executive Committee shall be convened to review and consider the action. Upon request, the member may attend and make a statement concerning the issues under investigation, on such terms and conditions as the Medical Executive Committee may impose, although in no event shall any meeting of the Medical Executive Committee, with or without the member, constitute a "hearing" within the meaning of Article IX, nor shall any procedural rules apply. The Medical Executive Committee may modify, continue, or terminate the summary restriction or suspension, but in any event it shall furnish the member with notice of its decision within two (2) working days of the meeting.

8.2-4 Procedural Rights

Except in the case of a summary suspension of less than fourteen (14) days, and unless the Medical Executive Committee promptly terminates the summary restriction or suspension, the member shall be entitled to the procedural rights afforded by Article IX. In addition, the affected practitioner shall have the following rights:

(a) Any affected practitioner shall have the right to challenge imposition of the summary suspension, particularly on the issue of whether or not the facts stated in the notice present a reasonable possibility of "imminent danger" to an individual. Initially, the practitioner may present this challenge to the Medical Executive Committee at the meeting held within one (1) week of imposition of the suspension. If the Medical Executive Committee's decision is to continue the summary suspension, then any practitioner who has properly requested a hearing under the Medical Staff bylaws may request that the hearing be bifurcated, with the first part of the hearing being devoted exclusively to procedural matters, including the propriety of summary suspension. Along with any other appropriate requests for rulings, the affected practitioner may request that the hearing officer or hearing panel stay the summary suspension, pending the final outcome of the hearing and any appeal.

(b) At the conclusion of the procedural portion of the hearing, the hearing officer or hearing panel shall issue a written opinion on the issues raised, including whether or not the facts stated in the written notice to the affected practitioner adequately support a determination that failure to summarily restrict or suspend could reasonably result in "imminent danger" to an individual. Such written opinion shall be transmitted to both the affected practitioner and the Medical Executive Committee within one (1) week of the date of the procedural hearing.

(c) If the hearing officer's or hearing panel's determination is that the facts stated in the notice required by Section 8.2-2 do not support a reasonable determination that failure to summarily restrict or suspend the practitioner's Privileges could

result in imminent danger, the summary suspension shall be immediately stayed pending the outcome of the hearing and any appeal.

(d) If the hearing officer or hearing panel determines that the facts stated in the notice required by Section 8.2-2 support a reasonable determination that summary suspension was necessary to avoid imminent danger to an individual, the summary suspension shall remain in effect pending conclusion of the hearing and any appellate review.

8.2-5 Initiation by Board of Trustees

If the Chief of Staff or members of the Medical Executive Committee are not available to summarily restrict or suspend the member's membership or Clinical Privileges, the Board of Trustees or the Chief Executive Officer as its designee may immediately suspend a member's Privileges if a failure to suspend those Privileges is likely to result in an imminent danger to the health of any person, provided that the Board of Trustees or its designee made reasonable attempts to contact the Chief of Staff, and members of the Medical Executive Committee before the suspension.

Such a suspension is subject to ratification by the Medical Executive Committee. If the Medical Executive Committee does not ratify such a summary suspension within two (2) working days, excluding weekends and holidays, the summary suspension shall terminate automatically. If the Medical Executive Committee does ratify the summary suspension, all other provisions under Section 8.2 of these bylaws will apply. In this event, the date of imposition of the summary suspension shall be considered to be the date of ratification by the Medical Executive Committee for purposes of compliance with notice and hearing requirements.

8.3 AUTOMATIC SUSPENSION OR LIMITATION OF MEMBERSHIP AND PRIVILEGES

In the following instances, the member's Privileges or membership may be suspended or limited as described and a hearing, if requested, shall be limited to the question of whether the grounds for automatic suspension as set forth below have occurred.

8.3-1 Licensure

(a) Revocation, Suspension and Renewal: Whenever a member's license or other legal credential authorizing practice in this state is revoked or suspended, or not renewed, Medical Staff membership and Clinical Privileges shall be automatically revoked as of the date such action becomes effective.

(b) Restriction: Whenever a member's license or other legal credential authorizing practice in this state is limited or restricted by the applicable licensing or certifying authority, any Clinical Privileges which the member has been granted at the Hospital which are within the scope of said limitation or restriction shall be

automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

(c) Probation: Whenever a member is placed on probation by the applicable licensing or certifying authority, membership status and Clinical Privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

8.3-2 Controlled Substances

(a) Probation: Whenever a member's DEA certificate is subject to probation, the member's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

(b) Other Circumstances: Whenever a member's DEA certificate is revoked, limited, or suspended, the member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.

8.3-3 Medical Records

Members of the Medical Staff are required to complete medical records within such reasonable time as may be prescribed by the Medical Executive Committee and noted in the Medical Staff Rules and Regulations. A limited suspension in the form of withdrawal of admitting and other related Privileges until medical records are completed, shall be imposed by the Chief of Staff, or the Chief of Staff's designee, after notice of delinquency for failure to complete medical records within such period.

8.3-4 Failure to Pay Dues or Assessments

Failure without good cause as determined by the Medical Executive Committee, to pay dues or assessments, as required under Section 15.3, shall be ground for automatic suspension of a member's Clinical Privileges, and if within 60 days after written warnings of the delinquency the member does not pay the required dues or assessments, the members membership shall be automatically terminated.

8.3-5 Professional Liability Insurance

Failure to maintain professional liability insurance, shall be grounds for automatic suspension of a member's Clinical Privileges, and if within 30 days after written warnings of the delinquency the member does not provide evidence of required professional liability insurance, the member's membership shall be automatically terminated.

8.3-6 Failure to Report Restrictions

Failure to report to the Hospital any restriction or condition imposed on or probation with respect to member's license by this state's licensing board within fifteen (15) days from members receipt of notice shall be grounds for automatic suspension of a member's Clinical Privileges.

8.3-7 Failure to Attend Meeting

Failure, without good cause, to appear at a meeting of the Board of Trustees that has been called in order to discuss proposed corrective action regarding the member, provided the member has been given reasonable notice and requested to attend, shall be grounds for automatic suspension of a member's Clinical Privileges.

8.3-8 Ineligible Person

Whenever a member shall have his/her name placed on any list of providers excluded from billing Medicare, Medicaid, or any other federal or state healthcare program, Medical Staff membership and Clinical Privileges shall be automatically revoked as of the date such action becomes effective.

8.3-9 Medical Executive Committee Deliberation

As soon as practicable after action is taken or warranted as described in Section 8.3, the Medical Executive Committee shall convene to review and consider the facts, and may recommend any further action as it may deem appropriate in accordance with these bylaws.

ARTICLE IX HEARINGS AND APPELLATE REVIEW

9.1 GENERAL PROVISIONS

9.1-1 Exhaustion of Remedies

If adverse action described in Section 9.2 is taken or recommended, the applicant or member must exhaust the remedies afforded by these bylaws before resorting to legal action.

9.1-2 Application of Article

For purposes of this Article, the term "member" does include "applicant," as it may be applicable under the circumstances, unless otherwise stated.

9.1-3 Timely Completion of Process

The hearing and appeal process shall be completed within a reasonable time.

9.1-4 Final Action

Recommended adverse actions described in Section 9.2 shall become final only after the hearing and appellate rights set forth in these bylaws have either been exhausted or waived, and only upon being adopted as final actions by the Board of Trustees.

9.1-5 Applicability of the Wyoming Administrative Procedures Act

The Wyoming Administrative Procedures Act, Wyo. Stat §§ 16-3-101 through 16-3-115, et seq. shall apply to actions giving rise to a hearing pursuant to Section 9.2 of these bylaws. Medical Staff Privileges granted pursuant to these bylaws are not "licenses" as defined in Wyo. Stat § 16-3-101(b)(iii) and an application for Medical Staff Privileges or an adverse action against Medical Staff Privileges as defined in Section 9.2 of these bylaws are not "licensing" as defined in Wyo. Stat. § 16-3-101(b)(iv).

9.2 GROUNDS FOR HEARING

Except as otherwise specified in these bylaws, any one or more of the following actions or recommended actions shall be deemed actual or potential adverse action and constitute grounds for a hearing:

(a) denial of Medical Staff membership;

(b) denial of requested advancement in staff membership status, or category;

(c) denial of Medical Staff reappointment;

(d) demotion to lower Medical Staff category or membership status;

(e) suspension of staff membership for a period of more than fourteen (14) days;

(f) revocation of Medical Staff membership;

(g) denial of requested Clinical Privileges;

(h) involuntary reduction of current Clinical Privileges;

(i) suspension of Clinical Privileges;

(j) termination of all Clinical Privileges; or

(k) involuntary imposition of significant consultation or monitoring requirements, excluding monitoring incidental to provisional status or for observation purposes.

9.3 REQUESTS FOR HEARING

9.3-1 Notice of Action or Proposed Action

In all cases in which action has been taken or a recommendation made as set forth in Section 9.2, the Chief of Staff or designee on behalf of the Medical Executive Committee shall give the member prompt written notice of (1) the recommendation or final proposed action and that such action, if adopted, shall be taken and reported to the National Practitioner Data Bank if required; (2) the reasons for the proposed action including the acts or omissions with which the member is charged; (3) the right to request a hearing pursuant to Section 9.3-2, and that such hearing must be requested within thirty (30) days; and (4) a summary of the rights granted in the hearing pursuant to the Medical Staff bylaws. If the recommendation or final proposed action is reportable to the Wyoming licensing authority and/or to the National Practitioner Data Bank, the written notice shall state the proposed text of the report(s).

9.3-2 Request for Hearing

The member shall have ninety (90) days following receipt of notice of such action to request a hearing. The request shall be in writing addressed to the Medical Executive Committee with a copy to the Board of Trustees. In the event the member does not request a hearing within the time and in the manner described, the member shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved.

9.3-3 Time and Place for Hearing

Upon receipt of a request for hearing, the Medical Executive Committee shall schedule a hearing and give notice to the member of the time, place, and date of the hearing. Unless extended by the judicial review committee, the date of the commencement of the hearing shall be not less than thirty (30) days from the date of notice, nor more than ninety (90) days from the date of receipt of the request by the Medical Executive Committee for a hearing; provided, however, that when the request is received from a member who is under summary suspension the hearing shall be held as soon as the arrangements may reasonably be made, so long as the member has at least thirty (30) days from the date of notice to prepare for the hearing or waives this right.

9.3-4 Notice of Hearing

Together with the notice stating the place, time and date of the hearing, which date shall not be less than thirty (30) days after the date of the notice unless waived by a member under summary suspension, the Chief of Staff or designee on behalf of the Medical Executive Committee shall provide the reasons for the recommended action, including the acts or omissions with which the member is charged, a list of the charts in question, where applicable, and a list of the witnesses (if any) expected to testify at the hearing on behalf of the Medical Executive Committee. The content of this list is subject to update pursuant to Section 9.4-1.

9.3-5 Judicial Review Committee

When a hearing is requested, the Medical Executive Committee shall recommend a judicial review committee to the Board of Trustees for appointment. The Board of Trustees shall be deemed to approve the selection unless it provides written notice to the Medical Executive Committee stating the reasons for its objection within five (5) days. The judicial review committee shall be composed of not less than three (3) members of the Medical Staff. The judicial review committee members shall gain no direct financial benefit from the outcome, and shall not have acted as accusers, investigators, fact finders, and initial decision makers or otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude a member of the Medical Staff from serving as a member of the judicial review committee. In the event that it is not feasible to appoint a judicial review committee from the active Medical Staff, the Medical Executive Committee may appoint members from other staff categories or practitioners who are not members of the Medical Staff. Such appointment shall include designation of the chair. Membership on a judicial review committee shall consist of one member who shall have the same healing arts licensure as the accused, and where feasible, include an individual practicing the same specialty as the member. All other members shall have MD or DO degrees or their equivalent as defined in Section 4.2-2.

9.3-6 Failure to Appear or Proceed

Failure without good cause of the member to personally attend and proceed at such a hearing in an efficient and orderly manner shall be deemed to constitute voluntary acceptance of the recommendations or actions involved.

9.3-7 Postponements and Extensions

Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these bylaws may be permitted by the hearing officer on a showing of good cause, or upon agreement of the parties.

9.4 HEARING PROCEDURE

9.4-1 Pre-hearing Procedure

(a) If either side to the hearing requests in writing a list of witnesses, within fifteen (15) days of such request, and in no event less than ten (10) days before commencement of the hearing, each party shall furnish to the other a written list of the names and addresses of the individuals, so far as is reasonably known or anticipated, who are anticipated to give testimony or evidence in support of that party at the hearing.

(b) The Medical Executive Committee and the member shall have the right to inspect and copy at his/her or its expense any documents or other evidence

relevant to the charges which the other party possesses or controls as soon as practicable after receiving the request.

(c) The failure by either party to provide access to this information at least thirty (30) days before the hearing shall constitute good cause for a continuance. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable members, other than the member under review.

(d) The hearing officer shall consider and rule upon any request for access to information and may impose any safeguards the protection of the peer review process and justice requires. In so doing, the hearing officer shall consider:

(i) whether the information sought may be introduced to support or defend the charges;

(ii) the exculpatory or inculpatory nature of the information sought, if any;

(iii) the burden imposed on the party in possession of the information sought, if access is granted; and

(iv) any previous requests for access to information submitted or resisted by the parties to the same proceeding.

(v) The member shall be entitled to a reasonable opportunity to question and challenge the impartiality of judicial review committee members and the hearing officer. Challenges to the impartiality of any judicial review committee member or the hearing officer shall be ruled on by the hearing officer.

(vi) It shall be the duty of the member and the Medical Executive Committee or its designee to exercise reasonable diligence in notifying the chair of the judicial review committee of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be succinctly made at the hearing.

9.4-2 Representation

The hearings provided for in these bylaws are for the purpose of intra-professional resolution of matters bearing on professional conduct, professional competency, or character.

The member shall be entitled to representation by legal counsel in any phase of the hearing, if the member so chooses, and shall receive notice of the right to obtain representation by an attorney at law. The Medical Executive Committee is entitled to

representation by legal counsel in any phase of the hearing, if the Committee so chooses and shall appoint a representative to present its action or recommendation; the materials in support thereof, examine witnesses, and respond to appropriate questions.

9.4-3 The Hearing Officer

The Medical Executive Committee shall recommend a hearing officer to the Board of Trustees to preside at the hearing. The Board of Trustees shall be deemed to approve the selection unless it provides written notice to the Medical Executive Committee stating the reasons for its objections within five (5) days. The hearing officer may be an attorney at law qualified to preside over a quasi-judicial hearing, but attorneys from a firm regularly utilized by the Hospital, the Medical Staff or the involved Medical Staff member or applicant for membership, for legal advice regarding their affairs and activities shall not be eligible to serve as hearing officer. The hearing officer shall gain no direct financial benefit from the outcome and must not act as a prosecuting officer or as an advocate. The hearing officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The hearing officer shall be entitled to determine the order of, or procedure for, presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions, which pertain to matters of law, procedure or the admissibility of evidence. If the hearing officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the hearing officer may take such discretionary action as warranted by the circumstances. If requested by the judicial review committee, the hearing officer may participate in the deliberations of such committee and be a legal advisor to it, but the hearing officer shall not be entitled to vote.

9.4-4 Record of the Hearing

A shorthand or court reporter shall be present to make a record of the hearing proceedings, and the pre-hearing proceedings if deemed appropriate by the hearing officer. The cost of attendance of the reporter shall be borne by the Hospital, but the cost of the transcript, if any, shall be borne by the party requesting it. The judicial review committee shall order that verbal evidence shall be taken only on oath administered by any person lawfully authorized to administer such oath.

9.4-5 Rights of the Parties

Within reasonable limitations as determined by the hearing officer, both sides at the hearing may call and examine witnesses for relevant testimony, introduce relevant exhibits or other documents, cross-examine or impeach witnesses who shall have testified verbally on any matter relevant to the issues, and otherwise rebut evidence, as long as these rights are exercised in an efficient and expeditious manner. The member may be called by the Medical Executive Committee and examined as if under cross-examination.

9.4-6 Miscellaneous Rules

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under this Article. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The judicial review committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate. At its discretion, the judicial review committee may request or permit both sides to file written arguments. The hearing process shall be completed within a reasonable time after the notice of the action is received; unless the hearing officer issues a written decision that the member or the Medical Executive Committee failed to provide information in a reasonable time or consented to the delay.

9.4-7 Burdens of Presenting Evidence and Proof

(a) At the hearing the Medical Executive Committee shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. The member shall be obligated to present evidence in response.

(b) An applicant shall bear the burden of persuading the judicial review committee, by a preponderance of the evidence, of the applicant's qualifications by producing information, which allows for adequate evaluation and resolution of reasonable doubts concerning the applicant's current qualifications for membership and Privileges. An applicant shall not be permitted to introduce information requested by the Medical Staff but not produced during the application process unless the applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

(c) Except as provided above for applicants, throughout the hearing, the Medical Executive Committee shall bear the burden of persuading the judicial review committee, by a preponderance of the evidence, that its action or recommendation is reasonable and warranted.

9.4-8 Adjournments and Conclusion

After consultation with the chair of the judicial review committee, the hearing officer may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted, with due consideration for reaching an expeditious conclusion to the hearing. Both the Medical Executive Committee and the member may submit a written statement at the close of the hearing. Upon conclusion of the presentation of verbal and written evidence, or the receipt of closing written arguments, if submitted, the hearing shall be closed.

9.4-9 Basis for Decision

The decision of the judicial review committee shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony. The decision of the judicial review committee shall be subject to such rights of appeal as described in these bylaws, but shall otherwise be affirmed by the Board of Trustees as the final action if it is supported by credible evidence, following a fair procedure.

9.4-10 Decision of the Judicial Review Committee

Within thirty (30) days after final adjournment of the hearing, the judicial review committee shall render a decision, which shall be accompanied by a report in writing and shall be delivered to the Medical Executive Committee. If the member is currently under suspension, however, the time for the decision and report shall be fifteen (15) days. A copy of said decision also shall be forwarded to the Hospital's Chief Executive Officer, the Board of Trustees, and to the member. The report shall contain a concise statement of the reasons in support of the decision including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the conclusion reached. If the final proposed action adversely affects the Clinical Privileges of a physician for a period longer than thirty (30) days and is based on competence or professional conduct, the decision shall state that the action if adopted will be reported to the National Practitioner Data Bank, and shall state the text of the report as agreed upon by the committee. The decision shall also state whether the action, if adopted, shall be reported to the Wyoming Board of Medicine and shall state the text of the report as agreed by the committee. Both the member and the Medical Executive Committee shall be provided a written explanation of the procedure for appealing the decision. The decision of the judicial review committee shall be subject to such rights of appeal or review as described in these bylaws, but shall otherwise be affirmed by the Board of Trustees as the final action if it is supported by credible evidence, following a fair procedure.

9.5 APPEAL

9.5-1 Time for Appeal

Within ten (10) days after receipt of the decision of the judicial review committee, either the member or the Medical Executive Committee may request an appellate review. A written request for such review shall be delivered to the Chief of Staff, the Hospital's Chief Executive Officer, and the other party in the hearing. If a request for appellate review is not requested within such period, that action or recommendation shall be affirmed by the Board of Trustees as the final action if it is supported by credible evidence, following a fair procedure.

9.5-2 Grounds for Appeal

A written request for an appeal shall include an identification of the grounds for appeal and a clear and concise statement of the facts in support of the appeal. The grounds for appeal from the hearing shall be:

(a) substantial non-compliance with the procedures required by these bylaws or applicable law which has created demonstrable prejudice;

(b) the decision was not supported by credible evidence based upon the hearing record or such additional information as may be permitted pursuant to Section 9.5-5; and/or

(c) the text of the report(s) to be filed with the Wyoming Board of Medicine and the National Practitioner Data Bank is not accurate.

9.5-3 Time, Place, and Notice

If an appellate review is to be conducted, the Board of Trustees shall, within fifteen (15) days after receipt of notice of appeal, schedule a review date and cause each side to be given notice of the time, place, and date of the appellate review. The date of appellate review shall not be less than thirty (30) nor more than sixty (60) days from the date of such notice, provided however, that when a request for appellate review concerns a member who is under suspension which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made, not to exceed fifteen (15) days from the date of the notice. The time for appellate review may be extended by the Board of Trustees for good cause.

9.5-4 Appeal Board

The Board of Trustees may sit as the Appeal Board, or it may appoint an Appeal Board that shall be composed of not less than three (3) members of the Board of Trustees. Knowledge of the matter involved shall not preclude any person from serving as a member of the Appeal Board, so long as that person did not take part in a prior hearing on the same matter. The Appeal Board may select an attorney to assist it in the proceeding, but that attorney shall not be entitled to vote with respect to the appeal. The attorney firm selected by the Board of Trustees shall be neither the attorney firm that represented either party at the hearing before the judicial review committee nor the attorney who assisted the hearing panel or served as hearing officer.

9.5-5 Appeal Procedure

The proceeding by the appeal Board shall be in the nature of an appellate hearing based upon the record of the hearing before the judicial review committee. The appeal Board may remand the matter to the judicial review committee for the taking of further evidence and for decision in the discretion of the Appeal Board. Each party shall have

the right to be represented by legal counsel, or any other representative designated by that party in connection with the appeal to present a written statement in support of that party's position on appeal, and to personally appear and make verbal argument. The appeal Board may thereupon conduct, at a time convenient to itself, deliberations outside the presence of the appellant and respondent and their representatives. The appeal Board shall present to the Board of Trustees its written recommendations as to whether the Board of Trustees should affirm, modify, or reverse the judicial review committee decision consistent with the standard set forth in Section 9.5-6, or remand the matter to the judicial review committee for further review and decision.

9.5-6 Decision

(a) Except as provided in Section 9.5-6(b), within thirty (30) days after the conclusion of the appellate review proceedings, the Board of Trustees shall render a final decision and shall affirm the decision of the judicial review committee if the judicial review committee's decision is supported by credible evidence, following a fair procedure.

(b) Should the Board of Trustees determine that the judicial review committee decision is not supported by credible evidence, the Board of Trustees may modify or reverse the decision of the judicial review committee and may instead, where a fair procedure has not been afforded, remand the matter to the judicial review committee for reconsideration, stating the purpose for the referral. If the matter is remanded to the judicial review committee for further review and recommendation, the committee shall promptly conduct its review and make its recommendations to the Board of Trustees. This further review and the time required to report back shall not exceed thirty (30) days in duration except as the parties may otherwise agree or for good cause as jointly determined by the President of the Board of Trustees and the judicial review committee.

(c) The decision shall be in writing, shall specify the reasons for the action taken, shall include the text of the report which shall be made to the National Practitioner Data Bank and the Wyoming Board of Medicine and shall be forwarded to the Chief of Staff, the medical executive and credential committees, the subject of the hearing, and the Hospital's Chief Executive Officer at least ten (10) days prior to submission to the Wyoming Board of Medicine.

9.5-9 Right to One Hearing

Except in circumstances where a new hearing is ordered by the Board of Trustees or a court because of procedural irregularities or otherwise for reasons not the fault of the member, no member shall be entitled to more than one evidentiary hearing and one appellate review on any matter which shall have been the subject of adverse action or recommendation.

9.6 EXCEPTIONS TO HEARING RIGHTS

9.6-1 Automatic Suspension or Limitation of Practice Privileges

No hearing is required when a member's license or legal credential(s) to practice has been revoked or suspended as set forth in Section 8.3-1(a). In other cases described in Sections 8.3-1 and 8.3-2, the issues which may be considered at a hearing, if requested, shall not include evidence designed to show that the determination by the licensing or credentialing authority or certifying authority was unwarranted, but only whether the member may continue practice in the Hospital with those limitations imposed.

9.7 EXPUNCTION OF DISCIPLINARY ACTION

Upon written petition, the Medical Executive Committee, in its sole discretion, may expunge previous disciplinary action upon a showing of good cause or rehabilitation.

9.8 NATIONAL PRACTITIONER DATA BANK REPORTING

The Hospital's Authorized Representative shall report an adverse action to the National Practitioner Data Bank only upon its adoption as final action and only using the description set forth in the final action as adopted by the Board of Trustees. The authorized representative shall report any and all revisions of an adverse action, including, but not limited to, any expiration of the final action consistent with the terms of that final action.

9.9 DISPUTING REPORT LANGUAGE

If no hearing was requested, a member who is the subject of a proposed adverse action report to the Wyoming Board of Medicine or the National Practitioner Data Bank may request an informal meeting to dispute the text of the report filed. The report dispute meeting shall not constitute a hearing and shall be limited to the issue of whether the report filed is consistent with the final action issued. The meeting shall be attended by the subject of the report, the Chief of Staff, and the Hospital's Authorized Representative, or their respective designees. If a hearing was held, the dispute process shall be deemed to have been completed.

9.10 EXCEPTIONS TO HEARING RIGHTS

9.10-1 Exclusive Contracts

Privileges can be reduced or terminated as a result of a decision by the Board of Trustees to enter into an exclusive contract for professional services. This may have an effect of eliminating a service area.

9.10-2 Service Area Formation or Elimination

a) All or a separate portion of a new Medical Staff service area may be formed or eliminated following a determination by the Board of Trustees of appropriateness of the service area elimination or formation.

b) The Medical Executive Committee may recommend to the Board of Trustees the formation or elimination of a service or service area to be appropriate based upon consideration of its effects on quality of care in the facility and/or community.

ARTICLE X OFFICERS OF THE MEDICAL STAFF

10.1 DESIGNATION

The officers of the Medical Staff shall be:

(a) Chief of Staff

(b) Vice Chief of Staff

(c) Secretary

(d) Treasurer

(e) Past Chief of Staff, if eligible to serve as an Officer of the Medical Staff

The positions of Secretary and Treasurer may be combined if desired by the Officers.

10.2 QUALIFICATIONS

Officers of the Medical Staff must be current members of the active Medical Staff in good standing at the time of nomination and election and must remain members in good standing during their terms of office. Failure to maintain such status shall immediately create a vacancy in the office involved. The officers of the staff must be practitioners with no less than one (1) year of demonstrated competence in their fields of practice and have demonstrated qualifications on the basis of experience and ability to direct and to lead the Medical Staff in its medical administrative activities.

10.3 NOMINATION OF OFFICERS

(a) If a vacancy exists, a nominating committee shall convene at least thirty (30) days prior to the December meeting of the Medical Staff, or at least thirty (30) days prior to any special meeting at which an election of Medical Staff officers is to be held. The nominating committee shall consist of two (2) members of the Medical Executive committee. If, for any reason, any of these two (2) individuals is unable to serve, the current presiding officer of the Medical Executive Committee shall appoint another member of the current Medical Executive Committee to serve in his/her place.

(b) The purpose of the nominating committee will be to select nominees to fill all existing or anticipated vacancies for the positions of Chief of Staff, Vice Chief of

Staff, Secretary, and Treasurer. Such nominations by the nominating committee shall be presented in writing to the current Medical Staff Coordinator at least twenty (20) days prior to the December meeting of the Medical Staff or any special meeting at which an election of Medical Staff officers is to be held. The final slate of nominees of the committee shall be chosen upon a two-thirds vote of the committee members.

(c) The Medical Staff Coordinator shall notify the members of the active Medical Staff of the committee's nominees in writing no less than fifteen (15) days prior to the date of the election.

(d) Additional nominees may be nominated by the individual members of the active Medical Staff. Such nominations must be presented to the Medical Staff Coordinator at least twenty (20) days prior to the date upon which the election is to be held.

(e) If all of the individuals nominated for an office pursuant to Sections 10.1-3(a), 10-3(b) and 10.3-1(d) shall be disqualified from, or otherwise be unable to accept nomination, then the nominating committee shall submit one or more substitute nominees at the December meeting, and nominations shall be accepted from the floor.

(f) Except for circumstances delineated in Section 10.1-3(e), nominations from the floor shall not be permitted at any meeting.

10.4 ELECTION OF OFFICERS

Officers shall be elected at the annual meeting of the Medical Staff, or at special meeting at which an election of Medical Staff officers is to be held, or by written ballot in lieu of meeting. In all cases voting shall be by secret written ballot, and voting by proxy shall not be permitted. A nominee shall be elected upon receiving a majority of the votes cast. If no candidate for the office receives a majority vote on the first ballot, a runoff election shall be held promptly between the two candidates receiving the highest number of votes.

10.5 TERM OF ELECTED OFFICE

Each officer shall serve a two-year term, commencing on the first day of the Medical Staff year following election. Each officer shall serve until the end of his/her term. Officers may serve unlimited consecutive terms.

10.6 REMOVAL OF OFFICERS

An officer shall be removed from office if a two-thirds majority of the active Medical Staff vote in favor of removal. Grounds for removal shall include, but not be limited to, mental and/or physical impairment and inability or unwillingness to perform the duties

and responsibilities of the office. Action directed towards removing an officer from office may be initiated by submission to the Medical Executive Committee of a petition seeking removal of an officer, signed by not less than 25% of the active Medical Staff. Upon receipt of such a petition, a vote on the issue shall be held within thirty (30) days.

10.7 VACANCIES IN MEDICAL STAFF OFFICES

(a) Vacancies in offices, other than that of Chief of Staff, shall be filled by the Medical Executive Committee.

(b) If there is a vacancy in the office of Chief of Staff, the Vice Chief of Staff shall become Chief of Staff and serve out the remaining term.

10.8 DUTIES OF ELECTED OFFICERS

10.8-1 Chief of Staff

The Chief of Staff shall serve as the chief administrative officer of the Medical Staff and principal elected official of the staff. As such, he/she shall:

(a) aid in coordinating the activities and concerns of the Hospital administration and of the nursing and other professional staff with those of the Medical Staff;

(b) be accountable to the Medical Executive Committee, for the quality and efficiency of clinical services and performance within the Hospital and for the effectiveness of the quality/utilization management and other performance improvement functions delegated to the Medical Staff;

(c) develop and implement methods for credentials review and for delineation of Privileges, continuing education programs, and effective performance improvement programs;

(d) appoint the Medical Staff representatives to Medical Staff and Hospital committees, unless otherwise expressly provided by these bylaws or Hospital bylaws, policies or procedures;

(e) communicate and represent the opinions, policies, concerns, needs and grievances of the Medical Staff to the Board of Trustees, the Chief Executive Officer of the Hospital, and other officials of the Medical Staff;

(f) be responsible for the enforcement of Medical Staff bylaws, rules and regulations, for implementation of sanctions where these are indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;

(g) call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;

(h) serve as chairman of the Medical Executive Committee and as an ex officio member without vote of all other Medical Staff committees.

10.8-2 Vice Chief of Staff

The Vice Chief of Staff shall be a member of the Medical Executive Committee. In the temporary absence of the Chief of Staff, he/she shall assume all the duties and have the authority of the Chief of Staff. He/she shall perform such additional duties as may be assigned to him/her by the Chief of Staff, or the Medical Executive Committee.

10.8-3 Secretary-Treasurer

The Secretary-Treasurer shall be a member of the Medical Executive Committee. Duties of the Secretary-Treasurer shall be to:

(a) Ensure that the medical staff coordinator is providing proper notice of all staff meetings on order of the appropriate authority;

(b) supervise the preparation of accurate and complete minutes for all meetings

(c) supervise the collection and accounting for any funds that may be collected in the form of Medical Staff dues or assessments, and maintain proper records of such funds;

(d) render an annual report for presentation at the December meeting of the general Medical Staff each year;

(e) perform such other duties as ordinarily pertain to this office.

ARTICLE XI MEDICAL STAFF SERVICE AREAS

11.1 ORGANIZATION OF SERVICES

11.1-1 The Medical Executive Committee may recommend the designation of service areas, subject to Board of Trustees approval.

11.1-2 Clinical Medical Directors shall be designated to include but not limited to: Medical Director for Outpatient Services, Respiratory Therapy, Clinical Laboratory and Pathology, and Radiology

11.2 QUALIFICATIONS, SELECTION, AND TENURE OF SERVICE AREA CHIEFS

11.2-1 Qualifications

Each service area chief shall be a member of the active staff and shall be board certified in his/her specialty area unless otherwise excused.

11.2-2 Selection

Each service area chief shall be recommended by the Medical Executive Committee, subject to approval of the Board of Trustees.

11.2-3 Tenure

The term of service for each service area chief shall be for 24 months, commencing on the first day of each Medical Staff year and ending on the last day of each Medical Staff year.

11.2-4 Committee Membership

Service chiefs shall be members of the Medical Executive Committee

11-2-5 Role in Appointment and Reappointment Process and Delineation of Privileges

If a service area is defined, then the Service Chief shall serve as the designee for the Chief of Staff in the appointment and reappointment process as defined in Article VI and Article VII for members of their service area.

11.3 REMOVAL OF SERVICE AREA CHIEFS

A service area chief may be removed from office:

(1) Automatically upon suspension of Hospital Privileges in accordance with the bylaws.

(2) As effected by a two-thirds majority vote of all active staff members of that service area, subject to approval by both the Medical Executive Committee and the Board of Trustees.

(3) At the discretion of the Chief of Staff.

11.4 FUNCTIONS OF SERVICE AREA CHIEFS

Each service chief is responsible for:

(1) Clinically related activities of the service area.
(2) Administratively related activities of the service area unless otherwise provided for by the Hospital.
(3) The development and implementation of policies and procedures that guide and support the provision of care within the service area.
(4) The recommendations for a sufficient number of qualified and competent persons available to provide care and treatment of patients within the service area.
(5) Continuing surveillance of the professional performance of all individuals who have delineated Clinical Privileges in the service area to include those

practitioners, dentists, podiatrists and allied health professionals assigned to that service area, as well as those assigned to another service area, but awarded certain Privileges in that service area.

(6) Recommendations to the Medical Staff of the criteria for Clinical Privileges in the service area.

(7) Recommendation regarding the award of Clinical Privileges for each member of the service and those Practitioners, dentists, podiatrists and allied health professionals assigned to another service area, but awarded certain Privileges in that service.

(8) The assessment and improvement of the quality of care and services provided.

(9) The maintenance of quality control programs, as appropriate.

(10) Recommendations for space and other resources needed by the service area.

11.5 FUNCTIONS OF EACH SERVICE AREA

11.5-1 Each service area shall establish its own criteria, consistent with the policies of the Medical Staff and of the Board of Trustees, for the granting of Clinical Privileges in the service.

11.5-2 Each service area shall conduct a review of committee reports concerning completed records of discharged patients and other pertinent sources of medical information related to patient care. Each service area shall have the responsibility to reach conclusions, make recommendations, and take action on the quality improvement finding of these reviews and to evaluate on-going programs. Such reviews shall include:

(1) death review;

(2) patients with infections, complications and /or errors in diagnosis and treatment;

(3) unsolved clinical problems of patients;

(4) proper utilization of Hospital facilities and services;

(5) review of surgical matters to include a comprehensive tissue review for justification of all surgery performed; whether or not tissue was removed; acceptability of chosen procedure; and agreement/disagreement between preoperative and pathological diagnoses; and

(6) other significant patient care matters as determined by each service area.

11.5-3 The service area chiefs, or their designees, shall present periodic reports to the Medical Executive Committee, which will be recorded in the minutes.

11.6 ASSIGNMENTS TO SERVICE AREAS

11.6-1 The Credentials Committee shall, after consideration of a completed application, recommend initial service area assignments for all Medical Staff appointees.

11.6-2 Each Medical Staff member shall have Clinical Privileges in one or more service area in accordance with their education, training, experience, and demonstrated competence. They shall be subject to all of the rules of such service area and to the jurisdiction of the service area chief involved.

11.6-3 Each Medical Staff member shall be assigned to one clinical service area for the purpose of participating in the required functions of the Medical Staff, for holding office, and for fulfilling all of the other obligations, which go with Medical Staff appointment.

ARTICLE XII COMMITTEES OF THE MEDICAL STAFF

12.1 GENERAL DESIGNATIONS

Medical Staff committees shall include but not be limited to:

(a) the Medical Staff meeting as a committee of the whole;

(b) meetings of standing committees of the Medical Staff established under this Article; and

(d) meetings of special or ad hoc committees created by the Medical Executive Committee.

The committees described in this Article shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the Medical Executive Committee to perform specified tasks. Unless otherwise specified, the chair and members of all committees shall be appointed by and may be removed by the Chief of Staff, subject to consultation with and approval by the Medical Executive Committee. Medical Staff committees shall be responsible to the Medical Executive Committee. The CEO of the Hospital, in concurrence with the Chief of the Medical Staff, shall appoint Hospital professional personnel to serve on Medical Staff committees as required.

All committees shall maintain a record of attendance at their meetings, maintain a record of their proceedings, and submit timely reports of their activities and copies of the minutes of their meetings to the Medical Executive Committee.

12.2 TERMS, VACANCIES AND REMOVAL

12.2-1 Terms of Committee Members

Unless otherwise specified, committee members shall be appointed for a term of twenty-four (24) months. Appointments shall start on the first day of the second month of the Medical Staff year and committee members shall serve until the last day of the first month of the subsequent Medical Staff year or until the member's successor is appointed, unless the member shall sooner resign or be removed from the committee. Committee members may serve consecutive terms.

12.2-2 Removal

If a member of a committee ceases to be a member in good standing of the Medical Staff, suffers a loss or significant limitation of practice Privileges, or if any other good cause exists, that member may be removed by the Medical Executive Committee.

12.2-3 Vacancies

Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made; provided however, that if an individual who obtains membership by virtue of these bylaws (e.g., Chief of the Medical Staff) is removed for cause, a successor may be selected by the Medical Executive Committee.

12.3 DESIGNATIONS OF STANDING COMMITTEES OF THE MEDICAL STAFF

There shall be three standing committees of the Medical Staff.

12.3-1 Administrative Committees

The administrative standing committees of the Medical Staff shall be:

(a) Medical Executive Committee; and

(b) Credentials Committee.

12.3-2 Professional Improvement Committees

There shall be a Performance Improvement Committee designated as a standing committee of the Medical Staff.

12.4 MEDICAL EXECUTIVE COMMITTEE

12.4-1 Composition

The Medical Executive Committee shall be a standing committee and shall consist of representatives from each major specialty of the Medical Staff in addition to the Chief of Staff. The Chief Executive Officer of the Hospital and the Chief Nursing Officer will serve as ex-officio members of the Medical Executive Committee but shall not participate in any proceedings or activities of the Medical Executive Committee when it

is acting as a peer review or medical review committee. The Medical Executive Committee has been empowered by the Board of Trustees for the establishment, maintenance, and improvement of professional and quality care. Therefore, the Medical Executive Committee shall encourage and participate in the ongoing monitoring and review of the factors that relate to quality patient care. The chairperson shall report to the Board of Trustees. Recommendations and decisions of the Medical Executive Committee will be determined by majority vote of its members.

12.4-2 Duties

INTENTIONALLY OMITTED. *See*, Medical Staff Policy No 603-04.

12.4-3 Meetings

The Medical Executive Committee shall meet as often as is necessary but not less than four (4) times a year. The Medical Executive Committee shall maintain a permanent record of its proceedings and actions.

12.5 CREDENTIALS COMMITTEE

12.5-1 Composition

The credentials committee shall consist of not less than three (3) members of the active staff selected by the Chief of Staff on a basis that will ensure, insofar as feasible, representation of major clinical specialties. The Medical Executive Committee may fulfill the functions of the credentials committee.

12.5-2 Duties

INTENTIONALLY OMITTED. *See*, Medical Staff Policy No 603-05.

12.5-3 Meetings

The committee shall meet at least quarterly, and more often as necessary to perform its duties, maintain a permanent record of its proceedings and actions and report to the Medical Executive Committee.

12.6 MEDICAL STAFF COMMITTEES

12.6-1 Composition

The Medical Staff Committees shall consist of medical staff members; selected by the Chief of the Medical Staff on a basis that will ensure, insofar as feasible, representation of major clinical specialties. In addition, the CEO of the Hospital and Director of Quality shall appoint additional Hospital personnel to serve on the Medical Staff Committees as appropriate. The Chief of the Medical Staff shall appoint a medical staff member to serve as chair for each of the Medical Staff Committees.

12.6-2 Duties

INTENTIONALLY OMITTED. *See*, Medical Staff Policy No. 603-06.

12.6-3 Meetings

The Medical Staff Committees shall meet at least quarterly, or as often as deemed necessary by the committee chairperson or required by the Medical Executive Committee.

ARTICLE XIII MEETINGS

13.1 GENERAL STAFF MEETINGS

13.1-1 Regular Meetings

The Medical Staff shall hold a committee of the whole meeting at least annually in order to elect officers of the Medical Staff. The committee of the whole meeting will be held in July, but may be reasonably adjusted as Hospital and medical staff members schedules require. In no event will the committee of the whole meeting be scheduled later than September.

13.1-2 Order of Business and Agenda

INTENTIONALLY OMITTED. *See*, Medical Staff Policy No. 603-07.

13.1-3 Special Meetings

Special meetings of the Medical Staff shall be called upon request of the Board of Trustees, the Chief of the Medical Staff, the Medical Executive Committee, or not less than one-third (1/3) of current members of the active Medical Staff. Special meetings shall be held at the time and place designated in the meeting notice. No business shall be transacted at any special meeting except the business stated in the meeting notice.

13.2 COMMITTEE MEETINGS

13.2-1 Regular Meetings

Committees shall, by resolution, provide the time for holding regular meetings, and no notice other than such resolution shall then be required. The frequency of such meetings shall be as required by these bylaws.

13.2-2 Special Meetings

A special meeting of any committee area shall be called at the request of the chairman of the committee or appropriate individual, the Board of Trustees, the Chief of the Medical

Staff, or one-third of the group's current members. No business shall be transacted at any special meeting except that stated in the meeting notice.

13.3 NOTICE OF MEETINGS WITH AGENDA

Written or printed notice stating the place, day and hour of any general staff meeting, of a service area meeting, of any special meeting, or of any regular committee meeting not held pursuant to resolution shall be delivered either personally, by email, or by mail to each person entitled to be present there at not less than five (5) days nor more than thirty (30) days before the date of such meeting. Notice of committee or service area meetings may be given verbally. If mailed, the notice of the meeting shall be deemed delivered 48 hours after deposited, postage prepaid, in the United States mail, addressed to each person entitled to such notice at his/her address as it appears on the records of the Hospital. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

13.4 QUORUM

13.4-1 General Staff Meetings

The presence of thirty-three percent or more of the members of the active Medical Staff at any regular or special meeting shall constitute a quorum for the purposes of amendment to these bylaws and the transaction of all other business.

13.4-2 Committee Meetings

Thirty-three percent of the medical staff members of the committee shall constitute a quorum at any medical staff meeting.

13.5 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. Action may be taken without a meeting by a committee by a writing setting forth the action so taken signed by each member entitled to vote there at.

13.6 MINUTES

Minutes of all meetings shall be prepared by the medical staff coordinator and shall include a record of attendance and the vote taken on each matter. Copies of such minutes shall be approved by the attendees, forwarded to the Medical Executive Committee, and made available to the staff. The medical staff coordinator shall maintain a file of the minutes of each meeting.

13.7 ATTENDANCE REQUIREMENTS

13.7-1 Regular Attendance

Each member of any Medical Staff category that is required to attend meetings shall be required to attend the following during the member's appointment period:

(a) at least fifty percent of all Medical Staff meetings duly convened pursuant to these bylaws; and

(b) at least fifty percent of all meetings of each committee on which member serves.

13.7-2 Absence from Meetings

Medical staff members will make their best effort to attend medical staff meetings.

13.7-3 Special Appearances

A Medical Staff member whose patient's clinical course of treatment is scheduled for discussion at a regular committee meeting, may be requested to attend the meeting. If requested, the member must be given written notice of the matter and of the time and place of the meeting at least five business days prior to the meeting. Whenever possible deviation from standard clinical practice is involved, special notice may be given at least five business days prior to the meeting by the presiding officer or his/her designee and shall include a statement of the issue involved and that the staff member's appearance is mandatory. Failure of a staff member to appear at any meeting for which member was given such special notice, shall, unless excused by the Medical Executive Committee upon a showing of good cause, result in an automatic suspension of all or such portion of the staff member's Clinical Privileges as the Medical Executive Committee may direct. Such suspension shall remain in effect until the matter is resolved by subsequent action of the Medical Executive Committee or of the Board of Trustees or through corrective action, if necessary. If a staff member makes a timely request for postponement supported by an adequate showing of good cause the presiding officer may grant postponement of the special appearance.

ARTICLE XIV CONFIDENTIALITY, IMMUNITY AND RELEASES

14.1 AUTHORIZATION AND CONDITIONS

By applying for or exercising Clinical Privileges within this Hospital, an applicant:

(a) authorizes representatives of the Hospital and the Medical Staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the applicant's professional ability and qualifications;

(b) authorizes persons and organizations to provide information concerning such practitioner to the Medical Staff;

(c) agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the Medical Staff or the Hospital who would be immune from liability under Section 14.3 of this Article; and

(d) acknowledges that the provisions of this Article are express conditions to an application for Medical Staff membership, the continuation of such membership, and to the exercise of Clinical Privileges at this Hospital.

14.2 CONFIDENTIALITY OF INFORMATION

14.2-1 General

Records and proceedings of all Medical Staff committees having the responsibility of evaluation and improvement of quality of care rendered in this Hospital, including, but not limited to, meetings of the Medical Staff meeting as a committee of the whole, meetings of committees, and meetings of special or ad hoc committees created by the Medical Executive Committee and including information regarding any member or applicant to this Medical Staff shall, to the fullest extent permitted by law, be confidential.

Access to such records shall be limited to duly appointed officers and committees of the Medical Staff for the sole purpose of executing Medical Staff responsibilities and subject to the requirement that confidentiality be maintained.

Information which is disclosed to the Board of Trustees of the Hospital or its appointed representatives in order that the Board of Trustees may discharge its lawful obligations and responsibilities shall be maintained by that body as confidential.

14.2-2 Breach of Confidentiality

As effective peer review and consideration of the qualifications of Medical Staff members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of committees, except in conjunction with other hospital, professional society, or licensing authority, is outside appropriate standards of conduct for this Medical Staff, violates the Medical Staff bylaws, and will be deemed disruptive to the operations of the Hospital. If it is determined that such a breach has occurred, the Medical Executive Committee may undertake such corrective action as it deems appropriate.

14.2-3 Access to Credentials File

A Medical Staff member shall be granted access to his/her credentials file, subject to the following provisions:

(i) notice of such request shall be made by the member to the Chief of Staff, Chief Executive Officer or the Chief of Staff's designee;

(ii) the member may review, and receive a copy of, only those documents provided by or addressed personally to the member. A summary of all other information including peer review committee findings, letters of reference, proctoring reports, complaints, etc., may be provided to the member, in writing, by the Chief Executive Officer, within a reasonable period of time, as determined by the Chief Executive Officer. Such summary may disclose the substance, but not the source, of the information summarized;

(iii) the review by the member shall take place in the Medical Staff office, during normal work hours, with an officer or designee of the Medical Staff present.

(iv) in the event a notice of action or proposed action is filed against a member, Section 9.4-1 shall govern access to that member's credentials file.

14.3 IMMUNITY FROM LIABILITY

14.3-1 For Action Taken

Each representative of the Medical Staff and Hospital shall be immune, to the fullest extent provided by law, from liability to an applicant or member for damages or other relief for any action taken or statements or recommendations made within the scope of duties exercised as a representative of the Medical Staff or Hospital.

14.3-2 For Providing Information

Each representative of the Medical Staff and Hospital and all third parties shall be immune, to the fullest extent provided by law, from liability to an applicant or member for damages or other relief by reason of providing information to a representative of the Medical Staff or Hospital concerning such person who is, or has been, an applicant to or member of the staff or who did, or does, exercise Clinical Privileges or provide services at this Hospital.

14.4 ACTIVITIES AND INFORMATION COVERED

The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health care facility's or organization's activities concerning, but not limited to:

(a) application for appointment, reappointment, or Clinical Privileges;

(b) corrective action;

(c) hearings and appellate reviews;

(d) quality improvement or utilization reviews;

(e) committee, or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and

(f) queries and reports concerning the National Practitioner Data Bank, peer review organization, the Wyoming Board of Medicine and similar queries and reports.

14.5 INDEMNIFICATION

14.5-1 General

The Hospital shall indemnify, defend and hold harmless the Medical Staff and its individual members from and against losses and expenses (including, judgments, settlements, and all other costs, direct or indirect, including attorney's fees) incurred or suffered by reason of or based upon any threatened, pending or completed action, suit, proceeding, investigation, or other dispute relating or pertaining to any alleged act or failure to act within the scope of duties exercised as a representative of the Medical Staff or Hospital including, but not limited to, (1) as a member of or witness for a service area, committee or hearing panel, (2) as a member of or witness for the Hospital or any Hospital task force, group, or committee, and (3) as a person providing information to any Medical Staff or Hospital group, officer, Board of Trustees member or employee for the purpose of aiding in the evaluation of the qualifications, fitness or character of a Medical Staff member or applicant. Payment of any losses or expenses by the Medical Staff or member is not a condition precedent to the Hospital's indemnification obligations hereunder.

14.5-2 Notice Provisions

If any member seeks indemnification pursuant to these Bylaws, the parties to be indemnified shall give written notice thereof to the Hospital party. Upon receipt of such notice, the Hospital shall have the right to undertake, by counsel or representatives of its choosing, the good faith defense, compromise, or settlement of the claims, such defense, compromise or settlement to be taken on behalf of and for the account and risk for the indemnified party. The indemnified party shall cooperate with the Hospital, in such defense at the Hospital's expense and provide the Hospital with all information and assistance reasonably necessary to permit the Hospital to settle and/or defend any such claim. An indemnified party shall have the right to participate in such defense at its own choice, but such participation shall be at its own expense. At the discretion of and as determined by the Board of Trustees, an indemnified party who refuses or fails to cooperate with the Hospital in the defense of a claim against the indemnified party shall forfeit and waive all rights of indemnification pursuant to Section 14.5-1.

ARTICLE XV RULES, REGULATIONS AND GENERAL PROVISIONS

15.1 RULES, REGULATIONS AND POLICIES OF THE MEDICAL STAFF

The Medical Staff may adopt such rules, regulations, and policies as may be necessary to implement more specifically the general principles found within these bylaws. Following adoption, such polices, rules and regulations shall become effective upon approval of the Board of Trustees, which approval shall not be withheld unreasonably, or automatically after thirty days if no action is taken by the Board of Trustees. In the latter event, the Board of Trustees shall be deemed to have approved the policies, rule(s) and regulation(s) adopted by the Medical Staff. Policies, rules and regulations shall be reviewed at least every three years.

Medical Staff polices, rules and regulations shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each staff member or allied health practitioner in the Hospital. Such polices, rules and regulations shall be a part of these bylaws, except that they may be amended or repealed at any regular meeting of the Medical Staff or at a regularly scheduled Medical Executive Committee meeting at which a quorum is present and without previous notice, or at any special meeting on notice, by a majority vote of those present and eligible to vote subject to the approval of the Board of Trustees.

15.2 DUES OR ASSESSMENTS

The Medical Executive Committee shall have the power to recommend the amount of annual dues or assessments, if any, for each category of Medical Staff membership, subject to the approval of the Medical Staff, and to determine the manner of expenditure of such funds received.

15.3 DIVISION OF FEES

Any division of fees by members of the Medical Staff is forbidden and any such division of fees shall be cause for exclusion or expulsion from the Medical Staff.

15.4 NOTICES

Except where specific notice provisions are otherwise provided in these bylaws, any and all notices, demands, requests required or permitted to be mailed shall be in writing properly sealed, and shall be sent through United States Postal Service, first-class postage prepaid. An alternative delivery mechanism may be used if it is reliable, as expeditious, and if evidence of its use is obtained. Notice to the Medical Staff or officers or committees thereof, shall be addressed as follows:

> Name and proper title of addressee, (if known or applicable) and name of committee, c/o Chief of Staff, Memorial Hospital of Carbon County Center, 2221 West Elm Street, Rawlins, Wyoming 82301. Mailed notices to a member, applicant, or other party shall be to the addressee at the address as it last appears in the official records of the Medical Staff or the Hospital.

15.5 DISCLOSURE OF INTEREST

All nominees for election or appointment to Medical Staff offices, or to the Medical Executive Committee shall, at least twenty days prior to the date of election or appointment, disclose in writing to the Medical Executive Committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff. A conflict of interest may take many forms, but arises when a staff member in relation to an outside person or organization is in position to influence the Hospital's business or decisions in ways that could lead directly or indirectly to financial gain for the staff member or member's family or to give improper advantage to others to the detriment of the Hospital.

15.6 FORMS

Application forms and any other prescribed forms required by these bylaws for use in connection with staff appointments, reappointments, delineation of Clinical Privileges, corrective action, notices, recommendations, reports, and other matters shall be adopted by the Board of Trustees after considering the advice of the Medical Executive Committee.

15.7 TRANSMITTAL OF REPORTS

Reports and other information, which these bylaws require the Medical Staff to transmit to the Board of Trustees, shall be deemed so transmitted when delivered, unless otherwise specified, to the Hospital's Chief Executive Officer.

15.8 GOOD STANDING

The prerogatives and rights provided by these bylaws to staff members to vote at staff meetings, to be nominated for and to hold staff office or serve as a member of the Medical Executive Committee or committee chairman shall be limited to staff members in good standing.

15.9 SUBSTANTIAL COMPLIANCE

Non-material deviations from the procedures set forth in these bylaws shall not be grounds for invalidating the action taken.

15.10 PERFORMANCE BY DESIGNEES

Any responsibility assigned, or authority granted, to the Chief Executive Officer of the Hospital may be fulfilled or exercised by another administrative official of the Hospital, designated by the CEO to perform such function, except as otherwise provided by the Board of Trustees or in the Hospital bylaws.

15.11 MEDICAL STAFF ROLE IN EXCLUSIVE CONTRACTING

The Medical Executive Committee shall review and make recommendations to the Board of Trustees regarding quality of care issues related to exclusive arrangements for Practitioner and/or professional services, prior to any decision being made, in the following situations:

(a) the decision to execute an exclusive contract in a previously open portion of a service area;

(b) the decision to renew or modify an exclusive contract in a particular portion of a service area;

(c) the decision to terminate an exclusive contract in a particular portion of a service area.

ARTICLE XVI ADOPTION AND AMENDMENT OF BYLAWS

16.1 AMENDMENT

Upon the request of (1) the Medical Executive Committee, or the Chief of Staff, or (2) upon timely written petition signed by at least 33% of the members of the Medical Staff in good standing who are entitled to vote, consideration shall be given to the adoption, amendment, or repeal of these bylaws. Such action shall be taken at a regular or special meeting of the Medical Staff, or by written ballot in lieu of meeting, provided:

(a) written notice of the proposed change was sent to all members on or before the last regular or special meeting of the Medical Staff, and such changes were offered at such prior meeting;

(b) notice of the next regular or special meeting at which action is to be taken included notice that a bylaw change would be considered; and

(c) both notices shall include the wording of the existing bylaw language, if any, and the proposed change(s).

16.2 ACTION ON BYLAW CHANGES

If a quorum is present for the purpose of enacting a bylaw change, the change shall require an affirmative vote of greater than 50% of the members voting in person or by written ballot.

16.3 APPROVAL OF BYLAW CHANGES

Bylaw changes adopted by the Medical Staff shall become effective following approval by the Board of Trustees, which approval shall not be withheld unreasonably, or automatically within ninety days if no action is taken by the Board of Trustees. Medical Staff members are provided with copies of the revisions in the bylaws, rules and regulations and Medical Staff policies. If approval is withheld, the reasons for doing so

shall be specified by the Board of Trustees in writing, and shall be forwarded to the Chief of Staff and the Medical Executive Committee.

16.4 EXCLUSIVITY OF MECHANISM

The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff bylaws.

16.5 CONSTRUCTION OF TERMS AND HEADINGS

The captions or headings in these bylaws are for convenience only and are not intended to limit or define the scope of or affect any of the substantive provisions of these bylaws. These bylaws apply with equal force to both genders wherever either term is used.

16.6 ADOPTION OF BYLAWS

These bylaws together with any appended policies, rules and regulations when adopted by the Medical Staff shall replace any previous bylaws, policies, rules and regulations and shall become effective when approved by the Board of Trustees of The Hospital.

ADOPTED by the Medical Staff on:

Date: November 14, 2023

_____
Chief of Staff

Date: November 14, 2023

_____
Secretary - Treasurer

APPROVED by the Board of Trustees on

Date: December 7, 2023

President, Board of Trustees

Date: December 7, 2023

Secretary, Board of Trustees