CREDENTIALING POLICY
FOR
ALLIED HEALTH PROFESSIONALS
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ARTICLE 1

DEFINITIONS

The following definitions shall apply to terms used in this Policy.

A. "Allied Health Professionals" means individuals other than Medical Staff members who are authorized by law and by the Hospital to provide patient care services within the Hospital.

B. "Board of Directors" or "Board" means the governing body of Saint Francis Health System or, as appropriate to the context, any committee or individual authorized by the Board to act on its behalf on certain matters.

C. "Clinical Privileges" means permission granted by the Board to a practitioner to provide those diagnostic or therapeutic medical or surgical services specifically delineated to him or her.

D. "Executive Committee" means the committee composed of Medical Staff officers and elected members that represent all staff members and provide them with the medical and administrative leadership necessary to fulfill the staff's accountability to the Board for the quality and efficiency of patient care.

E. "Ex officio" means service as a member of a body by virtue of office or position held and with or without vote as specified.

F. "Hospital" means Saint Francis South Hospital.

G. "Medical Staff" means all physicians, dentists, oral surgeons and podiatrists who have been appointed to the Medical Staff by the Board.

H. "Medical Staff Bylaws or related Medical Staff documents" means any one or more of the following documents as appropriate to the context:

1. Bylaws of the Medical Staff;
2. Medical Staff Credentialing Policy;
3. Medical Staff Fair Hearing Plan;
4. Rules and Regulations of the Medical Staff;
5. Procedures to Address Impaired or Disruptive Physicians;
6. Impaired Professional Program; and
7. Allied Health Professionals Credentialing Policy and Fair Hearing Plan.

I. "Medical Staff Leader" means any Medical Staff officer, medical director, and committee chair.

J. "Member" means any physician, dentist, oral surgeon, and podiatrist who has been granted Medical Staff appointment and clinical privileges by the Board to practice at the Hospital.
K. "Physician" means an individual with an M.D. or D.O. degree who is licensed to practice medicine.

L. "Scope of Practice" means the authorization granted by the Board to render specific patient care services in the Hospital within defined limits.

M. "Senior Vice President of Operations" means the individual appointed by the Board of Directors to act on its behalf in the overall management of the Hospital, who functions as the Chief Executive Officer ("CEO") of Saint Francis South Hospital. The title of this individual may be Vice President of Operations or Administrator.

N. "SFHS" means Saint Francis Health System.

O. "Special Notice" means notification by certified mail with a request for a return receipt.

P. "Supervision" means the oversight of, or collaboration with, a Licensed Dependent Practitioner or a Dependent Practitioner by a supervising physician that does not require the actual presence of the supervising physician, but that does require that the supervising physician be readily available for consultation.

Words used in this Policy shall be read as the masculine or feminine gender, and as the singular or plural, as the content requires. The captions or headings are for convenience only and are not intended to limit or define the scope or effect of any provision of this Policy.
ARTICLE 2

SCOPE AND OVERVIEW OF POLICY

2.1 Scope of Policy

A. This Policy addresses those Allied Health Professionals who are permitted to practice or provide services within the Hospital.

B. Qualified Allied Health Professionals shall be appointed as Licensed Independent Practitioners, Licensed Dependent Practitioners, or Dependent Practitioners and shall be granted clinical privileges or a scope of practice at the Hospital, provided they meet the criteria for the exercise of clinical privileges/scope of practice. The granting of permission to practice at any particular SFHS Hospital does not permit an Allied Health Professional to practice at any other SFHS Hospital unless the individual has formally requested, and has been granted permission to do so, in accordance with the terms of this Policy.

C. This Policy shall not apply to Allied Health Professionals who are employed by the Hospital (except to the extent set forth in Article 9).

2.2 Classification of Allied Health Professionals

This Policy sets forth the credentialing processes for Allied Health Professionals, as well as the general practice parameters for these individuals. All such practitioners who are permitted to practice at the Hospital shall be classified in one of three broad categories, "Licensed Independent Practitioners," "Licensed Dependent Practitioners," or "Dependent Practitioners," each having a slightly different relationship to the Hospital.

2.3 Licensed Independent Practitioners

The "Licensed Independent Practitioners" category shall include all those Allied Health Professionals who are granted clinical privileges and are authorized to function independently at the Hospital. These individuals generally can bill independently for the services they provide and they require no formal or direct supervision by a physician. Only those classes of Licensed Independent Practitioners that have been approved by the Board of Directors shall be permitted to practice at the Hospital.

2.4 Licensed Dependent Practitioners

The "Licensed Dependent Practitioners" category shall include all those Allied Health Professionals who are licensed or certified under state law, are granted clinical privileges, and are authorized to function in the Hospital only under the supervision of, or in collaboration with, a practitioner(s) appointed to the Medical Staff. With respect to these practitioners, the supervising physician(s) shall remain fully responsible for the actions of the Dependent Practitioner in the Hospital. Only those classes of Licensed Dependent Practitioners that have been approved by the Board of Directors shall be permitted to practice at the Hospital.
2.5 Dependent Practitioners

The "Dependent Practitioners" category shall include all Allied Health Professionals who are granted permission to perform a scope of practice and are authorized to function in the Hospital only as employees of, or under direct supervision of, a physician(s) appointed to the Medical Staff. With respect to these practitioners, the employing and or supervising physician(s) shall remain fully responsible for the actions of the Dependent Practitioner in the Hospital. Only those classes of dependent practitioners that have been approved by the Board of Directors shall be permitted to practice at the Hospital.

2.6 Additional Policies

The Board shall adopt a separate policy for each category of Allied Health Professional that it approves to practice in the Hospital. These separate policies shall supplement this Policy and shall address the specific matters set forth in Section 3.2 of this Policy.
ARTICLE 3

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

3.1 Determination of Need:

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

A. the nature of the services that could be offered;

B. any Oklahoma license or regulation which outlines the scope of practice for the Allied Health Professional;

C. any state "non-discrimination" or "any willing provider" laws that would apply to the Allied Health Professional;

D. the patient care objectives of the Hospital, including patient convenience;

E. how well the community's needs are currently being met and whether they could be better met if the services offered by the Allied Health Professional were provided by the Hospital or as part of its facilities;

F. the type of training that is necessary to perform the services that could be offered and whether there are individuals with more training currently providing those services;

G. the availability of supplies, equipment, and other necessary Hospital resources;

H. the need for and availability of trained staff to support the services that would be offered; and

I. the ability to appropriately supervise performance.
3.2 Development of Policy:

A. If the ad hoc committee recommends that there is a need for the particular category of Allied Health Professionals at the Hospital, the committee shall recommend:

(1) any specific qualifications and/or training that they must possess beyond those set forth in this Policy;

(2) a detailed description of their authorized scope of practice or clinical privileges;

(3) any specific conditions that apply to their functioning within the Hospital; and

(4) any supervision requirements, if applicable.

B. In developing such policies, the ad hoc committee shall consult the Credentials Committee and applicable state law and may contact applicable professional societies or associations. The ad hoc committee may also recommend to the Board the number of Allied Health Professionals that are needed in a particular category.
ARTICLE 4

APPLICATION

4.1 General Qualifications of Applicants

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

A. Have a current, unrestricted license or certification to practice in the State of Oklahoma (as applicable) and have never had a license or certification to practice revoked or suspended by any state licensing agency.

B. Where applicable to his or her practice, have current, unrestricted DEA and Oklahoma controlled substances certificates.

C. Be located close enough to the Hospital to provide timely and continuous care for patients in the Hospital.

D. Be covered by current, valid professional liability insurance coverage in such form and in amounts satisfactory to the Hospital.

E. Have never been convicted of Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse or have been required to pay civil penalties for the same.

F. Have never been, and is not currently, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program.

G. Have never had clinical privileges or scope of practice denied, revoked, suspended, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct, and have never resigned or relinquished clinical privileges or scope of practice during an investigation or in exchange for not conducting an investigation.

H. Have never been convicted of, or entered a plea of guilty or no contest to, any felony; or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, or violence.

I. Satisfy all additional eligibility qualifications relating to his or her specific area of practice.

J. If seeking to practice as a Licensed Dependent Practitioner or a Dependent Practitioner, have a supervision agreement with a supervising/employing physician who is appointed to the Medical Staff.

K. Be able to document his or her:
(1) relevant training, experience, demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, and clinical judgment, and an understanding of the contexts and systems within which care is provided;

(2) adherence to the ethics of the profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients and the profession;

(3) good reputation and character;

(4) ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable him or her to maintain professional relationships with patients, families and other members of health care teams;

(5) ability to safely and competently perform the clinical privileges or scope of practice requested; and

(6) recognition of the importance of, and willingness to support, the Hospital's commitment to quality care and a recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

4.2 Waiver of Criteria

A. Any individual who does not satisfy a criterion may request that it be waived. The individual requesting the waiver bears the burden of demonstrating that his or her qualifications are equivalent to, or exceed, the criterion in question.

B. The Board may grant waivers in exceptional cases after considering the findings of the Credentials Committee and the Executive Committee, the specific qualifications of the individual in question, and the best interests of the Hospital and the community it serves. The granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals.

C. No individual is entitled to a waiver or to a hearing if the Board determinates not to grant a waiver.

D. A determination that an individual is not entitled to a waiver is not a "denial" of clinical privileges or scope of practice. Rather, that individual is ineligible to request clinical privileges or scope of practice.

4.3 No Entitlement to Medical Staff Appointment

Individuals who are applying to practice at the Hospital as Allied Health Professionals shall not be eligible for appointment to the Medical Staff or entitled to the rights, privileges, and/or prerogatives of Medical Staff appointment.

4.4 Non-Discrimination Policy
No individual shall be denied permission to practice at the Hospital on the basis of sex, race, creed, religion, color, or national origin, or on the basis of any criteria unrelated to professional qualifications or to the Hospital's purposes, needs, and capabilities.

4.5 Assumption of Duties and Responsibilities

As a condition of consideration of an application, and as a condition of continued permission to practice within the Hospital, practitioners shall assume such reasonable duties and responsibilities as the Credentials Committee, Executive Committee, and/or the Board (or its designated committee) shall require, including:

A. Providing appropriate continuous and timely care and supervision to patients in the hospital for whom the individual has responsibility.

B. Abiding by the bylaws and policies of the Hospital, including the applicable bylaws, rules and regulations of the Medical Staff as shall be in force during the time the individual is granted permission to practice at the Hospital.

C. Accepting committee assignments, participation in performance improvement and peer review activities, and such other reasonable duties and responsibilities as shall be assigned.

D. Constructively participating in the development, review, and revision of clinical protocols and pathways pertinent to his or her specialty, including those related to national patient safety initiatives and core measures.

E. Complying with adopted protocols and pathways or clearly document the clinical reasons for variance.

F. Providing to the Chief of Staff, with or without request, and, as it occurs, new or updated information that is pertinent to any question on the application form.

G. Appearing for personal interviews as requested in regard to the application.

H. Abiding by the terms of the Ethical and Religious Directives for Catholic Health Care Services promulgated by the National Conference of Catholic Bishops and performing no activity prohibited by said Directives.

I. Refraining from illegal fee splitting or other illegal inducements relating to patient referral.

J. Refraining from assuming responsibility for diagnoses or care of patients for which he or she is not qualified or without adequate supervision.

K. Refraining from deceiving patients as to his or her status as a non-physician practitioner.

L. Seeking consultation whenever necessary.
M. Promptly notifying the Chair of the Credentials Committee and the Chief of Staff of any change in eligibility for payments by third-party payors or for participation in the Medicare or Medicaid Program, including any sanctions imposed or recommended by the federal Department of Health and Human Services, and/or the receipt of PRO citation and/or quality denial letter concerning alleged quality problems in patient care.

N. Abiding by generally recognized ethical principles applicable to the individual's profession.

O. Participating in performance improvement and quality monitoring activities of the Hospital.

P. Completing, in a timely manner, the medical and other required records for all patients as required by the Medical Staff bylaws, policies, rules and regulations, this Policy, and other applicable policies of the Hospital.

Q. Working cooperatively and professionally with Medical Staff appointees, other non-physician practitioners, nurses, and other hospital personnel.

R. Participating in applicable continuing education programs.

S. Agreeing to submit to appropriate blood and/or urine testing if a concern has been raised regarding the practitioner's ability to safely and competently practice at the Hospital.

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

4.6 Professional Conduct

A. Individuals appointed as Allied Health Professionals are expected to relate in a positive and professional manner to other health care professionals and to cooperate and work collegially with the Medical Staff leadership and Hospital management and personnel. Disruptive conduct and behavior, specifically including threatening or abusive language and actions, are unacceptable and below the standard expected of individuals practicing at the Hospital.

B. All such individuals are specifically required to abide by the SFHS Sexual Harassment Policy.

C. All such individuals are also required to provide services and to conduct themselves in an ethical and lawful manner, in accordance with the SFHS Corporate Compliance Policy.
4.7 Request for Application Process

A. An application for permission to practice at the Hospital shall be sent only upon request to those classes of practitioners who have been approved by the Board (or its designated committee), who meet the general qualifications set forth in Section 4.1 A-J of this Policy, and who meet the specific qualifications relating to each applicant's specific area of practice.

B. Any Allied Health Professional who requests an application for permission to practice in the Hospital shall initially be sent:

1. A letter that outlines the general qualifications set forth in this Policy and the specific qualifications set forth in the policy relating to each applicant's area of practice, explains the review process, and outlines the scope of practice or clinical privileges approved by the Board (or its designated committee) for such practitioners in the Hospital.

2. A Request for Application form which requests proof that the individual meets the general qualifications outlined in this Policy and in the policies relating to the applicant's specific area of practice. A completed Request for Application form must be returned to the Medical Staff Office within (30) days after the individual's receipt of the Request for Application form if further consideration is desired.

C. The applicant shall indicate on the Request for Application form the specific procedures or clinical activities which the applicant desires to perform at the Hospital.

D. Only those individuals who meet the qualifications outlined in paragraph A of this section shall be given an application. Individuals who fail to meet these qualifications shall not be given an application and shall be so notified.

4.8 Information to be Submitted with Applications

A. Application forms shall be sent from the Medical Staff Office to those individuals who return completed Request for Application forms and who meet the general qualifications set forth in this Policy and the specific qualifications outlined in the policy relating to their areas of practice.

B. The application form shall require detailed information concerning the applicant's professional qualifications, including:

1. information as to whether the applicant's clinical privileges, scope of practice, permission to practice, and/or affiliation has ever been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, reduced, subjected to probationary or other conditions, limited, terminated, or not renewed at any hospital or health care facility, or is currently being investigated or challenged;
(2) information as to whether the applicant's license or certification to practice any profession in any state, DEA, or any state controlled substance license (if applicable) is or has ever been voluntarily or involuntarily relinquished, suspended, modified, terminated, restricted, or is currently being investigated or challenged;

(3) information concerning the applicant's professional liability litigation experience and/or any professional misconduct proceedings involving the applicant, in this state or any other state, whether such proceedings are closed or still pending, including the substance of the allegations of such proceedings or actions, the substance of the findings of such proceedings or actions, the ultimate disposition of any such proceedings or actions that have been closed, and any additional information concerning such proceedings or actions as the Credentials Committee, Executive Committee, or Board may deem appropriate;

(4) current information regarding the applicant's ability to perform, safely and competently, the scope of practice or clinical privileges requested and the duties of Allied Health Professionals; and

(5) a copy of a government-issued photo identification.

C. Any application that does not provide the information requested on the application form shall not be considered or processed.

4.9 Burden of Providing Information

A. Allied Health Professionals seeking permission to practice shall have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications, and for resolving any doubts about such qualifications.

B. Allied Health Professionals seeking permission to practice have the burden of providing evidence that all the statements made and information given on the application are accurate and complete.

C. An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information verified from primary sources. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time. Any application that continues to be incomplete 30 days after the individual has been notified of the additional information required shall be deemed to be withdrawn.

D. It is the responsibility of the individual seeking permission to practice to provide a complete application, including adequate responses from references. An incomplete application will not be processed.

4.10 Release and Immunity
By applying for permission to practice at the Hospital, Allied Health Professionals expressly accept the following conditions (i) during the processing and consideration of the application, whether or not permission to practice is granted, (ii) as a condition of continued permission to practice, if granted, (iii) should permission to practice be revoked, reduced, restricted, suspended, and/or otherwise affected as part of the Hospital's professional review activities, and (iv) with regard to any third party inquiries received after the individual leaves about his or her tenure at the Hospital:

A. Immunity:

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

B. Authorization to Obtain Information from Third Parties:

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

C. Authorization to Release Information to Third Parties:

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

D. Authorization to Share Information among Components of SFHS:

The individual specifically authorizes the Hospital to share credentialing and peer review information within SHFS pertaining to the individual's clinical competence and/or
professional conduct. This information may be shared at initial granting of permission to practice, at renewal of permission to practice, or at any time during an individual's affiliation with the Hospital.

E. **Procedural Rights:**

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

F. **Legal Actions:**

If, notwithstanding the provisions in this Section, an Allied Health Professional institutes legal action and does not prevail, he or she shall reimburse the Hospital and any of its authorized representatives named in the action for any and all costs incurred in defending such legal action, including reasonable attorney's fees.
ARTICLE 5
CREDENTIALING PROCEDURE

5.1 Submission of Application

A. A completed application, with copies of all required documents, shall be submitted to the Medical Staff Office. It must be accompanied by payment of such non-refundable processing fees as may be recommended by the Credentials Committee, Executive Committee, and approved by the Board. After reviewing the application to determine that all questions have been answered, and after reviewing all references and other information or materials deemed pertinent, and after verifying the information provided in the application with the primary sources, the Medical Staff Office shall transmit the completed application along with all supporting materials to the appropriate Initial Reviewer.

B. As may be necessary, the Hospital may designate a Centralized Verification Organization (CVO) to act as a centralized verification agency for applicants for the sole purpose of collecting and verifying objective data. The Hospital does not thereby relinquish its responsibility to evaluate and make an informed decision on each application. By making application, each applicant authorizes the use of the services of the CVO in the credentialing process.

5.2 Initial Review Procedure

A. For individuals applying to practice at the Hospital, the initial evaluation of the application shall be performed by the Credentials Committee or hospital supervisor. The individual performing this review shall be referred to as the "Initial Reviewer" throughout the remainder of this Article.

B. The appropriate Initial Reviewer, or the individual to whom the Initial Reviewer has assigned this responsibility, shall thoroughly evaluate the applicant's education, training, experience, and ability to work with others. The Initial Reviewer may also confer with other experts within the hospital or outside the hospital in reviewing these qualifications (i.e., other physicians, relevant hospital department heads, nurse managers).

C. As part of the process of performing this evaluation, the Credentials Committee has the right to meet with the applicant and, when appropriate, the employing or supervising physician to discuss any aspect of the application, qualifications, and requested clinical privileges/scope of practice.

D. The Initial Reviewer shall prepare a written statement concerning the applicant's qualifications for permission to practice and for the requested clinical privileges/scope of practice. This report shall be prepared no later than (30) thirty days from the time the Initial Reviewer receives the completed application.
E. The Initial Reviewer shall be available to answer any questions that may be raised with respect to that individual's report and findings.

5.3 Credentials Committee Procedure

A. The Credentials Committee shall review the report from the Initial Reviewer and the information contained in references given by the applicant and from other available sources. The Credentials Committee shall examine evidence of the applicant's character, professional competence, qualifications, prior behavior, and ethical standing and shall determine whether the applicant has established and satisfied all of the necessary qualifications for the clinical privileges or scope of practice requested.

B. The Credentials Committee may use the expertise of any individual on the Medical Staff or in the Hospital, or an outside consultant, if additional information is required regarding the applicant's qualifications. The Credentials Committee may also meet with the applicant and, when applicable, the supervising physician. The Initial Reviewer may participate in this interview.

C. After determining that an applicant is otherwise qualified for permission to practice and the scope of practice or clinical privileges requested, the Credentials Committee may require the applicant to undergo a physical and/or mental examination by a physician(s) satisfactory to the Credentials Committee if there is any question about the applicant's ability to perform the scope of practice or privileges requested and the responsibilities of permission to practice. The results of this examination shall be made available to the Committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall be considered an incomplete application and all processing of the application shall cease.

D. The Credentials Committee may recommend the imposition of specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring). The Credentials Committee may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of an individual's compliance with any conditions.

5.4 Executive Committee Procedure

A. At its next meeting, after receipt of the written findings and recommendation of the Credentials Committee, the Executive Committee shall:

(1) adopt the findings and recommendations of the Credentials Committee as its own; or

(2) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the Executive Committee; or
(3) set forth in its report and recommendation clear and convincing reasons, along with supporting information, for its disagreement with the Credentials Committee's recommendation.

B. If the Executive Committee's recommendation is favorable to the applicant, the Committee shall forward its recommendation to the Board, through the Vice President of Operations, including the findings and recommendation of the department chair and the Credentials Committee. The Executive Committee's recommendation must specifically address the clinical privileges or scope of practice requested by the applicant, which may be qualified by any probationary or other conditions or restrictions relating to such clinical privileges or scope of practice.

C. If the Executive Committee's recommendation would entitle the applicant to the procedural rights set forth in this Policy, the Executive Committee shall forward its recommendation to the Vice President of Operations, who shall notify the applicant of the recommendation and his or her procedural rights. The Vice President of Operations shall then hold the Executive Committee's recommendation until after the individual has completed or waived the procedural rights outlined in this Policy.

5.5 Board Action

A. The Board may delegate to a committee, consisting of at least two Board members, action on applications if there has been a favorable recommendation from the Credentials Committee and the Executive Committee (or their designees) and there is no evidence of any of the following:

(1) a current or previously successful challenge to any license, certification, or registration;

(2) an involuntary termination, limitation, reduction, denial, or loss of permission to practice, clinical privileges or scope of practice at any other hospital or other entity; or

(3) an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

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

B. When there has been no delegation to the Board Committee, upon receipt of a recommendation that the applicant be granted permission to practice and clinical privileges or scope of practice, the Board may:

(1) grant the applicant permission to practice and clinical privileges or scope of practice as recommended; or
(2) refer the matter back to the Credentials Committee or Executive Committee or to another source inside or outside the Hospital for additional research or information; or

(3) reject or modify the recommendation.

C. If the Board determines to reject a favorable recommendation, it should first discuss the matter with the Chair of the Credentials Committee and the Chief of Staff. If the Board's determination remains unfavorable to the applicant, the Hospital President shall promptly send special notice to the applicant that the applicant is entitled to request the procedural rights as outlined in this Policy.

5.6 Renewal of Permission to Practice

A. Permission to practice at the Hospital as an Allied Health Professional is a courtesy extended by the Board and, if granted, shall be for a period not to exceed two years. Renewal of clinical privileges or scope of practice shall be granted only upon submission of a completed renewal application.

B. Failure to submit an application at least two months prior to the expiration of the individual's current term shall result in automatic expiration of clinical privileges or scope of practice at the end of the then current term.

C. Once an application for renewal of permission to practice has been completed and submitted to the Medical Staff Office, it shall be evaluated in the same manner and follow the same procedures outlined in this Policy regarding initial applications.

D. As part of the process for renewal of clinical privileges for Licensed Independent Practitioners and Licensed Dependent Practitioners, the following factors shall be considered:

(1) the competency of the practitioner as assessed by the appropriate department chair and documented on a biennial evaluation form;

(2) a recommendation from a peer; and

(3) use of the Hospital's facilities, taking into consideration practitioner-specific information concerning other individuals in the same or similar specialty.

E. As part of the process for renewal of a Dependent Practitioner's scope of practice, the annual competency assessments of the individual performed by the supervising physician(s) and the applicable Hospital department heads or nurse managers shall be considered. These evaluation forms, along with other reasonable indicators of continuing qualifications, shall be factors in the renewal of Dependent Practitioners' continued permission to practice.
F. Applicants seeking renewal of clinical privileges or scope of practice who are the subject of an adverse recommendation shall be entitled to the procedural rights outlined in Article 8 before the Board takes final action.
6.1 Supervision by Employing or Supervising Physician

A. Any activities permitted by the Board to be done at the Hospital by a Licensed Dependent Practitioner or Dependent Practitioner shall be done only under the supervision of the physician supervising that individual.

B. Licensed Dependent Practitioners or Dependent Practitioners may function in the Hospital only so long as (i) they are supervised by a physician currently appointed to the Medical Staff, and (ii) they have a current, written supervision agreement with that physician. In addition, should the Medical Staff appointment or clinical privileges of the staff physician supervising a Licensed Dependent Practitioner or Dependent Practitioner be revoked or terminated, the individual's permission to practice at the Hospital and clinical privileges or scope of practice shall be automatically relinquished (unless the individual will be supervised by another physician on the Medical Staff).

C. As a condition for permission to practice at the Hospital, each Licensed Dependent Practitioner or Dependent Practitioner and his/her supervising physician must submit a copy of their written supervision or collaboration agreement to the Hospital. This agreement must meet the requirements of all applicable Oklahoma statutes and regulations, as well as any additional requirements of the Hospital. It is also the responsibility of the Licensed Dependent Practitioner or Dependent Practitioner and his/her supervising physician to provide the Hospital, in a timely manner, with any revisions or modifications that are made to the agreement.

6.2 Questions Regarding Authority of a Dependent Practitioner

A. Should any Medical Staff appointee or the Hospital employee who is licensed or certified by the state have any question regarding the clinical competence or authority of a Licensed Dependent Practitioner or Dependent Practitioner either to act or to issue instructions outside the physical presence of the employing or supervising physician in a particular instance, such Medical Staff appointee or the Hospital employee shall have the right to require that the Licensed Dependent Practitioner's or Dependent Practitioner's employer or supervisor validate, either at the time or later, the instructions of the Licensed Dependent Practitioner or Dependent Practitioner. Any act or instruction of the Licensed Dependent Practitioner or Dependent Practitioner shall be delayed until such time as the staff appointee or hospital employee can be certain that the act is clearly within the scope of the Licensed Dependent Practitioner's or Dependent Practitioner's activities as permitted by the Board (or its designated committee).
B. Any question regarding the professional conduct of a Licensed Dependent Practitioner or Dependent Practitioner shall be reported to the Credentials Committee and the director of the area in which the Licensed Dependent Practitioner or Dependent Practitioner functions.

6.3 Responsibilities of Employing or Supervising Physician

A. At all times, the employing or supervising physician shall remain responsible for all acts of the Licensed Dependent Practitioner or Dependent Practitioner while at the Hospital.

B. The number of Licensed Dependent Practitioners or Dependent Practitioners acting as employees of or under the supervision of one (1) physician, as well as the acts they may undertake, shall be consistent with applicable state statutes and regulations, the rules and regulations of the Medical Staff, and the policies of the Board.

C. It shall be the responsibility of the physician employing or supervising the Licensed Dependent Practitioner or Dependent Practitioner to provide, or to arrange for, professional liability insurance coverage for the Licensed Dependent Practitioner or Dependent Practitioner in amounts required by the Board (or its designated committee) that covers any activities of the Licensed Dependent Practitioner or Dependent Practitioner at the Hospital. The physician employing or supervising the Licensed Dependent Practitioner or Dependent Practitioner shall furnish evidence of such coverage to the Hospital in the form of an insurance certificate that specifically identifies the Licensed Dependent Practitioner or Dependent Practitioner. The Licensed Dependent Practitioner or Dependent Practitioner shall act at the Hospital only while such coverage is in effect.
ARTICLE 7

PEER REVIEW PROCEDURES FOR QUESTIONS INVOLVING ALLIED HEALTH PROFESSIONALS

7.1 Collegial Intervention

A. As part of the Hospital's performance improvement and professional and peer review activities, this Policy encourages the use of collegial intervention and progressive steps by Medical Staff leaders and Hospital administration to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised. Collegial intervention efforts are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders.

B. Collegial efforts may include, but are not limited to, counseling, sharing of comparative data, monitoring, and additional training or education.

7.2 Administrative Suspension

A. The Chief of Staff, the Chair of the Credentials Committee and the Vice President of Operations shall each have the authority to impose an administrative suspension of all or any portion of the scope of practice or clinical privileges of any Allied Health Professional whenever a concern has been raised about such individual's clinical practice or conduct.

B. An administrative suspension shall become effective immediately upon imposition, shall immediately be reported in writing to the Hospital Vice President of Operations and the Chief of Staff, and shall remain in effect unless or until modified by the Vice President of Operations or the Executive Committee.

C. Upon receipt of notice of the imposition of an administrative suspension, the Vice President of Operations or the Chief of Staff shall forward the matter to the full Executive Committee, which shall review and consider the question(s) raised and thereafter make an appropriate recommendation to the Board. If the Executive Committee's recommendation is to restrict or terminate the Allied Health Professional's scope of practice or clinical privileges, the individual and, when applicable, the supervising physician shall be entitled to the procedural rights outlined in Article 8 of this Policy before the Executive Committee's recommendation is considered by the Board.

7.3 Automatic Relinquishment of Scope of Practice or Clinical Privileges

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

A. the Medical Staff appointment or clinical privileges of the staff physician supervising a Licensed Dependent Practitioner or Dependent Practitioner are
revoked or terminated for any reason (unless theLicensed Dependent Practitioner or Dependent Practitioner will be supervised by another physician on the Medical Staff);

B. a Licensed Dependent Practitioner or Dependent Practitioner ceases to be supervised by a physician currently appointed to the Medical Staff for any reason (unless the Licensed Dependent Practitioner or Dependent Practitioner will be supervised by another physician on the Medical Staff);

C. an Allied Health Professional's license or certification expires, is revoked, or is suspended or restricted;

D. the Allied Health Professional no longer satisfies any of the threshold eligibility criteria set forth in Section 4.1 (A - J) or any additional threshold credentialing qualification set forth in the specific Hospital policy relating to his or her discipline;

E. the Allied Health Professional is indicted or convicted of a felony, or any misdemeanor related to (i) the practice of his or her profession or other health care-related matters; (ii) controlled substances or illegal drugs; (iii) third-party reimbursement; or (iv) violence;

F. the Allied Health Professional fails to provide information pertaining to his or her qualifications for the scope of practice or clinical privileges in response to a written request from the Credentials Committee, the Executive Committee, the Vice President of Operations, or any other committee authorized to request such information; or

G. a determination is made by the Board, after consultation with the Medical Staff leadership, that there is no longer a need for the services that are being provided by the Allied Health Professional.

7.4 Leave of Absence

A. An Allied Health Professional may request a leave of absence, for a period not to exceed a year, by submitting a written request to the Vice President of Operations. The Vice President of Operations will determine whether a request for a leave of absence shall be granted.

B. Allied Health Professionals must report to the Vice President of Operations or the Chief of Staff any time they are away from patient care responsibilities for longer than 30 days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Under such circumstances, the Vice President of Operations, in consultation with the Chief of Staff, may trigger an automatic leave of absence.

C. Individuals requesting reinstatement shall submit a written summary of their professional activities during the leave and any other information that may be requested by the Hospital at least 30 days prior to the conclusion of the leave of
absence. If the leave of absence was for health reasons (except for maternity leaves), the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges or scope of practice requested.

D. Requests for reinstatement shall then be reviewed by the Chair of the Credentials Committee, the Chief of Staff, and the Vice President of Operations. If all these individuals make a favorable recommendation on reinstatement, the Allied Health Professional may immediately resume clinical practice at the Hospital. This determination shall then be forwarded to the Credentials Committee, the Executive Committee, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee, Executive Committee, and Board for review and recommendation. If a request for reinstatement is not granted, for reasons related to clinical competence or professional conduct, the individual shall be entitled to the procedural rights set forth in Article 8 of this Policy.
ARTICLE 8

PROCEDURAL RIGHTS FOR ALLIED HEALTH PROFESSIONALS

8.1 General

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

8.2 Procedural Rights for Dependent Practitioners

A. In the event that a recommendation is made by the Executive Committee that a Dependent Practitioner not be granted a scope of practice or that a scope of practice previously granted be restricted or terminated, the individual shall be notified of the recommendation. The notice shall include a general statement of the reasons for the recommendation and shall advise the individual that he or she may request a meeting with the Committee before its recommendation is forwarded to the Board (or its designee) for final action.

B. If a meeting is requested by a Dependent Practitioner, the meeting shall be scheduled to take place within a reasonable time frame. The meeting shall be informal and shall not be considered a hearing. The Dependent Practitioner and his/her supervising physician shall both be permitted to attend and participate in this meeting.

C. Following this meeting, the Executive Committee shall make its final recommendation to the Board (or its designee).

8.3 Procedural Rights for Licensed Dependent Practitioners and Licensed Independent Practitioners

A. In the event that a recommendation is made by the Credentials Committee and Executive Committee that a Licensed Dependent Practitioner or Licensed Independent Practitioner not be granted clinical privileges, or that the clinical privileges previously granted be restricted or terminated, the individual shall be notified of the recommendation. The notice shall include a general statement of the reasons for the recommendation and shall advise the individual that he or she may request a hearing before the adverse recommendation is transmitted to the Board (or its designated committee) for final action.

B. Any request for a hearing must be in writing, directed to the Chief of Staff, within thirty (30) days after receipt of the written notice of the adverse recommendation.

C. If a request for a hearing is made timely, the Chief of Staff shall appoint an Ad Hoc Committee composed of up to three individuals (including, but not limited to, individuals appointed to the Medical Staff, Allied Health Professionals, Hospital management, individuals not connected to the Hospital, or any combination of...
these individuals) and a Presiding Officer, who may be legal counsel to the Hospital. The Ad Hoc Committee shall not include anyone who previously participated in the recommendation, any relatives or practice partners of the Licensed Dependent Practitioner or Licensed Independent Practitioner, or any competitors of this individual.

D. As an alternative to the Ad Hoc Committee described in paragraph C of this section, the Chief of Staff may instead appoint a Hearing Officer to perform the functions that would otherwise be carried out by the Ad Hoc Committee. The Hearing Officer shall preferably be an attorney at law. The Hearing Officer may not be in direct economic competition with the individual requesting the hearing and shall not act as a prosecuting officer or as an advocate to either side at the hearing. If the Hearing Officer is an attorney, he or she shall not represent clients who are in direct economic competition with the Licensed Dependent Practitioner or Licensed Independent Practitioner. In the event a Hearing Officer is appointed instead of an Ad Hoc Committee, all references in this Article to the "Ad Hoc Committee" shall be deemed to refer instead to the Hearing Officer, unless the context would clearly require otherwise.

E. The hearing shall be convened as soon as practical, but no sooner than (30) thirty days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to by the parties.

8.4 Hearing Process for Licensed Dependent Practitioners and Licensed Independent Practitioners

A. At the hearing, a representative of the Executive Committee shall first present the reasons for the recommendation. The Licensed Dependent Practitioner or Licensed Independent Practitioner shall be invited to present information, both orally and in writing, to refute the reasons for the recommendation, subject to a determination by the Presiding Officer (or the Hearing Officer) that the information is relevant. The Presiding Officer (or the Hearing Officer) shall have the discretion to determine the amount of time to be allotted to the presentations by the Executive Committee representative and the Licensed Dependent Practitioner or Licensed Independent Practitioner.

B. The Licensed Dependent Practitioner or Licensed Independent Practitioner shall not have the right to present other witnesses unless he or she can demonstrate to the satisfaction of the Presiding Officer (or the Hearing Officer) that the failure to permit witnesses to appear would be fundamentally unfair. In the event witnesses are allowed, the Presiding Officer (or the Hearing Officer) shall permit reasonable questioning of such witnesses.

C. Neither the Licensed Dependent Practitioner or Licensed Independent Practitioner nor the Executive Committee shall be represented by counsel at this hearing.

D. The Licensed Dependent Practitioner or Licensed Independent Practitioner shall have the burden of demonstrating that the recommendation of the Executive Committee was arbitrary, capricious, or not supported by substantial evidence.
The quality of care provided to patients and the smooth operation of the Hospital shall be the paramount considerations.

E. Minutes of this proceeding shall be kept and shall be attached to the report and recommendation of the Ad Hoc Committee (or the Hearing Officer).

8.5 Ad Hoc Committee or Hearing Officer Report

A. The Ad Hoc Committee (or the Hearing Officer) shall prepare a written report and recommendation within (30) thirty days after the conclusion of the proceeding, and shall forward it along with all supporting information to the Chief of Staff. The Chief of Staff shall send a copy of the written report and recommendation, via certified mail, return receipt requested, to the Licensed Dependent Practitioner or Licensed Independent Practitioner. A copy shall also be provided to the Credentials Committee.

B. Within (10) ten days after receiving notice of the recommendation, either the Licensed Dependent Practitioner or Licensed Independent Practitioner or the Executive Committee may make a request for an appeal to the Chief of Staff. The request must be in writing and must include a statement of the reasons for appeal, including specific facts, which justify further review. The request shall be delivered to the Chief of Staff either in person or by certified mail.

C. If a written request for appeal is not submitted within the (10) ten day time frame specified above, the recommendation and supporting information shall be forwarded by the Chief of Staff to the Board (or its designated committee) for final action. If a timely request for appeal is submitted, the Chief of Staff shall forward the report and recommendation, the supporting information, and the request for appeal to the Chair of the Board.

8.6 Appeals Process for Licensed Dependent Practitioners and Licensed Independent Practitioners

A. The grounds for appeal shall be limited to the following assertions:

1. There was substantial failure to comply with this policy and/or other applicable bylaws or policies of the Hospital or its Medical Staff.

2. The recommendation was arbitrary, capricious, or not supported by substantial evidence.

B. The Chair of the Board, or a committee appointed by the Chair, will consider the request for appeal and the record upon which the adverse recommendation was made. This review shall be conducted within (30) thirty days after receiving the request for appeal.

C. The Licensed Dependent Practitioner or Licensed Independent Practitioner and the Executive Committee shall each have the right to present a written statement in support of its position on appeal. New or additional written information that is
relevant, and that the Licensed Dependent Practitioner or Licensed Independent Practitioner or the Executive Committee demonstrates could not have been made available to the Ad Hoc Committee (or the Hearing Officer) during the initial review of the matter, may also be considered at the discretion of the Chair or the committee appointed by the Chair.

D. At the sole discretion of the Chair or the committee appointed by the Chair, the Licensed Dependent Practitioner or Licensed Independent Practitioner and the representative of the Executive Committee may also appear personally to discuss their position. In that event, however, neither party shall be represented by counsel at the appeal.

E. Upon completion of the review, the Chair of the committee appointed by the Chair shall provide a report and recommendation to the full Board for action. The Chair (or the committee) may also refer the matter to any committee or individual deemed appropriate for further review and recommendation to the full Board. The Board shall then make its final decision based upon the Board's ultimate legal responsibility to grant privileges and to authorize the performance of clinical activities at the Hospital.
ARTICLE 9

HOSPITAL EMPLOYEES

A. A request for clinical privileges, on an initial basis or for renewal, submitted by a Licensed Independent Practitioner or a Licensed Dependent Practitioner who is seeking employment or who is employed by the Hospital will be processed in accordance with the terms of Article 5 of this Policy. The findings of the Board regarding each individual's qualifications will be forwarded to Hospital management personnel or Human Resources (as appropriate) to assist the Hospital in making employment decisions.

B. All Dependent Practitioners who are seeking employment or who are employed by the Hospital shall be evaluated by Human Resources through Human Resources processes and procedures, but they must meet the qualifications set forth in Section 4.1 of this Policy.

C. Any disciplinary concern or action with respect to an employed Allied Health Professional will be governed by the Hospital's employment policies and manuals and the terms of the individual's employment relationship and/or written contract. If an Allied Health Professional's employment is terminated by the Hospital for any reason, the individual's permission to practice in the Hospital will automatically expire without any procedural rights set forth in this Policy.

D. Except as otherwise provided above, to the extent that the Hospital's employment policies or manuals, or the terms of any applicable employment contract, conflict with this Policy, the employment policies, manuals, and descriptions and terms of the individual's employment relationship and/or written contract will apply.
ARTICLE 10

AMENDMENTS

This Policy may be amended by a majority vote of the members of the Executive Committee present and voting at any meeting of that committee where a quorum exists, provided that the written recommendations of the Credentials Committee concerning the proposed amendments shall have first been received and reviewed by the Executive Committee. Notice of all proposed amendments shall be posted on the Medical Staff bulletin board at least 14 days prior to the Executive Committee meeting, and any member of the Medical Staff may submit written comments to the Executive Committee. No amendment shall be effective unless and until it has been approved by the Board.
ARTICLE 11

ADOPTION

This Policy is adopted and made effective upon approval of the Board, superseding and replacing any and all other medical staff bylaws, rules and regulations or Hospital policies pertaining to the subject matter thereof, and henceforth all activities and actions of the Medical Staff, and of each individual exercising clinical privileges at the Hospital, shall be taken under and pursuant to the requirements of this Policy.

__________________________________________

Adopted by the Medical Staff

__________________________________________
Chairman, Credentials Committee Date

__________________________________________
Chief of Staff Date

__________________________________________

Approved by the Board

__________________________________________
Board of Directors Date