UNIVERSITY HOSPITAL
Newark, New Jersey

MEDICAL STAFF BYLAWS

Volume I: Governance, Structure and Function of the Medical Staff

January 2014

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DEFINITIONS

ADVANCED PROFESSIONAL PRACTITIONER (APP): Advanced Practice Nurses, including advanced practice nurses, certified nurse midwives, and certified registered nurse anesthetists.

ADVERSE DECISION: A professional review action (as defined by the Federal Health Care Quality Improvement Act) in which the Board or MEC denies, terminates, limits, suspends, modifies a grant of privileges or Medical Staff membership for failure to adhere to the Hospital's or Medical Staff's code of conduct policy, other unprofessional conduct, or for issues related to clinical competence.

BOARD or BOARD OF DIRECTORS: The governing body of the Hospital.

BOARD CERTIFICATION: The designation conferred by one of the affiliated specialties of the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), the American Board of Oral and Maxillofacial Surgery, or the American Board of Podiatric Surgery (ABPS), upon a physician, oral surgeon or podiatrists, who has successfully completed an approved educational training program and an evaluation process, including passing an examination, in the applicant's area of clinical practice.

BYLAWS: The two volumes that make up the Medical Staff Bylaws are: Volume I – Governance, Structure and Functions of the Medical Staff; Volume II – Corrective Action and Fair Hearing Manual.

CHIEF EXECUTIVE OFFICER (CEO): The individual named by the Hospital Board of Directors to act on behalf of the Board in the overall management of the Hospital.

CHAIR: The individual responsible for directing the functions and meetings of a committee.

CHIEF OF SERVICE: The individual responsible for directing the functions and meetings of a clinical service.

CHIEF MEDICAL OFFICER (CMO): The senior physician executive appointed by the Hospital to assist it in various administrative capacities.

CORRECTIVE ACTION: An action taken by the Medical Staff or Board which modifies, limits, denies, suspends, or terminates the privileges or Medical Staff membership of a practitioner for reasons of unprofessional conduct or concerns about clinical competence and which entitles the practitioner to procedural rights as outlined in the Corrective Action and Fair Hearing Manual of these Bylaws. Required evaluations, warnings, reprimands, and performance monitoring are not considered corrective actions.

DATE OF RECEIPT: The date any notice, special notice, or other communication is delivered personally, by facsimile, or by electronic mail (email); or if such notice, special notice, or communication was sent by mail or other third party delivery service, it shall mean 72 hours after the notice, special notice, or if the communication was deposited, postage prepaid, in the United States mail or with the third party delivery service.

DAYS: Calendar days, unless otherwise noted.

DELEGATION OF FUNCTIONS: When a function is to be carried out by a person or committee, the person, or the committee through its Chair, may delegate performance of the function to one or more qualified designees.

DENTIST: A dentist or oral surgeon holding a D.D.S., D.M.D, or equivalent degree and a valid license to practice dentistry in the State of New Jersey.

EX OFFICIO: Service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means with voting rights.

FAIR HEARING PLAN: That part of the Medical Staff Bylaws that describes the formal hearing due process rights and which is articulated in Volume II of these Bylaws, referred to as the Corrective Action and Fair Hearing Manual.

FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE): Focused professional practice evaluation is a process whereby the hospital evaluates the privileges-specific competence of the practitioner who does not have documented evidence of competently performing the requested privileges(s) at the hospital. FPPE is a time-limited period during which the hospital evaluates and determines the practitioner's professional performance,.

HOSPITAL: University Hospital, including all of its related facilities and all of its personnel and organizational entities including the Medical Staff.

JOINT CONFERENCE: A meeting between representatives of the Board (appointed by the Board Chair) and representatives of the Medical Staff (appointed by the President of the Medical Staff).

MEDICAL EXECUTIVE COMMITTEE (MEC): The executive committee of the Medical Staff.

MEDICAL STAFF or STAFF: The formal organization created by the Board of Directors to carry out delegated functions and comprised of all practitioners who are appointed to it by the Board.

MEDICAL STAFF OFFICE (MSO): The office of the Hospital which coordinates verifies, and investigates appointments and reappointments to the Medical Staff.

MEDICAL STAFF YEAR: The period from January 1 to December 31.

MEMBER: A practitioner who has been appointed by the Board to the Medical Staff.

MONTHLY: Each month of the calendar year. Committees required by these Bylaws to meet "monthly" shall hold at least ten (10) meetings in a calendar year, at the discretion of such committee, but need not hold twelve (12) meetings.

NOTICE: A written or electronically transmitted communication delivered personally to the addressee or sent by United States mail, first-class postage prepaid, addressed to the addressee at the last known address as it appears in the official records of the Medical Staff or Hospital.

ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE): Ongoing professional practice evaluation is a process that allows the hospital to identify professional practice trends that impact on quality and patient safety. OPPE is done at a minimum, every six months after completion of the FPPE.

ORAL SURGEON: Oral and maxillofacial surgeons who have completed dental school and four or more years of a hospital surgical residency. Oral surgeons are certified by the American Board of Oral and Maxillofacial Surgery.

ORGANIZED HEALTHCARE ARRANGEMENT: A clinically integrated care setting in which individuals typically receive health care from more than one provider and which is defined in 45 C.F.R. §164.501 commonly known as the HIPAA Privacy Regulations.

PA-C: A physician assistant who is licensed in the state of New Jersey and certified by the National Association of Physician Assistants, to carry out clinical activities in accordance with the statutes and regulations applicable to those trained in an accredited training program for physician assistants.

PEER REVIEW: The process for review of a practitioner's professional conduct and/or competence as part of the Medical Staff's quality oversight, performance improvement and patient safety responsibilities.

PEER REVIEW COMMITTEE: A body of Medical Staff members and Hospital personnel, including invited guests, who are organized to address matters of quality performance, competence and professional conduct on the part of a practitioner with privileges.

PHYSICIAN: A Doctor of Medicine (MD) or a Doctor of Osteopathy (DO) who is licensed to practice in the State of New Jersey.

PODIATRIST: A podiatrist holding a Doctorate of Podiatric Medicine (DPM) degree and valid license to practice podiatry in the State of New Jersey.

POLICIES: Rules, regulations, guidelines, standards, and principles enacted to guide the activities and operations of the Medical Staff and its members. Medical Staff members may obtain copies of any policies through the Hospital's Policy and Procedure Search System (http://uhpolicies.core.uhnj.org.edu/live/default.htm)

PRACTITIONER: Any clinician who has been granted clinical privileges by the Board of Directors.

PRESIDENT OF THE MEDICAL STAFF: A member of the active Medical Staff who is elected in accordance with these Bylaws to serve as chief officer of the Medical Staff of the Hospital.

PRIVILEGES: The permission granted by the Board to a practitioner to render or exercise specific diagnostic, therapeutic, medical, surgical or dental services and/or procedures in the Hospital.

PRONOUNS: The use of the either pronoun (he/his/him) throughout these Bylaws is applicable to either male or female individuals.

RULES & REGULATIONS: Medical Staff policies approved by the MEC.

SPECIAL NOTICE: Written notification sent by hand delivery, certified or registered mail return receipt requested.

TIME LIMITS: All time limits referred to in these Bylaws, including those in the Corrective Action and Fair Hearing Procedures and in any other Medical Staff policies, are advisory only and are not mandatory unless a specific provision states that a particular right is waived by failing to take action within a specified time period.

ARTICLE I - PURPOSE

The Medical Staff of University Hospital is established by the Hospital Board of Directors to assist the Hospital in meeting its mission and to carry out duties assigned to it by the Board in order to enhance the quality and safety of care, treatment, and services provided to patients. The Medical Staff is considered part of an Organized Healthcare Arrangement and works with the Board and Hospital Administration to perform effective quality monitoring, peer review, credentialing, and performance improvement. The Medical Staff is also established to facilitate communication between practitioners utilizing the Hospital's facilities and the institution's management and Board.

The Medical Staff shall exercise its power as reasonably necessary to meet its obligations under these Bylaws, Rules and Regulations, and Medical Staff and hospital policies and procedures. The Medical Staff shall act in compliance with applicable laws, accreditation standards and regulations and subject to the approval and authority of the Board.

ARTICLE II - MEDICAL STAFF MEMBERSHIP, CATEGORIES, & RIGHTS

2.1 Eligibility and Qualification for Membership

Membership on the Medical Staff is a privilege granted to professionally competent physicians, dentists and oral surgeons, podiatrists, advanced professional practitioners (including advanced practice nurses (APNs), certified registered nurse anesthetists (CRNAs), and certified nurse midwives), physician assistants and clinical psychologists who continuously meet the qualifications, standards and requirements set forth in these Bylaws and in Medical Staff and Hospital Rules and Regulations, and policies.

Applicants to the Medical Staff must demonstrate to the satisfaction of the Board that they will contribute to meeting the mission of the Hospital and have the ability to do so competently, safely, and collaboratively by providing the following information, including but not limited to:

a. background
b. clinical experience
c. education and training
d. clinical judgment
e. demonstrated current professional competence
f. individual character and ability to work with others collaboratively
g. physical and mental capabilities and ability to safely and competently exercise any clinical privileges requested
h. intended insurance plans, and
i. adherence to the ethics of their profession.

Specifically, applicants requesting to be on the Medical Staff must:

a. have an applicable current and unrestricted license to practice in New Jersey;
b. where applicable to their practice, have a current, unrestricted DEA registration and New Jersey C.D.S. license;

c. maintain and provide evidence of professional liability insurance subject to limits of liability of not less than $1,000,000 per occurrence /$3,000,000 annual aggregate. Evidence may be in the form of confirmation of self-insurance coverage provided by the University (i.e.: Rutgers University, University Hospital, the State of New Jersey) pursuant to the State of N.J. Tort Claims Act terms and provisions and/or by a certificate of insurance naming University Hospital as certificate holder.
   This requirement is waived for applicants who will not be providing clinical care;
d. have successfully completed an ACGME or AOA approved residency training program, or a DDS or DMD post graduate training program approved by the American Dental Association's Commission on Dental Accreditation; a residency program approved by the Council on Podiatric Medical Education (CPME); an accredited program for training as an advanced practice nurse, physician assistant, certified nurse midwife, or clinical psychologist.
e. be eligible where applicable to participate in Medicare, Medicaid, and other federal or state payer programs;
f. have never been convicted of, or entered a plea of guilty or no contest to any felony, or any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, or violence;
g. request only those privileges for which the applicant has demonstrated the appropriate training, experience and competence to perform;
h. not request clinical privileges for procedures or activities for which the Hospital and Medical Staff have not adopted privileging criteria;
i. be able to demonstrate the ability to consistently work cooperatively with others and to treat patients, staff and colleagues in a respectful and professional manner;
j. be able to demonstrate that they have no physical or mental health issues which would compromise their ability to perform requested privileges safely;
k. be seeking clinical privileges that are not subject to an exclusive contract with the Hospital unless the applicant is a party to that contract; and
l. agree to comply with any health screening and physical examination requirements of the Hospital before exercising any privileges that may be granted by the Board.

In addition, all applicants for initial appointment to the Medical Staff must meet the criteria which apply to their qualifying degree or specialty:

- If an M.D. or D.O., the applicant must be certified by a specialty board approved by the American Board of Medical Specialties (ABMS) or by the American Osteopathic Association (AOA). However, a physician who is qualified or will be qualified to sit for the certifying examination of a specialty board approved by the American Board of Medical Specialties (ABMS) or AOA but is not yet certified may be appointed to the Medical Staff if within seven (7) years of completion of residency training. Such applicant is required to acquire board certification by an ABMS or AOA specialty within seven (7) years of completion of residency training.
- If an oral surgeon applying for oral surgery appointment and privileges, the applicant must be certified or qualified to sit for the certifying examination administered by the American Board of Oral and Maxillofacial Surgery as recognized by the American Dental Association and he must be certified within seven (7) years of completion of residency training.
- If a podiatrist is applying for appointment and privileges, the applicant must be certified or qualified to sit for the certifying examination administered by the American Board of Podiatric Surgery and must be certified within seven (7) years of completion of residency training.

- Practitioners on the Medical Staff as of April 25, 2007, who were not board certified or board eligible at that time, will not be required to first obtain board certification, in the specialty in which they were practicing at that time. Practitioners on the Medical Staff in the Honorary Category will not have to obtain or maintain board certification. All other physicians and oral surgeons and podiatrists on the Medical Staff must meet the recertification or maintenance of certification requirements of at least one specialty board. This specialty certification should be in the specialty in which the practitioner exercises a majority of his clinical privileges.
- A practitioner who does not meet membership qualifications as established by the Board is ineligible to apply for Medical Staff membership and the application shall not be processed. The qualifications for membership must be documented with sufficient adequacy to satisfy the Medical Staff and Board that each has enough information to make a fully informed decision regarding appointment and assignment of privileges. No practitioner is entitled to membership on the Medical Staff or to the exercise of particular clinical privileges in the Hospital merely by virtue of licensure to practice in New Jersey or any other state, membership in any professional organization, certification by any professional organization or certifying body, privileges at another hospital, or the demonstration of clinical competence.
- No applicant shall be appointed to the Medical Staff if the Hospital, in its sole discretion, is unable to provide adequate facilities and support services for the privileges requested by that applicant.
- The CEO or designee and the MEC may, individually or together, request an exception to a requirement for Medical Staff membership and present this to the Board for consideration. The Board, after consideration of this request, may approve this exception to the delineated process request for staff membership for a physician, dentist and podiatrists.

2.2 Histories and Physicals

A medical history and physical examination shall be completed for each Hospital patient no more than thirty days before or 24 hours after admission or registration. A history and physical must be completed prior to any surgery or procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a Medical Staff physician, or an oral maxillofacial surgeon, or other qualified licensed individual in accordance with state law if countersigned by a physician.

When the medical history and physical examination is completed within 30 days before admission or registration, the Medical Staff physician or oral maxillofacial surgeon must complete and document an updated examination of the patient within twenty-four hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

The following elements are required for a history and physical:

- A medical history that includes a chief complaint or reason for admission;
- details of present illness;
- relevant past, social, and family history;
- a review of systems and pain evaluation, current medications and drug allergies;
- Findings of a physical examination;
- Conclusions or impressions drawn from the medical history and physical exam;
- Diagnosis or diagnostic impressions;

- Dated and timed
- A plan of care

A focused History and Physical may be performed and documented when procedures that do not require anesthesia or moderate sedation will be performed on Hospital outpatients. A focused H&P should include a presenting diagnosis or condition, description of symptoms, significant past medical history, current medications, any drug allergies, indications for the procedure, focused physical exam as indicated, and proposed treatment or procedure(s).

A medical history and examination should be dated and authenticated at the time of completion. Except in an emergent situation, an invasive procedure will be delayed until a fully authenticated (signed and timed) history and physical is recorded in the patient's medical record.

Additional requirements relating to history and physical examinations may be found in Medical Staff and Hospital policies.

2.3 Non-Discrimination

The Hospital will not discriminate in granting Medical Staff membership and/or privileges on the basis of gender, race, religion, age, national origin, disability unrelated to the provision of patient care or required Medical Staff responsibilities, or any other basis prohibited by applicable law, to the extent the applicant is otherwise qualified.

2.4 Confidentiality, Immunity, Authorizations and Releases

2.4a Authorizations and Releases

Each practitioner shall, when requested by the Hospital, as part of initial appointment or reappointment to the Medical Staff or as part of an application for privileges, execute general and specific releases and provide documents when requested by the President of the Medical Staff, Chair of the Credentials Committee, the CEO, CMO or their respective designees. Failure to execute such releases or provide requested documentation shall result in an application for appointment, reappointment, and/or clinical privileges being deemed voluntarily withdrawn, and it shall not be further processed. By submitting an application for Medical Staff appointment or reappointment, or by applying for or exercising privileges or providing specified patient care services within the Hospital, all practitioners, without limitation:

a. Authorize representatives of the Hospital and of the Medical Staff to solicit, procure, provide, and/or act upon information bearing on or reasonably believed to bear upon the practitioner's professional abilities and qualifications;
b. Agree to be bound by the provisions of these Bylaws and Hospital policies, Medical Staff rules, regulations and policies regardless of whether membership or clinical privileges are granted or subsequently restricted;
c. Acknowledge that the provisions of this Article are express conditions to an application for, or acceptance of, Medical Staff membership, and the continuation of such membership and/or the exercise of privileges or provision of specified patient care services at the Hospital;
d. Agree to release from legal liability and hold harmless the Hospital, Medical Staff, and any representative of the Hospital or Medical Staff who acts to carry out Medical Staff or Hospital policies or functions, including all persons engaged in processing Medical Staff applications and

reapplications as well as those who participate in peer review and performance improvement activities. In addition, all practitioners agree that their sole remedy for any corrective action or peer review action taken or recommended by the MEC for failure to comply with these Bylaws or Medical Staff or Hospital policies, will be the right to seek legal or equitable relief after they have exhausted the administrative remedies in these Bylaws.

e. Agree to release from legal liability and hold harmless any individual who or entity which provides information (including peer review information) regarding the practitioner to the Hospital or its representatives within the limitations provided by law;

2.4b Confidentiality

Information with respect to any practitioner submitted, collected or prepared by any representative of the Hospital or any other health care facility or organization or Medical Staff, for the purpose of evaluating and improving quality patient care, reducing morbidity or mortality, promoting efficiency, or contributing to medical education or clinical research, shall, to the fullest extent permitted by law, be confidential except as otherwise provided herein. Confidential information shall not be disseminated to anyone other than a representative(s) of the Hospital or of the Medical Staff with a legitimate need for access in order to carry out required functions or third party health care entities performing legitimate credentialing and peer review activities. Such confidentiality shall also extend to information of like kind that may be provided by third parties.

2.4c Immunity from Liability

For Actions Taken

Representatives of the Hospital and the Medical Staff shall have absolute release from any and all liability in any judicial proceeding for damages or other relief for any action taken or statement or recommendation made within the scope of their duties as such representatives, after a reasonable effort under the circumstances to ascertain the facts underlying such actions, statements or recommendations and in the reasonable belief that the action, statement or recommendation is warranted by such facts.

Providing Information

Representatives of the Hospital, the Medical Staff and any third party shall have absolute release from any and all liability in any judicial proceeding for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative of the Hospital or of the Medical Staff or to any other hospital, organization or health professionals, or other health-related organizations, concerning practitioners who are or have been an applicant to or member of the staff or who did or does exercise privileges or provide specified services at this Hospital.

2.4d Activities and Information Covered

Activities

The provisions of this article shall apply to acts, communications, reports, recommendations, or disclosures in connection with this or any other health-related institution's or organization's activities to the extent provided by law, including:

- Applications for appointment, clinical privileges or specified services
- Periodic reappraisals for reappointment, clinical privileges or specified services

- Disciplinary measures, including warnings and reprimands
- Investigations and corrective actions
- Hearings and appellate reviews
- Performance improvement activities including the creation and dissemination of performance profiles
- Peer review activities, including external peer review
- Utilization and claims reviews
- Other Hospital, clinical service or committee activities related to monitoring and maintaining of quality patient care and appropriate professional conduct.

2.4e Information

The acts, communications, reports, disclosures and other information referred to in this Article may relate to a practitioner's professional qualifications, clinical or procedural abilities, judgment, character, physical and mental health, emotional stability, professional ethics, professional conduct or any other matter that might directly or indirectly affect patient care.

2.4f Cumulative Effect

Provisions in these Bylaws and in application forms relating to authorizations, releases, confidentiality of information and immunities from liability shall be in conformance with and in addition to other protections provided by local, state and federal law and not in limitation thereof.

2.4g Leave of Absence

A Medical Staff member may request a voluntary leave of absence from the Medical Staff by submitting a written request to the Chief of Service who will then submit to the Credentials Committee. The request should include the exact date the leave commences and the anticipated date of return. This request may not exceed one year, with the exception of military leave. Failure to request reinstatement from a Leave of Absence shall be deemed a voluntary resignation of Medical Staff membership status and privileges. The practitioner shall not be entitled to procedural rights as outlined in the Corrective Action and Fair Hearing Manual of the Medical Staff Bylaws.

2.5 Processing of Initial Applications

<u>Application Form</u>
Each application for appointment and reappointment shall be in writing or electronically submitted on the prescribed form in the prescribed format, to the Medical Staff Office.

a) A statement that the applicant has agreed to abide by the current Bylaws, Rules and Regulations, Hospital and Medical Staff Policies;
b) A statement that the applicant is willing to appear for an interview about the applicant, during which the applicant may need to provide information about, but not limited to, education, experience, physical and/or mental health;
c) A consent form signed by the applicant so that a representative of the Hospital can obtain records and documents not limited to, training, clinical competence, health status, recommendations and peer reviews;

d) At a minimum, the names and contact information of two or more professional references in the same discipline. These references must be able to attest to the applicant's clinical competence (within the past two years), ethical standards and ability to work with others;
e) The applicant must provide the name and contact information for a confidential evaluation. This must be someone in an authoritative position that can attest to the applicant's clinical competence (within the past two years), ethical standards, interpersonal skills and the ability to perform the privileges requested. This individual may not be a relative or partner in a practice;
f) If requested, the applicant must provide documentation of continuing training, education in the health care field, and experience which qualify the applicant's for the privileges requested;
g) Information on the chronological history of the applicant's entire employment history as a health care professional;
h) Information about the applicant's appointment status and/or clinical privileges at another health care institution and whether the applicant has had his privileges revoked, suspended, reduced, not renewed, terminated, or voluntarily relinquished for any reason;
i) Information as to whether the applicant's membership status and/or Medical Staff privileges have ever been voluntarily or involuntarily revoked, suspended, reduced, subjected to restrictions or limitation not applicable to all other practitioners in the same Medical Staff category, or not renewed at any other hospital or health care institution, and as to whether any of the following has ever been voluntarily or involuntarily suspended, revoked, or denied:

- Membership/fellowship in a local, state or national professional organization;
- Staff membership status or clinical privileges at any other hospital or health care institutions;
- Specialty board certification;
- Licensure to practice any profession in any jurisdiction;
- Drug Enforcement (DEA) registration or a state controlled substance license; or
- Current, pending, or previous participation in any Federal Healthcare Program or any actions which may cause the practitioner to become ineligible for such programs.

If any such actions were ever taken or if any such actions are currently pending, the particulars of these actions shall be included with the application;
j) Information about any prior, existing or pending challenges to licensure or registrations(s); voluntary relinquishment or reduction of the applicant's professional licensure, registration, or any past action on professional licensure or registration;
k) Information as to whether the applicant has ever been convicted of a felony or submitted a plea of guilty no contest, if a felony prosecution is now pending against the applicant, and the particulars of any such conviction, settlement or prosecution, if any;
l) Information about current/past professional liability insurance;

m) Information about the applicant's involvement in any professional liability actions, whether filed, pending or resolved, including details about all malpractice insurance claims, suits, and settlements;
n) Information about whether the applicant has a current, prior or pending sanction(s) by a government or third party payer which limits the practitioner's ability to provide medical care to patients;
o) Specific information about the applicant's professional ethics, qualifications, and abilities that may bear on his ability to provide good patient care in the Hospital, including a review of performance data;
p) Information about compliance with medical record activity;
q) Information regarding any adverse action as it relates to credentialing or privileging due to peer review activities;
r) A statement that the applicant shall hold harmless the Hospital, its representatives and employees and, also, the third party facility and its employees reports, recommendations or disclosures about the applicant with respect to information requests which are made to these third parties by University Hospital and, thereafter, provided by the third party to UH.
s) Information if the applicant has had any disciplinary action during residency/fellowship.

2.5.1 Applicant's Burden

The applicant shall have the burden of producing adequate information for a proper evaluation of his or her experience, background, training, clinical competence, and ability to adequately perform the privileges requested, and of resolving any doubts about these or any of the other qualifications specified in the Medical Staff Bylaws or in their associated Medical Staff manuals or policies. The applicant must be able to demonstrate to the satisfaction of the MEC and Board proficiency in the following six general competencies as described by the Accreditation Council for Graduate Medical Education (ACGME): patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. An application will not be processed by the Medical Staff until it is deemed complete by the Hospital Medical Staff Office. If a Medical Staff committee or the Board requests additional information from the applicant to process the application, the application will be deemed incomplete. If the application remains incomplete for more than sixty days, it will be considered voluntarily withdrawn by the Practitioner who submitted the application.

2.5.2 Applicant Interview

All applicants for appointment and/or clinical privileges to the Medical Staff may be required to participate in an interview at the discretion of the Medical Staff Credentials Committee, MEC, CMO or Board. The interview may take place in person or by telephone at the discretion of the party calling for the interview. The interview will be used to gather information about the applicant, to ask clinical questions pertaining to the privileges being requested and to communicate information to the applicant concerning Medical Staff responsibilities and expectations.

2.5.3 Verification of Information

The applicant shall deliver a completed application to the Hospital, which shall in a timely fashion, seek to collect or verify the references, licensure, and other qualifications evidence submitted. The Hospital

will also query the National Practitioner Data Bank (NPDB) at the time of initial application (as well as during reappointment/renewal of privileges and whenever new privileges are requested). The Hospital shall promptly notify the applicant of any problems in obtaining the information required, and it shall then be the applicant's obligation to obtain the required information and provide it to the Hospital in a timely manner. Once collection and verification is completed, the Hospital shall forward a complete verified application and supporting materials to the Credentials Committee.

If the requirements for membership and/or privileges enumerated in this policy or the Medical Staff Bylaws are not met, the applicant will be notified that he is ineligible to apply for membership or privileges. The application will not be processed further and no right to due process or to a hearing will be triggered.

2.5.4 Credentials Committee Action

Once the Hospital Medical Staff Office has a completed application, the verified application and its supporting materials shall be forwarded to the appropriate Chief of Service or designee. The Chief of Service shall review the application and provide input to the Credentials Committee on its disposition, including a recommendation on the appropriateness of the clinical privileges requested.

After review by the department Chief of Service, his recommendations along with the verified application and its supporting materials shall be forwarded Credentials Committee. This committee shall review the application, supporting documentation, and such other information available to it that may be relevant to consideration of the applicant's qualifications and it may conduct a personal interview. The committee or its chair may also request a subject matter expert(s) on the Medical Staff to review the application and provide input to the Credentials Committee.

After its review of the applicant's credentials, the Credentials Committee shall submit a written recommendation to the MEC. This recommendation shall address the applicant's request for Medical Staff membership and category, privileges, and any specific conditions relating to appointment and/or privileges. Minority views regarding any or all recommendations of the Credentials Committee may also be included.

2.5.5 Medical Executive Committee (MEC) Action

At its next meeting after receipt of the reports and recommendations of the Credentials Committee, the MEC shall review the applicant's request for membership and/or privileges. The MEC may utilize additional sources of information, including personal interviews with the applicant, as it deems necessary to complete its evaluation.

After completing its review of the applicant's qualifications the MEC shall transmit to the Board a written report and recommendation regarding appointment and/or privileges for the applicant, indicating whether the applicant's requests should be accepted, accepted with modifications or qualifications, or rejected. Where appointment is recommended, the MEC shall also recommend staff category. Where the MEC recommends that the applicant's requests for membership and/or privileges be rejected, modified, qualified, or otherwise restricted, the report of the MEC shall set forth reasons for such recommendation(s).

If an MEC recommendation is not unanimous, a minority report may be submitted to the Board.

2.5.6 Effect of Medical Executive Committee Action (MEC)

Favorable Recommendation: When the recommendation of the MEC is favorable to the applicant, the recommendation together with supporting documentation shall be forwarded to the Board.

Deferred: Any action by the MEC to defer a recommendation on the application in order to carry out further evaluation must be followed up within ninety (90) days with a recommendation to the Board.

Adverse Executive Committee Recommendation: When the MEC recommends denial or a restriction of membership or a requested privilege based on a determination of unprofessional conduct or inadequate clinical competence, the President of the Medical Staff and Hospital Chief Executive Officer or designee shall inform the practitioner by special notice within ten (10) days. The Hospital Board shall also be notified. The applicant shall be entitled to the procedural rights as provided in the Corrective Action and Fair Hearing Manual of the Medical Staff Bylaws.

2.5.7 Action of the Board

Applicants for Consideration by the Board

At its next meeting after receipt of the reports and recommendations of the MEC regarding an application for membership and/or privileges, the charge of the Board shall be to consider and act on such recommendations. If the Board decides to defer action on the application pending further consideration by the MEC, or if the Board does not accept the recommendation of the MEC, it shall notify the MEC for further consideration, subject to the requirement that a final recommendation be provided to the Board by the MEC within ninety (90) days. At the next meeting following the receipt of the second report of the MEC, the Board shall render its final decision regarding the application.

If the Board accepts a favorable MEC recommendation this action will grant the requested membership and/or Privileges.

If the recommendation of the MEC is adverse to the applicant, as defined under the Medical Staff Bylaws the MEC shall notify the Board so that the Board may postpone its final decision on the applicant, pending the applicant's decision to utilize or waive procedural rights. If an eligible applicant waives his right to a fair hearing and appellate review, the Board will be notified by the MEC so that the Board may approve the MEC action. If an eligible applicant requests a fair hearing, the MEC will notify the Board of findings of the hearing panel In order for the Board to act on the recommendations. When the applicant further requests an appellate review by the Board, its final determination will result from the decision made by the Board Appellate Review Committee.

When the Board decides to appoint an applicant to the Medical Staff, its decision and the notice of appointment shall include:

- the length of the appointment (not to exceed 24 months);
- the Medical Staff category to which the applicant is appointed;
- the privileges the applicant may exercise; and
- any special conditions attached to the appointment or exercise of privileges.

2.5.8 Basis for Recommendation

The Board's decision concerning the appointment of a practitioner's membership and/or privileges shall be based upon review not only of those matters set forth in the Medical Staff Bylaws and policies pertaining to such practitioner, but also on any other information bearing on the ability and willingness of the practitioner to contribute to the rendering of quality health care within the Hospital and to contribute to the mission of the Hospital.

2.5.9 Conflict Resolution

Whenever the Board's proposed decision will be contrary to the recommendation of the MEC, the Board shall submit the matter for conflict resolution through the use of meetings and, if necessary, formation of a Joint Conference Committee as provided in Section 9.5 of Volume I of the Medical Staff Bylaws. Any such joint conference will be held as soon as practicable and the Board will postpone any final determination on an applicant until such conference is held

2.5.10 Notice of Final Decision

Notice of the final action of the Board on an applicant shall be given to the Hospital CEO or designee, who will provide the applicant with either written notice of the Board's grant of membership and/or privileges or special notice of any adverse action on the application in a timely manner. The Board shall give notice of its final decision through the CEO or to the President of the Medical Staff and the MEC.

2.5.11 Time Periods for Processing

Applications for Medical Staff appointment and/or privileges shall be considered timely and in good faith by all individuals and groups required by Medical Staff Bylaws and policies to act upon them and shall be processed whenever possible within the time periods specified in this section. Any application that remains incomplete after three (3) months from receipt of the Medical Staff Office shall be considered voluntarily withdrawn.

1) Within ninety (90) days after the receipt of the completed and verified application, the Credentials Committee, through its chair, shall submit a written recommendation to the Medical Executive Committee.

2) Within ninety (90) days after receipt of recommendations from the Medical Staff Credentials Committee or its chair, the MEC shall submit a recommendation regarding appointment and/or privileges to the Hospital Board.

3) The Hospital Board will act on recommendations from the MEC at its next regularly scheduled meeting that shall occur within ninety (90) days.

4) The time periods in this section are guidelines and deviations will not entitle the applicant to any procedural due process rights.

2.6.2 Content of Application

The application for reappointment shall be in a prescribed electronic or written format, providing, the following information:

a) Specific requests setting forth the category of staff membership to which the applicant seeks to be reappointed and the privileges for which the applicant wishes to be considered.

b) Continuing training, education, and experience that qualify the staff member for the privileges sought on reappointment. Proof of Continuing Medical Education (CME) and any other requirements as required by the New Jersey State Board of Medical Examiners as a condition for biennial registration; and

c) A statement that no health problems exist that could affect the applicant's ability to safely perform the privileges requested;

d) The name and address of any other health care organization or practice setting where the staff member provided professional services during the preceding appointment period.

e) Any membership, awards, or other recognition conferred or granted by any professional health care societies, institutions or organizations.

f) Current, unrestricted New Jersey State License, Drug Enforcement (DEA) and State of New Jersey C.D.S. registration, as applicable.

g) Information as to whether the applicant's membership status and/or Medical Staff privileges have ever been voluntarily or involuntary revoked, suspended, reduced, subjected to restrictions or limitation if not applicable to all other practitioners in the same Medical Staff category, or not renewed at any other Hospital or health care institution, and as to whether any of the following has ever been voluntary or involuntarily suspended, revoked, or denied:

    1) staff membership status or clinical privileges at any other Hospital or health care institutions;
    2) membership/fellowship in a local, state or national professional organization;
    3) specialty board certification;
    4) privileges in any health plan which carries out credentialing of health plan practitioners;
    5) licensure to practice any profession in any jurisdiction; or
    6) Drug Enforcement (DEA) registration;

    If any such actions were ever taken or if any such actions are pending, the particulars shall be included by the applicant as part of the application for reappointment.

h) National Practitioner Data Bank (NPDB) information (proactive disclosure);

i) Information as to whether the applicant has ever been prosecuted for, convicted of or pled no contest to a felony and, if so, the particulars of any such convictions.

j) Information as to whether the applicant has ever been named as a defendant in any criminal proceedings, regardless of the outcome.

k) Evidence of continuous malpractice insurance coverage in an amount that may be determined by action of the Board.

l) A list of all malpractice complaints filed against the practitioner and the particulars regarding any adverse malpractice decisions or settlements, within the past five (5) years.

m) Such specific information about the staff member's professional ethics, qualifications, and ability that may bear on his ability to provide medical or surgical care in the Hospital.

n) Information regarding whether the applicant has been convicted of any type of insurance fraud, been found guilty under the False Claims Act, or is on the OIG Excluded Provider list for Medicare and Medicaid.

2.6.3 Completion and Verification of Information

The information provided on each application for appointment and all other supporting materials and documentation, including information regarding the staff member's professional activities, performance and conduct in the Hospital and query reports from the National Practitioner Data Bank shall be collected and verified. The applicant shall have the burden of producing adequate information for a proper evaluation of his qualifications and of resolving any questions regarding such qualifications. When collection and verification have been completed and the Hospital has determined that the application is complete, it shall transmit the application and all supporting material to the Credentials Committee.

2.6.4 Application Fee

A non–refundable fee, shall be payable at the time of application for appointment. Applications submitted without an accompanying fee will not be accepted for processing.

2.6.5 Conditions of Initial Appointment

a. Initial appointment to the Medical Staff shall be made by the Board. The Board shall act on initial appointments only after there has been a recommendation or an opportunity for a recommendation from the MEC.
b. Initial appointment to the Medical Staff will be for a period up to twenty-four (24) calendar months.
c. Initial appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted by the Board.

2.6.6 Credentials Committee Action

The Credentials Committee shall review each application and all relevant information available to it including Focused Professional Practice Evaluation (FPPE). The Credentials Committee may choose to interview the applicant prior to rendering a recommendation and it may request input from any relevant subject matter expert. The Credentials Committee shall make a report to the Medical Executive Committee regarding its recommendations on the application for reappointment. The report of the

Credentials Committee shall be accompanied by all relevant documentation, including the application, and supporting information.

2.6.7 Medical Executive Committee Action

The MEC shall review each application for appointment and all relevant information available to it. The MEC may choose to interview the applicant prior to rendering a recommendation. The MEC shall make a report to the Board regarding its recommendations on the application for appointment, including recommendations regarding requested privileges and assignment of Medical Staff category. The report of the MEC shall be accompanied by all relevant documentation, including the application, supporting information, and the report of the Credentials Committee.

2.6.8 Final Processing and Board Action

Following the report of the MEC to the Board, the procedure described for initial applications shall be followed and the Board shall render a decision prior to the expiration date of the applicant's appointment. Where the Board disagrees with the recommendation of the MEC, the matter will be addressed through the conflict resolution process as described in Section 10.5 in Volume I of the Medical Staff Bylaws.

2.6.9 Basis for Recommendation

Each recommendation concerning the appointment of a practitioner's membership and/or privileges shall be based upon review not only of those matters set forth in the Medical Staff Bylaws and policies pertaining to such practitioner, but also on any other information bearing on the ability and willingness of the practitioner to contribute to the rendering of quality health care within the Hospital and to contribute to the mission of the Hospital.

2.7 Processing Reappointment Applications

2.7.1 Application for Reappointment

Reappointment will be for a period of two (2) years unless the Board determines a shorter time period is warranted. At least one hundred and twenty (120) days prior to the expiration date of current appointment of membership and/or privileges, the Hospital shall provide each practitioner with an updated application form for reappointment and any required Hospital specific forms and documents for completion, which must be received prior to the reappointment application being acted upon. Each practitioner who desires reappointment shall complete such forms by the prescribed date given, and return them to the Hospital. Failure of the practitioner to return the completed form(s) and supporting documentation within this time frame may, at the discretion of the Hospital, be considered a voluntary resignation of membership and clinical privileges effective at the end of the practitioner's current term of membership and/or privileges.

2.7.2 Effective Date of Reappointment/Modifications of Appointments and/or Staff Privileges

Reappointments approved by the Board, including privileges awarded in connection with such reappointments, membership, and/or privileges, shall take effect on the date such modifications are approved by Board.

2.7.3 Conditions of Reappointment

a. Reappointment to the Medical Staff shall be made by the Board. The Board shall act on appointments and reappointments only after there has been a recommendation or an opportunity for a recommendation from the MEC.
b. Reappointment to the Medical Staff will be for a period up to twenty-four (24) calendar months.
c. Reappointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted by the Board.

2.7.4 Requests for Modification of Membership Status and/or Privileges

A Medical Staff member or practitioner with privileges (as applicable) may, either in connection with reappointment or at any other time, request modification of his staff category or clinical privileges by submitting a written application to the Hospital in such form as may be prescribed by the MEC and the Board. Such staff member shall have the burden of justifying such modification(s). Such application shall be processed in substantially the same manner as applications for reappointment to Medical Staff membership and/or privileges.

2.7.5 Reapplication After Modifications of Membership Status or Privileges

A practitioner who has received a final adverse decision by the Board regarding membership or privileges, or who has resigned or withdrawn an application for appointment or reappointment or privileges while under Investigation or to avoid Investigation, will be ineligible to reapply to the Medical Staff or for privileges for a period of four (4) years from the date of such resignation or withdrawal or the date of notice of a final adverse action by the Board.

2.7.6 Responsibilities of Membership

Each member of the Medical Staff must continuously comply with the provisions of these Bylaws, Rules and Regulations, and hospital policies and procedures. Members must:

a. Provide for the continuous and timely care to all patients for whom the practitioner has responsibility;
b. Provide, with or without request, new and updated information to the Medical Staff Office as it occurs, pertinent to any question found on the initial application or reappointment forms;
c. Appear for personal interviews (in person or by teleconference) in regard to an application for initial appointment or reappointment as requested by a department Chief of Service or by committees of the Medical Staff;
d. Abide by all applicable state and federal laws regarding healthcare fraud and abuse;
e. Refrain from deceiving patients as to the identity of any individual providing treatment or services;
f. Seek appropriate consultation whenever necessary to promote adequate quality of care;
g. Complete in a manner consistent with Medical Staff policies all medical and other required records, entering all information required by the Hospital;

h. Satisfy continuing medical education requirements as may be required under policies adopted from time to time by the Medical Staff and mandated by the New Jersey Department of Health and Senior Services (NJ-DOHSS);
i. Supervise the work of any advance practice professionals and/or physician assistants under the member's direction;
j. Pay all fees and dues assessed by the Medical Staff;
k. Treat Hospital employees, patients, visitors, and other practitioners and professionals in a dignified and courteous manner at all times.

Furthermore, each member of the Medical Staff by accepting a Medical Staff appointment agrees:

l. If there is any material misstatement in, or material omission from, an application for appointment or reappointment, the Hospital may stop processing the application (or, if appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed by the Board to be automatically relinquished). In either situation, there shall be no entitlement to a hearing or appeal;
n. To participate in, and collaborate with the peer review, risk management and performance improvement activities of the Medical Staff and Hospital. These include monitoring and evaluation tasks performed as part of the Medical Staff and Hospital efforts to meet quality standards such as those established by the Joint Commission (TJC), the Centers for Medicare and Medicaid Services (CMS), the NJ Department of Health & Senior Services (NJ-DOHSS) and other governmental agencies and private insurers;
o. To assist the Hospital in fulfilling its responsibilities for providing emergency and charitable care in accordance with policies passed by the MEC and Board;
p. To provide patient care and management only within the parameters of his or her professional competence, as reflected in the scope of clinical privileges granted the Practitioner by the Board;
q. To undergo any type of health evaluation as requested by the President of the Medical Staff, the CEO, CMO, and/or the MEC when it appears necessary to protect the well-being of patients and/or staff, or when requested by the MEC or Credentials Committee as part of an evaluation of the member's ability to exercise privileges safely and competently, or as part of a post-treatment monitoring plan consistent with the provisions of any Medical Staff and Hospital policies addressing physician health or impairment;
r. To participate in any type of competency evaluation when determined necessary by the MEC and/or Board in order to properly delineate that member's clinical privileges;
s. To hold harmless and agree to refrain from legal action against any individual, the Medical Staff, or Hospital that appropriately shares peer review and performance information with a legitimate health care entity or state medical board assessing the credentials of the member (including but not limited to hospitals, third party payers, government agencies, and others);
t. To abide by any applicable codes of conduct adopted by the Medical Staff and/or Hospital, including corporate compliance policies and codes of ethics;
u. To abide by all local, state and federal laws and regulations, Joint Commission standards, and state licensure and professional review regulations and standards, as applicable to the practitioner's professional practice;

v. To maintain the capability to receive email communication from the Hospital and members of the Medical Staff and to agree to be trained for and to utilize any electronic health record tools implemented by the Hospital for use with hospitalized patients or utilized in the Hospital's ambulatory facilities where applicable; and
w. To provide patients with a quality of care that meets at all times the professional standards and requirements of the Medical Staff and Hospital.

2.8 Categories of Medical Staff Membership

The Medical Staff shall be divided into the following categories:

1) Active Attending
2) Courtesy
3) Honorary
4) Administrative Non-Clinical
5) Affiliate
6) Active Adjunct

Category status for each practitioner will be recommended by the MEC at initial appointment or reappointment and ratified by the Board.

2.8.1(1) Active Attending Staff

a. QUALIFICATIONS: Appointees to this category must:

1) Be either a member of the faculty or in the process of obtaining a faculty appointment at the New Jersey Medical School or the New Jersey Dental School with the exception of Podiatry. Applicants in the category of active teaching attending must be recommended for membership in the Medical-Dental Staff by the Chief of Service of the designated Clinical Department.
2) Be a physician, dentist, or podiatrist involved in a minimum of forty (40) patient contacts at the Hospital or a Hospital sponsored facility, over a 24-month period. A patient contact is defined as any inpatient admission, inpatient consultation, and treatment of a patient in the Emergency Department or out patients in a hospital based clinic, a procedure performed in the Hospital or a Hospital sponsored facility, or a regularly scheduled day on the Medical Staff call schedule. Members may be appointed to this category at initial appointment where it is anticipated they will meet this criterion. If they have not completed 20 contacts in their first twelve months on staff, their category status will be changed to courtesy. Otherwise, after initial appointment, category status will be assigned at reappointment time based on contact activity during the previous 24-month period. This information will be documented in OPPE files and confirmed by the Chief of Service.

b. PREROGATIVES: Appointees to this category may:

1) Exercise those clinical privileges granted by the Board.
2) Vote on all matters presented to the Medical Staff, and at meetings of the clinical departments and committees to which the member is appointed.

3) Hold office and sit on or act as chair of any committee, unless otherwise specified elsewhere in these Bylaws.
4) Participate in the Graduate and Undergraduate Medical/Dental Education Program at University Hospital.

c. RESPONSIBILITIES: Appointees to this category must:

1) Meet the basic responsibilities of Medical Staff membership, as defined in Article 2.3, and contribute to the organizational and administrative affairs of the Medical Staff.
2) Actively participate in recognized functions of staff appointment as required or requested, including performance improvement, peer review, risk and utilization management, the monitoring of initial appointees through FPPE, credentialing activities, medical records completion, and the discharge of other Medical Staff functions, Medical Staff committee and clinical department obligations as may be required.
3) Comply with all applicable Hospital and Medical Staff Bylaws, Rules, and Regulations, policies and procedures.
4) Participate in providing call coverage (where applicable) and other coverage arrangements as defined in policies adopted by the MEC and Board.
5) Perform such further duties as may be required under these Bylaws or Medical Staff policies and procedures and Rules and Regulations, as may be amended from time to time.

2.8.1(2) Active Non-Teaching Attending Staff

a. QUALIFICATIONS: Appointees to this category must:

1) Be an otherwise qualified physician, dentist or podiatrist who is recommended for membership in the Medical-Dental Staff by the Chief of Service of the designated Clinical Department.
2) Be a physician, dentist, or podiatrist involved in a minimum of forty (40) patient contacts at the Hospital or a Hospital sponsored facility, over a 24-month period. A patient contact is defined as any inpatient admission, inpatient consultation, and treatment of a patient in the Emergency Department or out patients in a hospital based clinic, a procedure performed in the Hospital or a Hospital sponsored facility, or a regularly scheduled day on the Medical Staff call schedule. Members may be appointed to this category at initial appointment where it is anticipated they will meet this criterion. If they have not completed 20 contacts in their first twelve months on staff, their category status will be changed to courtesy. Otherwise, after initial appointment, category status will be assigned at reappointment time based on contact activity during the previous 24-month period. This information will be documented in OPPE files and confirmed by the Chief of Service.

b. PREROGATIVES: Appointees to this category may:

1) Exercise those clinical privileges granted by the Board.
2) Vote on all matters presented to the Medical Staff, and at meetings of the clinical departments and committees to which the member is appointed.

3) Hold office and sit on or act as chair of any committee, unless otherwise specified elsewhere in these Bylaws.

c. RESPONSIBILITIES: Appointees to this category must:

1) Meet the basic responsibilities of Medical Staff membership, as defined in Article 2.3, and contribute to the organizational and administrative affairs of the Medical Staff.
2) Actively participate in recognized functions of staff appointment as required or requested, including performance improvement, peer review, risk and utilization management, the monitoring of initial appointees through FPPE, credentialing activities, medical records completion, and the discharge of other Medical Staff functions, Medical Staff committee and clinical department obligations as may be required.
3) Comply with all applicable Hospital and Medical Staff Bylaws, Rules, and Regulations, policies and procedures.
4) Participate in providing call coverage (where applicable) and other coverage arrangements as defined in policies adopted by the MEC and Board.
5) Perform such further duties as may be required under these Bylaws or Medical Staff policies and procedures and Rules and Regulations, as may be amended from time to time.

d. RESTRICTIONS: Medical-Dental Staff members who are not NJMS or NJDS faculty may not participate in the Graduate or Undergraduate Programs at University Hospital.

2.8.2 Courtesy Staff

a. QUALIFICATIONS: Medical Staff members appointed to this category must:

1) Maintain privileges to actively manage patient care or to refer and follow hospitalized patients or out patients in hospital based clinics.
2) Admit or otherwise be involved in the care or treatment of less than forty (40) patient contacts (as defined in Article II, Section 2.7.1. (a) Qualifications) in an appointment period.
3) If engaged in the active practice of medicine at a private office or an accredited/licensed healthcare facility other than the Hospital, will provide information and documentation of OPPE, so that the Medical Staff and Board can assess the practitioner's compliance with membership and privileging requirements as stated under these Bylaws and Medical Staff policies.

b. PREROGATIVES: Appointees to this category may:

1) Exercise those privileges granted by the Board.
2) Attend meetings of the staff and clinical services to which the member is appointed in a non-voting capacity. Courtesy members may attend all educational programs presented by the Medical Staff and/or Hospital and applicable Medical Staff social functions.

3) Not vote or hold office within the Medical Staff organization. A Courtesy staff member may serve on committees of the Medical Staff or Hospital and may attend Medical Staff and clinical service meetings only as a non-voting member.

c. RESPONSIBILITIES: Appointees to this category must:

1) Meet the basic responsibilities of Medical Staff membership, as defined in Article 2.3, and contribute to the organizational and administrative affairs of the Medical Staff.
2) Actively participate, where required or when asked, in recognized functions of staff appointment, including performance improvement, peer review, risk and utilization management, the monitoring of initial appointees through FPPE, credentialing activities, medical records completion, and the discharge of other Medical Staff functions and clinical service obligations as may be required from time to time.
3) Comply with all applicable Hospital and Medical Staff Bylaws, Rules and Regulations, policies and procedures.
4) Participate in providing call coverage (where applicable) and other coverage arrangements as defined in policies adopted by the MEC and Board.
5) For any Courtesy staff member who does not maintain a staff appointment at another hospital, he shall provide other information as may be requested by the Medical Staff or Board in order to perform an appropriate evaluation of qualifications. Such information may include, but will not be limited to, data from the individual's office practice, information from managed care organizations in which the individual participates, and/or receipt of confidential evaluations forms completed by referring/referred to physicians.
6) Perform such further duties as may be required under these Bylaws or Medical Staff policies and procedures and Rules and Regulations that may be amended from time to time.

2.8.3 Honorary Staff

The Honorary staff category is granted to those individuals the Medical Staff wishes to honor, including, but not limited to clinical professionals who have a history of participation in Medical Staff and/or Hospital affairs and those who may have had a Medical Staff leadership role. Members on the Honorary Staff do not need to be in the active practice of medicine and do not need to maintain board certification. Honorary staff members shall not be eligible to admit patients to the Hospital or to exercise clinical privileges in the Hospital, or vote at any meetings attended or hold office. Honorary staff members may, however, attend Medical Staff and clinical service meetings and participate in Hospital and Medical Staff educational programs. They may also be appointed as non-voting members of committees when interested so that the Medical Staff may take advantage of their unique experience or talents.

Prerogatives: Practitioners in the honorary Medical Staff category shall be invited to attend education and social functions of the Hospital and Medical Staff as appropriate.

2.8.4 Administrative Physician - Non Clinical

a. Qualifications: Medical Staff Members who are appointed to this category and who do not have clinical privileges must:

1) Present documented evidence of his or her qualifications, each must meet the basic qualifications set forth in Article III;
2) Must be a faculty member at the New Jersey Medical School, New Jersey Dental School, with the exception of Podiatry.

b. Prerogatives: Medical Staff Members who are appointed to this category and who do not have clinical privileges will maintain Medical Staff membership with the following citizenship privileges:

1) Shall be a full time member of the faculty of the New Jersey Medical School or New Jersey Dental School, with the exception of Podiatry.
2) May not be appointed Chief of Service
3) May not hold office in the Medical Staff Organization
4) May assume Medical Staff administrative duties.

c. Responsibilities

1) Meet the basic responsibilities of Medical Staff membership, as defined in Article II, Section 2.7.6; s.t.u. and contribute to the organizational and administrative affairs of the Medical Staff.

2) Comply with all applicable Hospital and Medical Staff Bylaws, Rules and Regulations, policies and procedures.

2.8.5 Affiliate Staff

The Affiliate Staff shall consist of practitioners who do not wish to have admitting or clinical privileges, or to manage the care of their patients in the Hospital.

a. Qualifications: Applicants for Affiliate Staff membership must meet all the requirements for membership to this category, and will be appointed and reappointed pursuant to an abbreviated application process. This will include but will not be limited to, primary source verification, professional references, and quality information.

b. Prerogatives: Affiliate staff members shall be appointed to a specific service and be responsible to the appropriate Chief of Service. They shall have no admitting, operating, or consulting privileges and have no patient care duties at the Hospital, but if requested, shall have access to the practitioner's referred patient's medical record.

c. Responsibilities:

1) Must meet the basic responsibilities (abbreviated process) for membership, as defined in Article II, Section 2.7.6; s.t.u., and may contribute to the organizational and administrative affairs of the Medical Staff if required.
2) Comply with all applicable Hospital and Medical Staff Bylaws, Rules and Regulations, Policies and Procedures.

2.8.6 Adjunct Staff

The members of the Adjunct Staff are practitioners as defined by the individual's specific license or certification. The Adjunct Staff shall consist of licensed and/or certified practitioners permitted by law and by the hospital, to provide specific patient care services within their scope of training, education, and experience. They include, but are not limited to, Advanced Practice Nurses, Certified Nurse Midwives, Certified Registered Nurse Anesthetists, Physician Assistants and Psychologists. They shall not admit patients, and may attend patients only in collaboration with or under the supervision of a member of the active attending staff (MD/DO), depending upon license or certification requirement. Psychologists shall not admit or discharge patients, but may consult within their scope of training, education, and experience.

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a) Qualifications: Applicants for appointment to the adjunct staff must meet all of the requirements for privileges and will be appointed and reappointed pursuant to the procedures outlined in Article III.

b) Prerogatives: The members of the Adjunct Staff may provide only such patient care services as are specifically designated by the Board of Directors of UH. Such services must be consistent with limitations stated in these Bylaws. An Adjunct Staff member may vote on all matters presented to the committees to which the member is appointed. The Adjunct Staff shall be subject to disciplinary action, when indicated, according to the Fair Hearing and Corrective Action Manual Vol. II of these Bylaws, Policies and Procedures and the Rules and Regulations.

c) Responsibilities:

1) Meet the basic responsibilities for membership and privileges as defined in Article II, Section 2.7.6; s.t.u.
2) Comply with all applicable hospital policies and procedures, Rules and Regulations and Bylaws of the Medical Staff.
3) Members of the Adjunct Staff may elect a representative of the Adjunct Staff to serve not more than a two-year term on the MEC, by using a similar methodology as is used for the Attending Medical Staff election process (Reference: 4.3 and 4.4 of these Bylaws.

2.8.7 Change in Staff Category

Pursuant to a request by the Medical Staff member or Chief of Service, with a recommendation by the Credentials Committee, the MEC may recommend a change in Medical Staff category of a member consistent with the requirements of these Bylaws. The Board shall approve any change in category. Determinations regarding assignment of staff category are not subject to review under the due process provisions of the Corrective Action and Fair Hearing Manual of these Bylaws.

2.8.8 Limitation of Prerogatives

The prerogatives of Medical Staff membership set forth in these Bylaws are general in nature and may be subject to limitation or restriction by special conditions recommended by the MEC and attached by the Board to a practitioner's appointment, reappointment, or privileges, by state or federal law or regulations, by other provisions of these Bylaws or by other Medical Staff and Hospital policies, or by commitments, contracts, or agreements of the Hospital.

2.9 Member Rights and Conflict Management Mechanisms

Members appointed to the Medical Staff shall have the following rights, in addition to the procedural due process rights enumerated in the Corrective Action and Fair Hearing Manual of these Bylaws or as limited by Section 2.8.12 below:

2.9.1 Immunity from Liability

There shall be, to the fullest extent permitted by law, immunity from civil liability arising from any act, communication, report, recommendation or disclosure, performed at the request of an authorized member of the Hospital, Medical Staff or any other health care facility or accrediting/regulating agency for the purpose of improving or maintaining the quality of patient care.

2.9.2 Right of Indemnification

University Hospital shall indemnify the legal related expenses of any Medical Staff member that are incurred as a result of carrying out assigned Medical Staff administrative duties (including peer review and credentialing) which were performed in good faith.

2.9.3 Right to Notification of Investigations

Members of the Medical Staff shall be notified if they are the subject of an investigation (as defined in Volume II of these Bylaws) within seven days of the commencement of such Investigation.

2.9.4 Access to Committees

Members of the Medical Staff are entitled to be present at any Medical Staff committee meeting except during proceedings designated by the chair to involve peer review activities or when a committee is in executive session with only the voting committee members or others whose presence is specifically requested to provide relevant information. Presence at a meeting shall not entitle a member to speak unless permitted to do so by the committee chair.

2.9.5 Communication with MEC

Each member of the Medical Staff has the right to meet with the MEC on matters relevant to the responsibilities of the MEC process:

In the event that the President of the Medical Staff determines that such member is unable to resolve a matter of concern after discussion with the appropriate clinical service, committee chair or other appropriate Medical Staff leader(s), that the member may, upon written notice to and approval of the President of the Medical Staff at least two (2) weeks in advance of a regular meeting of the MEC, meet with the MEC or an MEC subcommittee to discuss the issue. The President of the Medical Staff will have discretion regarding the meeting date, timing and placement of the issue on the MEC agenda or direction of the issue to a subcommittee.

2.9.6 Right to Information

The MEC will publish by post on the Medical Staff website and/or notify active members by email, of any pending or proposed changes to the Bylaws (Volumes I and II) and Rules and Regulations, approximately seven (7) days in advance of a Medical Staff vote, for all active Medical Staff members to review and comment.

The Medical Staff Bylaws, Rules and Regulations, policies and procedures will be posted on the Medical Staff website: http://www.uhnj.org/mdstfweb/. The Hospital policies and procedures will be posted on the hospital website.

2.9.7 Access to Credentials Files

Each member shall be allowed an opportunity to review his own credential file or peer review/clinical performance file in the manner prescribed by the Medical Staff or in accordance with relevant Medical Staff or Hospital policies.

2.9.8 Confidentiality

Effort shall be made to maintain as confidential any matter discussed in committee or by representatives of the Medical Staff when the matter is deemed to be confidential by Hospital or Medical Staff leaders.

2.9.9 Recall of Elected Leaders

Each member of the Medical Staff in the active category has the right to initiate a recall vote of Medical Staff Officers in accordance with the recall provisions provided in these Bylaws.

2.9.10 Right to Initiate Meetings and Address Medical Staff Conflicts

Each staff member in the active staff category may request a general Medical Staff meeting to discuss a matter relevant to the Medical Staff, including addressing conflicts that may arise between the MEC and other Medical Staff members. Upon presentation of a petition signed by twenty percent (20%) of the members of the active staff category, the MEC shall schedule a general staff meeting within thirty (30) days for the specific purposes addressed by the petitioners. No business other than that detailed in the petition may be transacted.

2.9.11 Right to Request Review of Policies

Each member of the Medical Staff in the active category may raise a challenge to any rule, regulation, or policy established by the MEC. If presented by such a member with a petition signed by at least twenty percent (20%) of the active members of the Medical Staff, the MEC, shall do one of the following:

(a) Provide the petitioners with information clarifying the intent of such rule, regulation, or policy and the justifications for its adoption; and/or
(b) Schedule a meeting with the petitioners to discuss the issues that are raised with regard to the rule, regulation, or policy.

2.9.12 Further Due Process Rights

The above sections on Member Rights (2.5.1 through 2.5.11) do not pertain to issues involving individual peer review or performance evaluation (including Focused and Ongoing Professional Practice Evaluation), formal investigations of professional performance or conduct, denial of requests for appointment or privileges, restriction or conditions placed on appointment or privileges, or any other matter relating to individual membership or privileges. Recourse with regard to these matters is described in the Corrective Action and Fair Hearing Manual (Volume II) of these Bylaws.

ARTICLE III - CREDENTIALING AND THE DETERMINATION OF PRIVILEGES

3.1 General Procedure

The Medical Staff through designated committees and officers shall evaluate and consider each application for appointment or reappointment and clinical privileges and each request for modification of staff membership or privileges and shall adopt and transmit recommendations to the Board.

3.2 Appointment and Reappointment to Medical Staff Membership

The following steps describe the process for credentialing (appointment and granting of privileges and reappointment and privileging) of Medical Staff members.

a. Individuals desiring an appointment to the Medical Staff may request an application from the Chief of Service of the clinical service of the Hospital and a list of the eligibility requirements for membership. Eligible members of the Medical Staff will automatically be sent an application for reappointment in a timely fashion. .
b. Upon completion and submission of the application to the Hospital, an individual designated by the Hospital will verify the contents and confirm that the applicant is eligible to have the application processed further. If the application shows the applicant is not eligible for membership, he will be notified that no further evaluation or action will occur regarding the application. An incomplete application will not be forwarded for consideration by the Medical Staff or Board. An application that remains incomplete for more than ninety (90) days after submission to the Medical Staff Office will be considered to have been voluntarily withdrawn.
c. A completed and verified application will be forwarded by the Medical Staff Office (MSO) to the appropriate clinical Chief of Service (or designee) The Chief of Service's review will include consideration of the applicant's character, current clinical competence, training and education, clinical experience, ability to perform privileges requested, and evidence of professional judgment and conduct. The Chief of Service will forward recommendations concerning appointment and clinical privileges for the applicant to the Credentials Committee.
d. The Credentials Committee will review the Chief of Service review of the applicant's character, current clinical competence, training and education, clinical experience, ability to perform privileges requested, and evidence of professional judgment and conduct. The Committee will forward its recommendation to the Medical Executive Committee (MEC).
e. The MEC will review the recommendation by the Credentials Committee and forward its recommendation to the Board regarding membership, staff category, and privileges. The MEC may also refer an application back to the Credentials Committee if more information or evaluation concerning the applicant is necessary before it can render a recommendation to the Board.
f. Upon receipt of a recommendation from the MEC, the Board will review the recommendation and application and determine whether to grant the applicant membership and/or privileges and whether

any restrictions or conditions should be attached to a grant of membership or clinical privileges. Membership and/or privileges will become effective upon action by the Board granting membership and/or privileges. Practitioners shall be entitled to exercise only those privileges specifically granted to them by the Board. The Board will determine, and upon recommendation from the Medical Staff, which privileges may be granted and exercised at University Hospital

g. Applicants may appeal recommendations by the MEC and decisions made by the Board in accordance with provisions in the Medical Staff Corrective Action and Fair Hearing Manual of these Bylaws.

3.3 Granting and Modification of Clinical Privileges

The following steps describe the process for granting clinical privileges to qualified practitioners. Practitioners shall be entitled to exercise only those privileges specifically granted to them by the Board. The Board will determine, and upon recommendation from the Medical Staff, which privileges may be granted and exercised at University Hospital.

a. Upon completion and submission of the appropriate privileging forms to the Medical Staff Office, the Hospital will confirm that the applicant has the appropriate training and education, experience and demonstrated competence. Privilege requests that do not demonstrate compliance with eligibility requirements will not be processed. Individuals applying for privileges without membership being granted temporary privileges, must meet the applicable eligibility and qualification requirements for members found in Section 2.1 of these Bylaws. They must also agree to meet the responsibilities for members listed in Section 2.4 of these Bylaws.
b. Completed privilege request forms will be forwarded by the Medical Staff Office to the appropriate Chief of Service for review. This review(s) will include consideration of the practitioner's, clinical competence, training, experience, and professional judgment and conduct.
c. The Chief of Service will forward a recommendation to the Credentials Committee.
d. The Credentials Committee will review the applicant's requests and recommend a specific action to the MEC.
e. The MEC will review the privileging requests and recommend specific actions to the Board. The MEC may also refer the application back to the Credentials Committee if it feels additional information or evaluation is required.
f. Applicants may appeal certain adverse recommendations of the MEC in accordance with provisions in the Corrective Action and Fair Hearing Manual of these Bylaws.
g. The Board will review the privileging requests and either reject the requests, modify them, or grant the privileges being sought.
h. Applicants may appeal adverse recommendations made by the Board in accordance with provisions in the Medical Staff Corrective Action and Fair Hearing Manual.

3.4 Temporary, Disaster and Emergency Privileges

3.4-1 Temporary Privileges for a New Applicant

Temporary privileges are privileges to meet an important patient care need for the time period defined in these Bylaws. Privileges granted under this Article shall continue, unless terminated, until action on the application is taken by the Board, but in no event shall exceed 120 days.

Upon written request of the Chief of Service, temporary privileges are granted on the recommendation of the Chief Medical Officer or designee. The CEO of the Hospital or designee, shall have the authority

to grant temporary privileges to a new applicant for a period not to exceed 120 days in duration, provided there is verification and adequate justification of:

1) Current licensure
2) Relevant training or experience
3) Current competence
4) Ability to perform privileges requested
5) Other criteria required by these Bylaws
6) A query and evaluation of the National Practitioner Data Bank
7) All primary source verifications
8) A complete application
9) No current or previously successful challenge to licensure or registration
10) No subjection to involuntary termination of Medical Staff membership at another organization
11) No subjection to involuntary limitation, reduction, denial or loss of clinical privileges

3.4-2 Disaster Privileges (Temporary)

Disaster privileges may be granted by the CEO or designee when The Disaster Plan is activated and the Hospital's Medical Staff is unable to provide for immediate patient care needs. This can be a major local or regional occurrence, which may result in the presentation of more patients than can be safely accommodated within the normal resources available at the Hospital. Disaster privileges may be granted to a Licensed Independent Practitioner (LIP) who presents to the Hospital his valid government issued photo identification and at least one of the following:

- A current picture identification card from a health care organization that clearly identifies professional designation
- A current license to practice
- Primary source verification of licensure
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT) , the Medical Reserve Corps (MRC), the Emergency System for Advanced Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group.
- Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances
- Confirmation by a licensed independent practitioner currently privileged by the Hospital or by a staff member with personal knowledge of the volunteer practitioner's ability to act as a licensed independent practitioner during a disaster.

The practitioner granted disaster privileges, shall work under the supervision of the CMO or designee. Primary source verification of the credentials and privileges are to begin once the disaster situation is deemed under control or within 72 hours of when the practitioner presents to the Hospital. If primary source verification cannot be completed in the required time frame, The Hospital must document the reason why.

3.4-3 Emergency Privileges (Temporary/Time-Limited)

Emergency privileges are granted to meet an emergent or urgent patient care need for the time period defined in these Bylaws. Upon request of the clinical Chief of Service, Emergency Privileges are granted on the recommendation of the Medical Staff President or designee or Chief Medical Officer or designee. The CEO of the Hospital or designee shall have the authority to grant emergency privileges to a practitioner for a period not to exceed 72 hours (renewable once) in duration, provided there is verification and adequate justification of:

1) Current licensure
2) Relevant training or experience
3) Current competence
4) Ability to perform privileges requested
5) All primary source verifications
6) A query and evaluation of the National Practitioner Data Bank
7) A complete Emergency Privilege application
8) No current or previously successful challenge to licensure or registration
9) No subjection to involuntary termination of Medical Staff membership at another organization
10) No subjection to involuntary limitation, reduction, denial or loss of clinical privileges

ARTICLE IV - OFFICERS

4.1 Officers of the Medical Staff

The officers of the Medical Staff shall be:

President
President-Elect
Secretary/Treasurer
Past-President

4.2 Qualifications

Officers of the Medical Staff must satisfy the following criteria at the time of nomination and continually throughout the term of their office:

a. Be a member of the active Medical Staff and have been a member of the active Medical Staff for at least three years;
b. Have no pending adverse recommendation concerning staff appointment or clinical privileges;
c. Have constructively participated in Medical Staff activities and committees, including, but not limited to performance improvement, peer review and/or credentialing;
d. Have the ability and be willing to discharge faithfully the duties and responsibilities of the position;
e. Has experience in a hospital leadership position, which may include the involvement in performance improvement or serve as a Chair of a MEC Committee, for at least the previous three (3) years;
f. Is willing to attend continuing education programs relating to Medical Staff leadership and/or peer review and credentialing functions prior to or during the term of office;
g. Be in compliance with any and all policies of the Medical Staff and Hospital

including any Conflict of Interest Policy;

h. Have demonstrated an ability to work well with and communicate well with others;
i. May not be the Chief Medical Officer or other administrative leader, Chief of Service, Medical Staff Officer or executive committee member at any other hospital or Medical Staff;
j. May not be the CMO, COS, CEO, CQO at the Hospital or the Dean of affiliated schools;

4.3 Selection

The Medical Staff Nominations Committee will meet four (4) months in advance of the annual general Medical Staff meeting in years where elections will be held. The Nominations Committee shall select nominees for placement on the election ballot for all officers except for the President and the Immediate Past President. If the current President-Elect cannot or is not willing to assume the role of President then the Nominations Committee will also nominate one or more candidates to run for President of the Medical Staff. The Nominations Committee will be comprised of the President of the Medical Staff, the President-Elect and Past-President of the Medical Staff, The Secretary/Treasurer and the members at large of the MEC. The CEO and CMO will be invited to attend meetings of the committee.

a. The Nominations Committee will produce a slate of nominees with at least one (1) name placed on the ballot for each officer position, at least ninety (90) days prior to the general staff meeting at which the results of the election will be announced.
b. The Nominations Committee shall circulate and formally post its list of nominees to the active members of the Medical Staff at least forty-five (45) days prior to the annual meeting at which election results will be announced.
c. In order for a nominee, not on the slate of nominees by the Nomination Committee, to be placed on the ballot, the following criteria must be met:

    1) Candidates must meet the qualifications listed in these Bylaws for the position to which they wish to be elected. The Nominations Committee will have sole discretion to determine if these criteria have been met.

    2) Candidates must be approved by the Nominations Committee for placement on the ballot and candidates must agree to be placed on the ballot.

    3) A petition signed by at least twenty percent (20%) of the dues paying members of the active staff may also make nominations. Such petition must be submitted to the Nominations Committee at least thirty days prior to the election for placement on the ballot. The candidate nominated by petition must be confirmed by the Nominations Committee to meet the qualifications in Section 4.2 above before he can be placed on the ballot.

4.4 Election

1. The officers of the Medical Staff shall be elected using a secret ballot which may be distributed to eligible voting members of the Medical Staff at a general Medical Staff meeting, by mail, or electronically. Only members of the active Medical Staff shall be eligible to vote. The winner of an election shall be the individual who receives the greatest number of votes from the dues paying active Medical Staff members who received ballots and voted. Voting by proxy is not permitted.
2. The newly elected officers of the Medical Staff shall be eligible to assume office on January 1st following the election.
3. Elections for officers will take place in the last calendar quarter of the year as scheduled.

4.5 Term

The officers of the Medical Staff shall serve a term of two (2) years from the first day of January following their election.

4.6 Duties of Elected Officers

a. President of the Medical Staff:

The President of the Medical Staff shall serve as the chief administrative officer and principal elected official of the Medical Staff. As such, she/he shall be responsible for implementing the general responsibilities of the Medical Staff, including, without limitation:

1) Aiding and coordinating Medical Staff activities with the activities and concerns of the Board, Administration of the Hospital, Nursing, and other patient care services.

2) Accounting to the Board and Medical Staff, in conjunction with the MEC, for the quality, efficiency and performance of patient care services within the Hospital.

3) Developing and implementing, in coordination with other Medical Staff leaders and experts, continuing education programs, utilization review activities, performance improvement programs, methods for credentials review, delineation of privileges, and the monitoring of the quality of patient care.

4) Communicating and representing the concerns and recommendations of the Medical Staff to the Board, the Hospital CEO, CMO, and other leaders of the Medical Staff.

5) Assuming responsibility for the enforcement of these Bylaws, Hospital policies, and Medical Staff Rules and Regulations or policies, and for implementation of appropriate sanctions where indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where appropriate, as provided under these Bylaws.

6) Calling, setting the agenda, and presiding at all general and special meetings of the Medical Staff and of the MEC.

7) May serve as an ex-officio member of all Medical Staff committees with the right to vote.

8) Appointing the members of all standing, special and multi-disciplinary Medical Staff committees except the MEC, in consultation with the chair of each such committee and the CMO, except as such committee membership is otherwise determined by Medical Staff policy or these Bylaws.

9) Reporting to the Board on quality of care and performance improvement issues as recommended by the Medical Staff.

10) Representing the Medical Staff in its professional and community relations.

11) Attend a minimum of 75% of MEC meetings and Board meetings scheduled.

12) Unless not confirmed by the Governor's Office within thirty (30) days of the annual election as President, may serve on the Board for the duration of the term as Medical Staff President.

b. President-Elect of the Medical Staff:

The President-Elect of the Medical Staff shall be a member of the MEC and shall be required to assist the President of the Medical Staff to perform such duties as may be assigned to him by the President of the Medical Staff. In the absence of the President of the Medical Staff or upon the occurrence of a vacancy in the office of President of the Medical Staff, the President-Elect shall assume the responsibilities, exercise the authority, and perform the duties assigned to the President of the Medical Staff until the President of the Medical Staff returns. The President-Elect of the Medical Staff shall attend a minimum of seventy-five (75%) of all MEC and QI committee meetings.

c. Secretary/Treasurer:

The Secretary/Treasurer shall be a member of the MEC, shall be responsible for the accuracy of minutes for all general Medical Staff and MEC meetings, and shall serve as an advisor to the President of the Medical Staff and perform those functions delegated to him by the President. The Secretary/Treasurer shall be expected to attend a minimum of 75% of MEC meetings.

d. Past President:

The Past President shall serve in an advisory capacity to the current elected officers and shall be a voting member of the MEC.

e. Members At-Large Members:

The six (6) elected at-large members of the MEC shall serve in an advisory capacity to the elected officers, for a two year term of office and will be expected to attend 75% of the MEC meetings as voting members.

4.7 Removal

a. A recall election of an officer shall be held if requested through a petition signed by no fewer than twenty percent (20%) of the active members in good standing of the Medical Staff, a request signed by at least two-thirds of the voting members of the MEC, or a request made by the Board. Officers may be removed by an affirmative vote of two-thirds of the active members in good standing of the Medical Staff. The following conditions constitute a reasonable basis for removal of an officer from office:

1) Failure to comply with or support enforcement of the Medical Staff Bylaws, Rules and Regulations, or policies;
2) Failure to perform the required duties of the office;
3) Failure to adhere to professional ethics;
4) Abuse of office;
5) Conduct unbecoming a Medical Staff member and officer;
6) Failure to continuously meet the qualifying criteria to be an officer as set forth above in these Bylaws; or

7) Failure to comply with the obligations of Medical Staff membership.

b. At least ten (10) days prior to the initiation of any removal action, the officer shall be given special notice of the date of the meeting at which action is to be considered. The officer shall be afforded an opportunity to speak to the Medical Staff prior to a vote on removal.

c. Automatic removal will occur (without need for a vote) in the event any of the following affects the officer in question:

1) Loss or suspension of the officer's medical license in the State of New Jersey;
2) Ineligibility of membership in the active staff category;
3) Summary suspension by the Hospital CEO for patient safety.

4.8 The Governing Council

The six elected members of the Governing Council, who are the At-Large Voting Members of the MEC, will participate in advising the officers of the Medical Staff. These individuals will be active members of the Medical Staff who shall meet all qualifications for officers enumerated in 4.2 and shall be selected by the Nominating Committee as in 4.3 and elected as in 4.4 for the same two year term as officers of the Medical Staff. Members of the Governing Council shall attend a minimum of 75% of all MEC meeting scheduled over their two year term of office and will be removed under the same process and same criteria as in 4.7. Vacancies shall be filled by the President of the Medical Staff for the remainder of the member's term.

4.9 Vacancies

If the President of the Medical Staff is temporarily unable to fulfill the responsibilities of the office, the President-Elect of the Medical Staff shall assume these responsibilities until President of the Medical Staff can resume those duties. When a permanent vacancy occurs in the position of President of the Medical Staff, the President-Elect of the Medical Staff will assume this position for the remainder of the existing term. In the event the position of President-Elect becomes vacant, it will be immediately filled by the Secretary/Treasurer for the remainder of the existing term. If there is a vacancy in the position of the Secretary /Treasurer, the President of the Medical Staff will appoint an active member of the Medical Staff to fill the remainder of the Secretary/Treasurer's term.

ARTICLE V - CLINICAL ORGANIZATION OF THE MEDICAL STAFF

The Medical Staff of University Hospital is a departmentalized organization that carries out its responsibilities through clinical services and divisions, committees and individuals assigned specific tasks.

5.1 Designation of Medical Staff Services

The Medical Staff shall be divided into clinical services.

With the recommendation from the MEC and in consultation with and approval of the CEO, the Board may eliminate, consolidate, or create additional Medical Staff services where this would improve the effectiveness of the Medical Staff in carrying out its responsibilities. It is the responsibility of the MEC to determine which clinical specialties will be assigned to each service.

Organization of Medical Staff Services

Each Medical Staff service shall be established as an organizational division of the Medical Staff and shall have a Chief of Service that has the authority, duties, and responsibilities set forth in these Bylaws. Each service is accountable to the oversight and authority of the MEC, the CEO and CMO, and the Board. Each service may organize itself into divisions with the approval of the MEC and the CEO and CMO where this would enhance the efficiency and effectiveness of Medical Staff activities.

5.3 Functions of Medical Staff Services

a. Review and Evaluation Activities

The primary responsibility delegated to each Medical Staff service shall be to evaluate and improve the quality, appropriateness, safety and efficiency of patient care provided by members of the clinical department in the Hospital.

b. Additional Activities

At the discretion of service members and its Chief of Service, the department may organize and promote any of the following collegial and professional activities: continuing medical education; communication and dialogue regarding issues relevant to members of the department; social networking; and interdisciplinary projects and coordination.

c. Member Accountability

Members assigned to the service are accountable to the Chief of Service and must be responsive to requests for information, participation in department activities, participation in any mandatory special meetings, and compliance with Hospital, Medical Staff, or department rules, regulations, policies, procedures, or requirements.

5.4 Chief of Service

a. Qualifications

Each Chief of Service shall be:

1) A faculty member of the NJMS, or NJDS, with the exception of podiatry;
2) A member of the active attending staff category;
3) Board certified by a specialty board recognized by the ABMS, AOA, OMFS or ABPS, or found to have comparable competency by actions of the Credentials Committee and MEC;
4) Qualified by experience within the clinical service and/or by administrative ability to supervise the functions of the department; and

5) Willing and able to discharge the functions of the department Chief of Service.

b. Selection

1) After mutual consultation with the CEO, the Dean of the New Jersey Medical School or the Dean of the New Jersey Dental School shall nominate candidates for Chiefs of Services. The CEO shall either appoint the Dean's nominee as Chief of Service or reject the nominee. If the CEO rejects the nominee as Chief of Service, the Dean shall nominate a different candidate for the position of Chief of Service.
2) The Chief of Service for Podiatric Services shall be selected by the CEO of the hospital in consultation with the CMO.

5.5 Chief of Service Performance

1) The Chief of Service shall be reviewed annually by the Hospital CEO or designee;
2) Upon petition by twenty-five percent (25%) of clinical service members in the active attending category or upon recommendation of the MEC, the Hospital CEO shall review the performance of the Chief of Service and determine whether or not to continue the individual in that capacity in consultation with the Dean of the NJMS or NJDS.

5.6 Chief of Service Responsibilities

Each Chief of Service shall have responsibility for the organization and administration of the service, including, without limitation:

1) All clinically related activities of the department;

2) All Hospital administrative related activities of the department (which may include presiding at all meetings of the service), unless otherwise provided for by the Hospital;

3) Initial surveillance FPPE and continuing surveillance of OPPE of all individuals in the department who have delineated clinical privileges;

4) Recommending to the Credentials Committee, the MEC and the Board the criteria for clinical privileges that are relevant to the care provided in the department;

5) Recommending the appointment, reappointment, clinical privileges and modification of clinical privileges for each member of the service;

6) Assessing and recommending to the relevant Hospital authority those community resources for needed patient care services not provided by the department or the organization;

7) The integration of the service into the primary functions of the Hospital;

8) The coordination and integration of inter-departmental and intra-departmental services;

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

10) The recommendation to the CEO and CMO for a sufficient number of qualified and competent persons to provide care, treatment, and services for Hospital patients;

11) Surveillance, evaluating and advising on the qualifications and competence of healthcare providers who are not licensed independent practitioners and who provide patient care services;

12) The continuous assessment and improvement of the quality of care, treatment, and services, through quality improvement programs;

13) The orientation and continuing education of all persons in the department; and,

14) Recommendations for space and other resources needed by the department.

5.7 Removal of Chief of Service:

The CEO in consultation with the Dean, with the exception of podiatry, shall be able to remove the Chief of Service.

5.8 Organization of Clinical Services

Each service shall be organized as a separate part of the staff and shall be administered by a Chief of Service. The Chief of each service thus created may be the Chairperson of the respective Department of the NJMS or NJDS. In addition, Services may be established by the MEC. Each Chief of Service shall be a voting member of the MEC and shall have the authority, duties, and responsibilities as specified in Article 5.6. There will be no proxy vote. Each section or division shall be organized as a subspecialty within a service and shall be responsible to the Chief of Service.

5.8.1 Clinical Services

1) Anesthesiology
2) Emergency Medicine
3) Family Medicine
4) Dental Medicine
5) Pathology and Laboratory Medicine
6) Medicine
7) Neurosciences
8) Neurosurgery
9) Obstetrics & Gynecology Women's Health
10) Ophthalmology
11) Orthopaedics
12) Otolaryngology
13) Pediatrics
14) Podiatry

15) Psychiatry
16) Radiology
17) Radiation Oncology
18) Physical Medicine & Rehabilitation
19) Surgery

ARTICLE VI - MEDICAL STAFF COMMITTEES AND LIAISONS

6.1 Types of Committees

There shall be an executive committee of the Medical Staff (referred to in these Bylaws as the Medical Executive Committee or MEC) and standing committees of the Medical Staff accountable to the MEC as may be established in these Bylaws or created by the President of the Medical Staff or MEC to accomplish Medical Staff functions.

The Medical Staff shall carry out its responsibilities through participation in committees of the Hospital and/or through individual members who act as liaisons to Hospital departments, or services.

A current list of standing Medical Staff committees, ad hoc committees, Medical Staff appointees to hospital committees, and Medical Staff liaisons regarding selected hospital functions, will be maintained.

In addition to the MEC, standing committees of the Medical Staff include, but are not limited to: Bylaws Committee, Clinical Practice Committee, Credentials Committee, Ethics Committee, Infection Control Committee, Medical Records Committee, Oncology Committee, Operating Room Committee, Quality Improvement Committee, Pharmacy & Therapeutics Committee and Medical Staff Impairment Committee. These committees shall be chaired by a member of the Medical Staff.

Hospital committees with Medical Staff representation may include: Blood Utilization Committee, Ambulatory Care Committee, Invasive and Other Procedure Review Committee, Combined Critical Care/Resuscitation Committee, Medical Informatics Committee, Radiation Safety Committee, and Utilization Management Committee.

The Nominations Committee is an ad hoc committee that meets whenever candidates for Medical Staff elections must be identified.

6.2 Committee Chairs

a. Selection: With the exception of the MEC, the chair of each Medical Staff committee shall be appointed, and vacancies filled, by the President of the Medical Staff in consultation with the CMO, subject to the approval of the MEC. The President of the Medical Staff shall serve as chair of the MEC.

b. Term: Unless specified otherwise in these Bylaws, each chair of a standing committee shall be appointed to a term of two (2) years unless relieved of his or her responsibilities earlier by action of the MEC. Chairs of ad hoc committees will have terms established when the

committee is formed. Any chair may be reappointed for an unlimited number of additional terms unless specified otherwise in these Bylaws.

6.3 Membership and Appointment to Committees

1. Eligibility and Appointment

a) The President of the Medical Staff shall appoint all Medical Staff committee members with the exception of the MEC, after consultation with the CMO and committee chair.

b) Members of the active attending and active adjunct staff shall be eligible for appointment to any committee of the Medical Staff, with the exception of the MEC,.

c) Where specified in these Bylaws, or where the Medical Executive Committee deems it appropriate to the functions of a committee of the Medical Staff, representatives from various services of the Hospital, including, without limitation, Administration, Laboratory, Nursing, Hospital Systems Technology, Quality Management and Pharmacy Services, shall be eligible for appointment, to specific committees of the Medical Staff.

d. In making appointments to Medical Staff committees, the President of the Medical Staff in consultation with the CMO will have discretion to determine the committee size, unless otherwise specified in these Bylaws.

2. Hospital Chief Executive Officer

Unless otherwise provided in these Bylaws, the Hospital's Chief Executive Officer or his designee may serve as an ex-officio member without vote, on all Medical Staff committees.

3. Voting

Medical Staff members in the active attending staff category may vote on Medical Staff committees, unless specified otherwise in these Bylaws or Medical Staff policies or procedures.

4. Term

Unless specified otherwise in these Bylaws, each Medical Staff committee member shall be appointed to a term of two (2) years, and may be reappointed as often as the individual is willing to serve or the party responsible for such reappointment may deem advisable.

6.4 Medical Executive Committee

1. Membership
   Only active attending staff members are eligible for MEC membership.
2. Composition

The MEC shall consist of the following voting members:

1. President of the Medical Staff

2. President-Elect of the Medical Staff
3. Secretary/Treasurer of the Medical Staff
4. Past President of the Medical Staff
5. The Chair of the Bylaws Committee
6. The Chair of the Medical Staff Credentials Committee
7. Six members of the active Medical Staff elected by the voting members of the Medical Staff (Governing Council)
8. One member of the active Adjunct Staff elected by the voting members of the Adjunct Staff
9. The Chief of Service of each clinical department

The following will be non-voting ex officio members of the MEC:

Hospital Chief Executive Officer, Chief Medical Officer, Chief Operating Officer, Chief Nursing Officer, the Dean of New Jersey Medical School and the Dean of the New Jersey Dental School.

The MEC may invite to its meetings additional guests as needed to assist in carrying out its work.

3. Removal from the MEC

Membership on the MEC held by officers, elected members, chiefs of service and Medical Staff committee chairs will automatically terminate if an individual is removed from his position as an officer, Chief of Service, or committee chair as described elsewhere in these Bylaws.

Additional grounds for removal of the voting membership from the MEC include, but are not limited to:

a) Failure to attend 75% of MEC meetings;
b) Disruptive conduct at MEC meetings; and
c) Failure to carry out assigned duties as an MEC member.

Such removals will occur if recommended by a vote of at least two thirds of the current members of the MEC.

Physician members of the MEC will be considered to have voluntarily resigned from the committee if any of the following occur:

a) Termination or suspension of the member's license to practice in the State of New Jersey;
b) Loss of membership on the active attending staff category;
c) The MEC recommends to the Board that the member be subject to corrective action.

4. Responsibilities of the MEC

a) The MEC shall represent the Medical Staff, assume responsibility for the effectiveness of all medical activities of the Medical Staff, and act on matters of concern and importance to the Medical Staff.
b) The MEC is empowered to act for the Medical Staff in intervals between general Medical Staff meetings.

c) The MEC receives and acts on reports and recommendations from Medical Staff committees, clinical services, Hospital committees, consultants, and other relevant individuals.

d) The MEC may consult with Hospital senior management and the Board on quality-related aspects of contracts for patient care services, equipment and materials with entities outside the Hospital.

e) The MEC reviews and acts upon investigations in accordance with Corrective Action and Fair Hearing Procedures, Volume II of these Bylaws before making recommendations to the Board to terminate, limit, or restrict a practitioner's membership or privileges.

f) The MEC shall receive and review reports from the Graduate Medical Education programs at the Hospital to assure compliance with Joint Commission standards regarding the supervision, roles, responsibilities, and patient care activities of participants in those programs. This information shall be provided in the annual chief of service reports to the MEC.

g) The MEC is responsible for making Medical Staff recommendations directly to the Board for its approval. Such recommendations pertain to at least the following: The Medical Staff structure, membership, Bylaws, Rules and Regulations and policies; appointments, reappointments, modification of privileges for Medical Staff; participation of the Medical Staff in Hospital performance activities; corrective actions and fair hearing conclusions; MEC review of actions on reports of Medical Staff committees, clinical services and others and other assigned activity groups.

5. Meetings

The MEC shall meet monthly, no less than ten times per year and shall maintain a permanent record of all proceedings and actions at its meetings. The President of the Medical Staff or designee will preside at all meetings of the MEC.

6. Call of Special Meeting

The President of the Medical Staff may call special meetings of the MEC at any time. Such meetings may be held in person or through telephonic or electronic conferencing.

7. Notice

Notice of a special meeting of the MEC shall be by means of either facsimile, telephone, posting of notice or e-mail.

6.5 Standing Committees The chair of each committee shall determine the composition of the committee and how it will meet its charge.

6.5-1 Bylaws Committee: The charge of this committee shall be to review, recommend and revise the Medical Staff Bylaws and Rules and Regulations to reflect current practice and regulatory requirements. This committee will meet not less than annually, or at the call of the chair.

6.5-2 Clinical Practice Committee: The charge of this committee shall be to recommend and implement guidelines and procedures to clarify functions, duties and responsibilities of the Medical Staff. The

committee will review clinical care issues. This committee will meet at least ten (10) times a year, or at the call of the chair.

6.5-3 Credentials Committee: The charge of this committee shall be to review and evaluate the training, scope of practice, competency, ability to perform privileges requested of each initial appointment, reappointment and modification of clinical privileges and makes recommendations to the MEC. The Committee approves credentialing policies and procedures provides the oversight for Focused Professional Practice Evaluation (FPPE). This committee will meet at least ten (10) times a year, or at the call of the chair.

6.5-4 Ethics Committee: The charge of this committee shall be to create a forum for discussion of ethical issue, palliative care, and end-of-life decisions. This committee will plan and implement educational programs for Medical Staff and Hospital Staff and meet at least ten times (10) a year.

6.5-5 Infection Control Committee: The charge of this committee shall be to identify and analyze the causes and patterns of all nosocomial infections affecting patients. The committee will maintain permanent records of all activities and submit findings to the MEC. This committee will meet at least ten (10) times a year, or at the call of the chair.

6.5-6 Medical Records Committee**:** The charge of this committee shall be to ensure that the content and format of University Hospital medical record shall reflect all regulatory requirements as they pertain to clinical documentation, accuracy and confidentiality. This committee shall meet at least ten (10) times a year, or at the call of the chair.

6.5-7 Medical Staff Impairment Committee**:** The charge of this committee shall be to assess any allegation regarding potential impairment of a practitioner, and to refer the practitioner to the appropriate agency for evaluation, monitoring and treatment as deemed necessary. The confidentiality of all potentially impaired practitioners shall be strictly maintained as per regulatory requirements. The Chairperson of the MEC and the CMO shall designate three (3) members of the Medical Staff to serve on this committee. This committee will meet on an as needed basis.

6.5-8 Oncology Committee: Membership on the Oncology Committee shall consist of representatives from all medical specialties involved in the care of cancer patients. Required physician members represent surgery, medical oncology, radiation oncology, diagnostic radiology, pathology, and the cancer liaison physician; required nonphysician members represent administration, social service, quality improvement, Oncology Nursing, and a Certified Tumor Registrar (CTR). Additional nonphysician members are required for specific categories; these include, but are not limited to: Pain Control/Palliative Care Physician or specialist, and a clinical research data manager or nurse. The committee shall consist of at least one physician representative from the five major cancer sites seen at University Hospital, and other representatives as needed.

The charge of this committee shall be:

a. To develop and evaluate goals and objectives for clinical programs, community outreach, quality improvement, clinical programs and programmatic activities related to cancer;

b. To establish the frequency, format and multidisciplinary attendance requirements for tumor conferences, and ensures that the required number of cases are presented and discussed;
c. To establish and implement a policy and procedure to evaluate the quality, accuracy and timeliness of cancer registry data.

This committee shall meet at least four (4) times a year, or at the call of the chair.

6.5-9 Operating Room Committee: The charge of the Operating Room committee is to develop, recommend, review and implement policies and procedures to improve safety, patient outcomes and efficiency in the Operating Room. This committee will meet ten (10) times a year, or at the call of the chair.

6.5-10 Pharmacy and Therapeutics Committee: The charge of the Pharmacy and Therapeutics committee is to develop, monitor, maintain and make recommendations concerning a safe and effective hospital formulary. The committee will review all reported adverse drug reactions, medication errors and adverse outcomes from therapeutic interventions and recommend corrective action. This committee will meet ten (10) times a year, or at the call of the chair.

6.5-11 Quality Improvement Committee**:** The charge of this committee shall be to ensure and promote the quality of care provided by all services in University Hospital through the review and assessment of all quality activities and reports; to establish policies and procedures to promote and ensure improved patient outcomes and to compare these outcomes with established benchmarks and goals; to implement processes that ensure patient safety and to provide oversight for the process of Ongoing Professional Practice Evaluation. This committee will meet at least eleven (11) times a year, or at the call of the chair.

6.6 Medical Staff Representation on Hospital Committees

In order to further carry out the functions of the Medical Staff and to provide Medical Staff input where appropriate, the President of the Medical Staff and/or the Chief Medical Officer and the CEO may request members to serve on those Hospital committees. When Medical Staff members sit on a Hospital committee the minutes of that committee shall be available, upon request, to the MEC. It shall be the responsibility of the Medical Staff member(s) sitting on a Hospital committee to bring to the attention of the MEC or a Medical Staff Officer any matter brought before such committee that requires the attention of the Medical Staff leadership.

6.7 Medical Staff Liaisons

When the Medical Staff is required by regulatory bodies or internal policies to collaborate with Hospital staff in carrying out a particular function, the President of the Medical Staff and the CEO, CMO, or designee, may request a member of the Medical Staff to serve as a formal liaison for that work. The liaison will report periodically to the MEC or other appropriate committee when matters require the attention of Medical Staff leaders.

6.8 Special or Ad Hoc Committees

The President of the Medical Staff or MEC may appoint special or ad hoc committees to address specific issues or concerns on behalf of the Medical Staff. In establishing such committees, there will be a

notation made in the minutes of the MEC enumerating the committee's purpose and charge, timeframes for its work, and the duration of its appointment. Such committees will report to and be accountable to the MEC as a committee of the MEC.

ARTICLE VII - GENERAL MEDICAL STAFF MEETINGS

7.1 General Medical Staff Meetings

1. Frequency & Content

There shall be at least one general meeting of the Medical Staff held each year. Thirty (30) days written notice of the meeting shall be sent to all Medical Staff members in a manner determined reasonable and appropriate. The MEC shall determine the time and place at which the meeting shall be held. The President of the Medical Staff or the MEC may call additional general meetings for any reason they deem appropriate, including promoting communication with the Medical Staff, providing a forum for discussion on matters of Medical Staff interest to review quality and safety data and concerns, present educational programs, or to address proposed changes to the Medical Staff Bylaws.

7.1-2 Quorum

Those active staff members present shall constitute a quorum at a general Medical Staff meeting.

7.1-3 Minutes

Minutes of each regular and special meeting of the Medical Staff shall be prepared and shall include a record of the attendance of members and any votes taken on matters presented at the meeting. The minutes shall be signed by the presiding officer and the recorder of the minutes and maintained in a permanent file. Minutes shall be made available to any Medical Staff member upon request, in a manner that protects the confidentiality of peer review information consistent with state peer review protection statutes.

7.1-4 Conduct of Meetings

Meetings of the Medical Staff and meetings of committees will be run in a manner determined by the chair (or designee) who presides at such a meeting. Compliance with rules of parliamentary procedure is not required.

7.2 Special Meetings of the Medical Staff

1. Call of Special Meeting

A special meeting of the Medical Staff may be called at any time by the President of the Medical Staff, and shall also be called at the request of the Board, the MEC or in response to a petition presented to the President of the Medical Staff and signed by twenty percent (20%) of the active staff. No business shall be transacted at any special meeting, except that for which the meeting is called and stated in the notice of such meeting.

ARTICLE VIII - COMMITTEE MEETINGS

8.1 Regular Meetings

Medical Staff committees may, by resolution, establish the time for holding regular meetings.

8.2 Special Meetings

A special meeting of any committee may be called by or at the request of the committee chair or by the President of the Medical Staff.

8.3 Notice of Meetings

Written, electronic, or oral notice stating the place, day and hour of any special meeting or any regular meeting, shall be provided to each member of the committee that is to attend.

8.4 Quorum

A quorum for the MEC is 50% of voting members. For all other Medical Staff committees, unless otherwise specified in these Bylaws, a quorum will be those active attending staff members present, so long as at least two (2) members are present.

Once a quorum is present at a meeting, the failure to maintain a quorum throughout the meeting shall not preclude any subsequent action from being taken at that meeting.

Except as stated otherwise in these Bylaws, votes will be cast in person unless specified by the committee chair.

8.5 Manner of Action

A simple majority of the votes of the members present at a committee meeting at which a quorum exists shall approve an action of such committee. Action may not be taken without a meeting and a quorum; however, an electronic meeting may be held with consent of two thirds of the voting members of the committee. At such electronic meeting, a quorum will consist of fifty percent (50%) of the voting members for an action to be passed.

8.6 Minutes

Minutes of the meetings of Medical Staff and its committees and shall be prepared, including a record of the members in attendance and the results of any votes taken at the meeting. The presiding officer shall sign the minutes and copies shall be submitted to the attendees for approval. All minutes shall be made available to the MEC. Each Medical Staff committee shall maintain a permanent file of minutes and attendance..

8.7 Attendance Requirements

Members of Medical Staff committees are expected to attend at least seventy-five percent (75%) of committee meetings held each year. Failure to meet the attendance requirements of these committees will make the member eligible for removal by action of the President of the Medical Staff with ratification by the MEC.

ARTICLE IX - GENERAL PROVISIONS

9.1 Medical Staff Rules and Regulations and Policies

Subject to approval by the Board the Medical Staff shall adopt such Rules and Regulations and policies as may be necessary to carry out the responsibilities and functions of the Medical Staff and implement its operations. There shall be no substantive distinction between Medical Staff Rules and Regulations, and policies.

9.2 Payment of Fees and Dues

All members of the Medical Staff, APP's, PA-C's and Psychologists are required to pay any initial appointment fees, annual dues, and any accrued reappointment late fees. Failure to pay Medical Staff dues will cause the member to be considered not in good standing.

9.3 Conflict of Interest

All members of the Medical Staff are required to abide by any conflict of interest policies adopted by the Medical Staff and the Hospital in compliance with all regulatory agency requirements. In any instance in which a member of a committee has a conflict of interest in any matter that comes before that committee, that member, that member shall not participate in the discussion or vote on the matter and shall recuse himself from the meeting during that time.

9.4 Peer Review Body

The MEC, the Board, Medical Staff committees, or any group or body of Medical Staff members and/or Hospital personnel which monitors, evaluates, and/or takes action to review the credentials of Practitioners or to improve the delivery, quality, safety and/or efficiency of services provided by members of the Medical Staff and other Practitioners credentialed by The Hospital shall be considered, for purposes of protecting confidential information and providing immunity from liability under applicable law, a Peer Review Body as defined under applicable New Jersey law.

The files, records, findings, opinions, recommendations, evaluations, and reports of such committees and bodies, information provided to or obtained by such committees and bodies, and the identity of persons providing information to such committees or bodies, to the fullest extent permitted by law, shall be considered to be privileged and confidential information.

The members of such committees and bodies, persons acting as staff to such committees and bodies, persons who participate with or assist such committees or bodies, and such committees and bodies themselves, to the fullest extent permitted by law, shall be immune from liability for actions taken or recommendation made within the scope of the functions of the committee or body.

9.5 Joint Conference

Whenever the Board's proposed decision will be contrary to a recommendation of the MEC, the Board shall submit the matter to a Joint Conference of an equal number of Medical Staff and Board members for review and recommendation before making the Joint Conference's final decision and giving notice of that final decision. Individuals participating in a Joint Conference will be appointed by the President of the Medical Staff and Chair of the Board.

The MEC, the Board, or the Hospital CEO may also request the convening of a Joint Conference to discuss any matter of controversy or concern that would benefit from enhanced dialogue between Medical Staff, Hospital, and Board leaders.

ARTICLE X - ADOPTION AND AMENDMENT OF MEDICAL STAFF GOVERNING DOCUMENTS

10.1 Formulating and Reviewing Bylaws Amendments

The Medical Staff shall have the responsibility to formulate, review at least annually, and recommend to the Board any Medical Staff Bylaws amendments as needed, which shall be effective when approved by the Board. Neither the Board nor the Medical Staff shall unilaterally amend the Medical Staff Bylaws.

10.2 Methods of Adoption and Amendment to Volume I, (Medical Staff Governance, Structure and Function) and the Volume II (Corrective Action & Fair Hearing Manual) of these Bylaws

a. Proposed amendments to the Medical Staff Bylaws (Volume I or II) may be offered for consideration by any Medical Staff Committee, member of the active Medical Staff, or by the MEC.

b. The MEC will consider proposed Bylaws changes after hearing the recommendation of its Bylaws Committee.

c. The MEC shall vote on proposed amendments at a regular meeting, or at a special meeting called for such purpose if such proposals are compliant with Joint Commission standards and regulatory requirements. Following an affirmative vote by the MEC, all active members of the Medical Staff shall receive a description of the proposed amendment(s) by email. At least seven (7) days following this dissemination of the proposed amendment, all eligible members of the Medical Staff will be asked to vote on the proposed amendment(s). This vote may be conducted via electronic ballot in a manner determined by the MEC. To be adopted, the proposed amendment(s) must be affirmed by a majority of the members of the Medical Staff in the active category who cast votes and the Board must subsequently ratify the amendment.

d. If the MEC does not vote affirmatively to present a proposed amendment for vote by the Medical Staff, individuals supporting the amendment can nevertheless request such a vote by presenting the President of the Medical Staff with a supportive petition signed by twenty-five percent (25%) of the active members of the Medical Staff. Upon receiving such a petition, the President of the Medical Staff will proceed to arrange a vote by the entire active Medical Staff following the procedures above for an amendment proposal voted on affirmatively by the MEC.

e. In cases of documented need for an urgent Bylaws amendment in order to comply with law or regulation, the MEC may provisionally adopt and the Board may provisionally approve such urgent amendment without prior notification of the Medical Staff. In such cases the Medical Staff will be immediately notified by the MEC and a Medical Staff vote on the amendment will be held as soon as practicable.

10.3 Technical/Legal Changes to Medical Staff Documents

The MEC may adopt such changes to Medical Staff Bylaws, rules, regulations, and policies that are, in the committee's judgment, technical or legal modifications or clarifications, consist of reorganization or renumbering of material, or are needed due to punctuation, spelling, or other errors of grammar or expression. Such amendments made to the Medical Staff Bylaws must be ratified by the Board.

10.4 Adoption of the Bylaws

These Bylaws, upon adoption by the Medical Staff, shall replace and supersede existing Bylaws and shall become effective when approved by the Board. They shall, when adopted and approved, be equally binding on the Board and the Medical Staff.

Adopted by:
Medical Staff: December 2013
Hospital Board of Directors: January 2014