MEDICAL STAFF BYLAWS OF GENESIS MEDICAL CENTER, **DAVENPORT CAMPUS**:

Credentialing Manual

ADOPTED: December 5, 2013

Accredited by The Joint Commission

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DEFINITIONS

The definitions set forth in the Medical Staff Governance and Organization Manual shall apply to this Credentialing Manual unless otherwise indicated.

ARTICLE 1. CREDENTIALING PROCESS AND APPLICATION REQUIREMENTS

1.1. Application

1.1-1. Process

It is the Hospital's policy to process applications for Medical Staff membership and/or clinical privileges in accordance with the requirements set forth in the Bylaws, including this Credentialing Manual, only after Medical Staff Affairs has obtained a completed and verified application.

The Medical Staff, with the assistance of Medical Staff Affairs, through its designated Departments, Committees, and Officers, shall investigate and consider each application for Medical Staff membership and/or clinical privileges and shall adopt and forward related recommendations to the Medical Review Committee of the Governing Board ("MRC"). Practitioners in medico-administrative positions who desire Medical Staff membership and/or clinical privileges are subject to the same procedures as all other applicants applying for appointment and/or clinical privileges.

In the case of applications for initial appointment to the Medical Staff and/or clinical privileges, and for new or additional clinical privileges, the request must be compatible with any policies, plans or objectives formulated by the Governing Board concerning: (i) the Hospital's current and projected patient care needs; (ii) the Hospital's ability to provide the facilities, equipment, personnel, and financial resources that will be necessary if the application is approved; (iii) the Hospital's decision to contract exclusively for the provision of certain medical services with a practitioner or group of practitioners other than the applicant.

1.1-2. Application Request Form

Any individual seeking Medical Staff membership and/or clinical privileges must submit a request in writing to Medical Staff Affairs for an application request form and enclose a copy of his or her current curriculum vitae and any additional or supporting information requested as part of the Hospital's pre-application process. A dated application request form will be mailed in response to the individual. Application request forms shall only be accepted from an individual if the form is completed and returned to Medical Staff Affairs within thirty (30) days from the date the form was initially mailed. Once an application request is accepted, the individual will be considered a pre-applicant. Incomplete application request forms will be returned by Special Notice to the individual. If a completed application request form is not submitted to Medical Staff Affairs within thirty (30) days of the date the form was returned to the individual, the form shall be considered automatically withdrawn.

1.1-3. Receipt of Application Request Form

If Medical Staff Affairs determines that the pre-applicant has provided satisfactory and complete responses in the application request form, Medical Staff Affairs will forward an application packet to the pre-applicant. The application packet will include a Hospital prescribed application, a letter setting forth basic threshold criteria for Medical Staff membership and/or clinical privileges, a clinical privilege delineation overview, and clinical privilege request form(s) including specific criteria for clinical privileges. The pre-applicant will also be given a copy of, or access to, a copy of the Medical Staff Bylaws, other Hospital and Medical Staff policies relating to clinical practices in the Hospital, the Hospital Corporate Bylaws and the Hospital Corporate Compliance Plan. Pre-applicants who are denied an application will receive a written response to his or her request by Special Notice, explaining the reason or reasons for the denial, including any reasons based in whole or in part on the pre-applicant's qualifications or any other basis.

1.2. Content of Application for Medical Staff Membership and/or Clinical Privileges

Each applicant shall provide the following information at the time of application for Medical Staff membership and/or clinical privileges or for clinical privileges only:

1.2-1. Current Licensure and Controlled Substance Registration

Documentation of satisfaction of the licensure and controlled substance registration qualifications set forth in the Bylaws. The applicant's current licensure shall be verified with the primary source by a letter or computer printout obtained from the appropriate state licensing board or from any state licensing board if in a federal service. Verification through the primary source internet site or by telephone is also acceptable, if this verification is documented.

1.2-2. Education, Training, and Experience

Documentation of experience and satisfaction of the education and training qualifications set forth in the Bylaws. The applicant's education, training, and experience shall be verified with the primary source(s), whenever feasible. Verification shall be in the form of letters from professional schools or residency or postdoctoral programs. Information from credentials verification organizations, such as the American Medical Association's Physician Masterfile, may also be used. For applicants who have just completed training in an approved residency or postdoctoral program, a letter from the program director is sufficient.

Verification will also be required for any additional course work specified in the delineation of clinical privileges such as BLS, ACLS, PALS, etc.

1.2-3. Board Certification

Documentation of satisfaction of the qualifications regarding board certification set forth in the Bylaws and detailed in the applicable delineation of clinical privileges.

1.2-4. Current Competence

Evidence of current competence. The applicant's current competence shall be verified in writing by individuals personally acquainted with the applicant's professional and clinical performance, either in teaching facilities or in other hospitals. Verification shall be obtained from the primary source(s) in the form of letters from authoritative sources,

which address scope and level of performance, clinical performance, the satisfactory discharge of professional obligations as a medical staff appointee, and ethical performance. Whenever possible, letters should also address the types of operative procedures performed, including appropriateness and outcomes, or types and outcomes of medical conditions managed by the applicant.

1.2-5. Ability to Perform the Clinical Privileges Requested

A statement that the applicant is able to competently perform the clinical privileges requested, with or without reasonable accommodation, according to accepted standards of professional performance. This statement must be documented in the applicant's credentials file and confirmed by the director of a training program, by the appropriate medical staff leader at another hospital at which the applicant holds clinical privileges or by a currently licensed physician designated by the Hospital.

1.2-6. Peer Recommendations

Names and addresses of at least two (2) practitioners of the same specialty who have recently worked with the applicant and directly observed his or her professional performance and conduct over a reasonable period of time, who can and will provide reliable information regarding the applicant's current clinical ability, ethical conduct, character, and ability to work with others.

1.2-7. Professional Sanctions

The nature and specifics of any denial, non-renewal, voluntary or involuntary relinquishment (by resignation, expiration or revocation/termination), suspension, limitation(s), reduction, removal, cancellation, sanctions/corrective action, investigations or challenges regarding:

a) Medical Staff membership or clinical privileges at another hospital/health care facility or on a managed care organization's panel.

b) Any professional license or certificate to practice in Iowa or any other state or country; or any controlled substances registration.

c) Appointment or fellowship in a local, state or national organization.

d) Specialty board certification or eligibility.

e) Faculty appointment at any professional school.

f) Professional Liability Insurance.

g) Participation in any federal health care program.

1.2-8. Professional Liability Insurance

Proof of professional liability insurance and claims history.

1.2-9. Request

The Medical Staff category and/or clinical privileges requested.

1.2-10. Legal/Criminal Actions

The status and, if applicable, resolution of any past or current criminal charges against the applicant (other than routine traffic tickets).

1.2-11. Regulatory Actions

Information as to whether the applicant has been the subject of investigation by a federal health care program and, if so, the outcome of such investigation.

1.2-12. Proof of Identity

A form of government-issued photo identification must be provided to verify that he/she is, in fact, the individual requesting membership and/or clinical privileges. The photo will be maintained in the applicant's file for identification purposes but will not be distributed with the application during the review process.

1.2-13. Conflict of Interest

Applicants shall comply with the requirements of the Hospital's conflict of interest policy, if any.

1.2-14. Other

Such other information as identified in the application and/or requested by the MRC or Governing Board.

1.2-15. Signature

The applicant's signature on the completed application for Medical Staff membership and/or clinical privileges.

1.3. Attestation

Each applicant must sign the application and in doing so:

a) Attests to the correctness and completeness of all information furnished;

b) Signifies a willingness to appear for interviews in connection with the application;

c) Agrees to abide by the terms of the Hospital and Medical Staff Bylaws, Rules and Regulations, and Policies and Procedures if granted membership and/or clinical privileges, and to abide by the terms thereof and/or all matters relating to consideration of the application without regard to whether or not membership and/or clinical privileges are granted;

d) Agrees to maintain an ethical practice and to provide continuous care to patients;

e) Authorizes and consents to Hospital representatives consulting with prior associates or others who may have information bearing on professional or ethical qualifications and competence and consents to their inspecting all records and documents that may be material to evaluation of said qualifications and competence, including obtaining necessary professional and criminal background information;

f) Releases from any liability all those who, in good faith, and without malice, review, act on or provide information regarding the applicant's competence, professional ethics, character, health status, and other qualifications for Medical Staff membership and clinical privileges; and

g) Agrees to fulfill all obligations applicable to their Medical Staff membership and/or clinical privileges status.

1.4. Verification of Information/Burden

The applicant shall have the burden to produce adequate information for a proper evaluation of the applicant's licensure status, experience, education, background, training, current competence, demonstrated ability, physical and mental health status, emotional stability, character, and judgment, and of resolving any doubts about these or any of the other basic qualifications specified or referenced throughout the Bylaws. Determinations regarding the adequacy or

All information required to be provided or disclosed, including supplemental requests by the Department, Credentials Committee, MEC, MRC or Governing Board, must be provided within one hundred twenty (120) days of the application submission. Exceptions due to circumstances beyond the control of the applicant may made by the MEC in its sole discretion. If an applicant fails to meet this burden, his or her application will be deemed withdrawn, and the applicant will not be eligible to submit a new application for a period of six (6) months from the date the initial application was deemed to be withdrawn. Applications following a previous withdrawal will be processed according to the initial application procedures described in this Credentialing Manual.

In the event that it is not feasible to obtain information from a primary source, the following designated equivalent sources may be accepted in the sole discretion of the MEC:

1.4-1. The American Medical Association (AMA) Physician Masterfile for verification of a Physician's medical school graduation and residency completion, and the American Board of Medical Specialties (ABMS) for verification of a Physician's board certification.

1.4-2. The Educational Commission for Foreign Medical Graduates (ECFMG) for verification of a Physician's graduation from a foreign medical school, and the American Osteopathic Association (AOA) Physician Database for predoctoral education.

1.4-3. The AOA Physician Database for predoctoral education accredited by the AOA Bureau of Professional Education, postdoctoral education approved by the AOA Council on Postdoctoral Training or Osteopathic Specialty Board Certification.

In addition to verifying all information required or requested under the Bylaws, the Hospital will: (a) query the National Practitioner Data Bank; and (b) query the Office of Inspector General's (OIG) Cumulative Sanction report, and any other appropriate sources to determine whether the

applicant has been convicted of a health care related offense or debarred, suspended, excluded or otherwise made ineligible for participation in a Federal Health Care Program.

1.5. Transmittal for Evaluation

Medical Staff Affairs shall, after determining that the application is complete and all pertinent materials have been secured, present the credentials file to the Chairperson of each Department in which the applicant seeks clinical privileges for review in accordance with the credentialing process set forth in Article 2 below.

ARTICLE 2. PROCEDURES FOR INITIAL APPOINTMENT AND/OR CLINICAL PRIVILEGES

2.1. Department Action

Upon receipt of the above information, the Department Chairperson(s) shall initially review the application and all supporting materials furnished by the applicant. The Department Chairperson has the discretion to call a meeting with the Credentials Committee or other members of the Department to assist the Chairperson in the credentialing and privileging process, and conduct an interview with the applicant. As soon as practicable, but not more than thirty (30) days after receiving the application, the Chairperson shall transmit a written recommendation on the prescribed form, including delineated clinical privileges, to the Credentials Committee or its designee. The recommendation should address whether the requested appointment and/or clinical privileges be either granted, denied, modified, including whether there are any Department specific input for the Credentials Committee or MEC to consider.

2.2. Credentials Committee Action

The Credentials Committee is responsible for confirming both the personal and professional qualifications of the applicant. Within ninety (90) days of receipt of the recommendation of the primary Department Chairperson and after complete evaluation of all elements of the application, the Credentials Committee shall make a written recommendation to the MEC concerning the application for appointment to the Medical Staff and/or clinical privileges. In arriving at its decision, the Credentials Committee may ask the applicant for an interview or request further documentation. The Credentials Committee may extend the period of time for its recommendation pending receipt of requested information. The recommendation shall be either to accept, reject or modify the application and/or requested clinical privileges.

2.3. Medical Executive Committee Action

At its next regular meeting, the MEC shall consider the application for appointment, related documentation, and recommendations of the Department Chairperson(s) and Credentials Committee. Upon completion of its review, the MEC shall take one of the following courses of action:

2.3-1. Deferral:

A decision by the MEC to defer action regarding the application for further consideration must, within forty-five (45) days, be followed by a subsequent recommendation to grant or deny the request for Medical Staff membership and/or clinical privileges. The

President of the Medical Staff shall promptly send the applicant written notice of a decision to defer action on the application.

2.3-2. Favorable Recommendation:

When the recommendation of the MEC is favorable to the applicant, a written report and recommendation regarding, as applicable, the membership, Medical Staff category, Department assignment, clinical privileges, and/or any special conditions to be attached to the membership and/or clinical privileges shall then be forwarded to the MRC. The reasons for each recommendation shall be stated and supported by reference to the completed application and related documentation, all of which shall be transmitted with the report.

2.3-3. Adverse Recommendation:

When the recommendation of the MEC is adverse to the applicant, the President of the Medical Staff shall so inform the applicant by Special Notice, and the applicant shall then be entitled to the procedural rights, if applicable, set forth in the Corrective Action and Fair Hearing Plan. No adverse recommendation shall be required to be forwarded to the MRC until after the applicant has exercised or has been deemed to have waived his or her right to a hearing, if any, as provided for in the Corrective Action and Fair Hearing Plan.

2.3-4. After Procedural Rights:

In the case of an adverse recommendation by the MEC or adverse decision by the MRC, the Governing Board shall take final action in the matter only after the applicant has exhausted or has waived his/her procedural rights, if any, as provided for in the Corrective Action and Fair Hearing Plan.

2.4. Governing Board Action

At its next regular meeting after receipt of the recommendation of the MEC, the MRC shall either accept the recommendation or refer the recommendation back to the MEC for further action stating its reasons.

a) Upon a favorable MEC recommendation: The MRC may accept or reject, in whole or in part, an MEC recommendation that is favorable to the applicant. If the recommendation is accepted, the Hospital Administrator or designee shall notify the applicant of membership and/or clinical privileges. If the MEC recommendation is favorable to the applicant and the MRC rejects the recommendation, the matter shall be referred to the Joint Conference Committee for further consideration. A Joint Conference Committee recommendation shall be sent to the MRC for final consideration of the application within sixty (60) days of the date of referral by the MRC. The Joint Conference Committee is not binding upon the MRC. If the proposed action of the MRC provides a right to hearing and/or appellate rights as set forth in the Corrective Action and Fair Hearing Plan, the Hospital Administrator shall give the applicant Special Notice of the adverse action as more fully described in the Corrective Action and Fair Hearing Plan.

b) Upon adverse MEC recommendation: If the MEC recommendation is adverse to the applicant, in whole or in part, the Governing Board shall take final action on the application only after the applicant has exhausted or waived his procedural rights as provided for in the Corrective Action and Fair Hearing Plan.

2.4-1. Notice of Final Decision

Notice of the Governing Board's final decision shall be given to the applicant by means of Special Notice from Hospital Administrator or designee. A decision and notice to grant membership and/or clinical privileges shall include, as applicable:

a) The Medical Staff category to which the applicant is appointed.

b) The Department (s) to which he/she is assigned.

c) The clinical privileges he/she may exercise.

d) Any special conditions attached to the membership and/or clinical privileges.

2.4-2. Time Periods for Processing

Transmittal of the application form to an applicant and his/her return of it shall be carried out in accordance with this Manual. The Credentials Committee, the MEC, MRC and the Governing Board shall strive to complete their activities in connection with membership and/or clinical privileges in a timely fashion.

ARTICLE 3. PROCEDURES FOR REAPPOINTMENT AND/OR RENEWAL OF CLINICAL PRIVILEGES

3.1. Application for Reappointment/Renewal

Medical Staff Affairs or a designated System credentialing verification organization resource shall, not less than one hundred twenty (120) days prior to the expiration date of a Medical Staff membership and/or expiration of clinical privileges, provide such practitioner with an appropriate reappointment or renewal application form for use in considering reappointment and/or renewal of clinical privileges. Each practitioner who desires reappointment or renewal shall, not less than ninety (90) days prior to such expiration date, send a completed reappointment/renewal application form to Medical Staff Affairs or centralized system resource, as appropriate. Failure to return the form within the time required shall be deemed a voluntary resignation from the Medical Staff and shall result in the automatic relinquishment of Medical Staff membership and/or clinical privileges at the expiration of the practitioner's current term. A practitioner who fails to comply with any of the reappointment or renewal requirements as specified in the Medical Staff Bylaws must reapply for Medical Staff membership or clinical privileges pursuant to the initial appointment process.

3.2. Content of Reappointment/Renewal Application Form

The content of the reappointment/renewal application form shall include, but not be limited to, the requested information set forth in Section 1.2 of this Credentialing Manual

3.2-1. Processing of Reappointment and/or Renewal of Clinical Privileges

a) Reappointment Burden

The practitioner shall have the same burden of producing adequate information and resolving doubts as provided in Section 1.4 of this Credentialing Manual.

b) Verification of Information

The Hospital and Medical Staff shall in a timely fashion, in conjunction with Medical Staff Affairs or its designee, seek to collect and verify all information made available on each reappointment application form and to collect any other materials or information required or deemed pertinent, including, but not limited to National Practitioner Data Bank and Healthcare Integrity and Protection Data Bank information, and information regarding the practitioner's professional activities, performance and conduct in the Hospital and fulfillment of Medical Staff membership and/or clinical privileges obligations, including fulfillment of Medical Staff, Department, and Committee responsibilities, as applicable. The Hospital may also request from the Iowa Medical Licensing Board information concerning the licensure status and any disciplinary action taken against a practitioner's license. The practitioner shall be promptly notified of any problems in obtaining the required information. Upon receipt of the completed reappointment/renewal application form, the President of the Medical Staff or designee shall transmit the form and all other supporting materials to the Chairperson of each Department in which the practitioner requests clinical privileges.

c) Department Action

The Department Chairperson shall review the prescribed reappointment/renewal form, all supporting materials furnished by the practitioner and all such other information and materials as deemed appropriate, including any performance distinction and other quality or peer review reports pertaining to the practitioner. The Department Chairperson may interview the practitioner and/or consult with other members of the Department and the Credentials Committee to assist the Chairperson in this credentialing and privileging process. As soon as practicable, but not more than thirty (30) days after receiving the prescribed reappointment/renewal form, the Chairperson shall transmit on the prescribed form written recommendations, including delineated clinical privileges, to the Credentials Committee that the requested reappointment and/or clinical privileges be renewed or that the requested reappointment be renewed with modified Medical Staff category and/or Department affiliation and/or clinical privileges or that the appointment and/or clinical privileges be terminated.

d) Credentials Committee, MEC, MRC and Governing Board Action

Thereafter, the procedures provided in Article II of this Credentialing Manual shall be followed. For purposes of reappointment or renewal, the term "appointment" as used in those Sections shall be read as "reappointment."

e) Basis for Recommendations

Each recommendation concerning the reappointment of a Medical Staff member and the clinical privileges to be granted upon reappointment shall be based upon documented evidence of such practitioner's eligibility, professional ability and clinical judgment in the treatment of patients, professional ethics, discharge of Medical Staff, Department and clinical privileges obligations, compliance with the Medical Staff Bylaws, the Hospital Corporate Compliance Plan, applicable Hospital policies, cooperation with other practitioners and with patients, the practitioner's health status (subject to applicable law), the practitioner's reasonable participation in continuing education activities relevant to their clinical privileges, and other matters bearing on ability and willingness to contribute to quality patient care in the Hospital. A practitioner's eligibility for reappointment of membership and/or renewal of clinical privileges will also be based on compliance with the minimum number of patient contacts per each appointment/clinical privileges period as required by the applicable Medical Staff category qualifications and/or established by the member's Department and Governing Board for the purpose of verifying clinical activity, clinical competence, and engagement in Medical Staff Affairs.

3.3. Modification of Appointment and/or Clinical Privileges

3.3-1. A practitioner may, either in connection with reappointment/renewal of clinical privileges or at any other time, request modification of his/her Medical Staff category, Department assignment or clinical privileges by submitting a written request, on the prescribed form, to Medical Staff Affairs. Modification requests shall be processed in substantially the same manner as provided in this Article for reappointment/renewal of clinical privileges.

3.3-2. A recommendation for new privileges shall carry with it focused professional practice evaluation requirements for supervision, consultation or other conditions for a specific period of time and/or for a specific number of cases as deemed necessary and appropriate by the applicable Department Chairperson to determine clinical competency.

3.4. Option to Expedite Reappointment/Renewal

3.4-1. Expedited Review

In the event that an applicant seeking reappointment and/or clinical privileges evidences or demonstrates the basic qualifications set forth in the Bylaws, has submitted a complete reapplication form and supporting documents, and otherwise meets all applicable criteria and any applicable regulatory and accrediting agencies' standards for expedited review, the Chairperson of the appropriate Department may initiate an expedited review process by assessing the reappointment application and forwarding a recommendation directly to the Chairperson of the Credentials Committee, requesting that the application be expedited. The Chairperson of the Credentials Committee may review the application and, if recommending the application for approval, may forward the application directly to the President of the Medical Staff. The President of the Medical Staff, in conjunction with two (2) members of the MEC, may then review the application, and if unanimously recommending the application for approval, may forward the application to the Governing Board or designee to review the application and take final action.

3.4-2. Restrictions and Objections

Applications for reappointment are usually ineligible for the expedited process if, since the time of last reappointment, any of the following has occurred: the application is incomplete; the applicant has a current challenge or a previously successful challenge to licensure or registration; the applicant has received an involuntary termination of medical staff membership at another organization; the applicant has received involuntary limitation, reduction, restriction, denial, loss of clinical privileges or is otherwise under current focused peer review or investigation; there has been a final judgment that is adverse to the applicant in a professional liability action; or there is a reasonable concern about the applicant's health status.

If either the Chairperson of the Department, the Chairperson of the Credentials Committee, the President of the Medical Staff and MEC members or the Governing Board or designee does not believe an application for reappointment should be expedited, for any reason, the prescribed application procedure set forth in this Credentialing Manual shall be followed. All applicants must satisfy the criteria and standards for Medical Staff membership and/or clinical privileges set forth in the Bylaws.

ARTICLE 4. DETERMINATION OF CLINICAL PRIVILEGES

4.1. Exercise of Clinical Privileges

Every practitioner providing clinical services within Hospital facilities must be granted appropriate clinical privileges to do so, and shall be entitled to exercise only those clinical privileges as are specifically granted pursuant to the provisions of the Bylaws and this Manual. Specific requests for clinical privileges, accompanied by information supporting these requests, will be included in the practitioner's application which is submitted to the clinical Department(s) in which the applicant seeks clinical privileges for review and evaluation as provided in section 2.2-4.

4.2. Clinical Privileges Requests

A request by a practitioner for clinical privileges must be submitted on the Hospital prescribed form(s) accompanied by documentation of training, experience, and other required information supportive of the request. A practitioner must submit a specific request for temporary privileges or modification of clinical privileges in the interim between reappraisals.

A Medical Staff member with clinical privileges wishing a change in clinical privileges shall make written application to the Department Chairperson stating the privileges desired and justification for the change. The Department Chairperson of designee shall evaluate the request and make a recommendation to the Credentials Committee. The Credentials Committee shall forward its written recommendation to the MEC within sixty (60) days and the MEC shall act on the request at its next meeting. The recommendation shall be forwarded to the MRC for action at its next meeting. An adverse recommendation by the MEC or decision by the MRC entitle the practitioner to the procedural rights set forth in the Corrective Action and Fair Hearing Plan.

4.3. Basis for Clinical Privileges Decisions

Recommendations re clinical privileges shall be based upon satisfaction of the qualifications set forth in the Bylaws and applicable Medical Staff and Governing Board approved policies and criteria, in addition to proof of general competency in the areas of patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills,

professionalism, and system-based practice consistent with the Bylaws, this Manual applicable Hospital and Medical Staff policies.

The Hospital will evaluate and process valid requests for Clinical privileges in accordance with the procedures set forth in Article I or II of this Manual, as applicable. Requests for temporary privileges shall be processed in accordance with Section 4.7.

4.4. New Technology or New Procedures

All requests for clinical privileges that involve the use of new technology or a new treatment protocol are processed by the procedures and standards set forth in the then current Medical Staff policy for Developing Privilege Criteria.

4.5. Special Conditions for Dental Privileges

4.5-1. Dentists may be granted privileges to admit patients to the Hospital for dental surgery. Patients admitted for dental care shall be admitted to the Department of Surgery and shall be the responsibility of the admitting dentist.. A responsible physician member of the Active Staff shall be identified by the dentist, if applicable, before admission of his/her patient for surgery. All dental patients shall receive the same basic medical appraisal as patients admitted to other Departments.

4.5-2. Each dentist is responsible for the dental care of the patient including the dental history and examination, operative report, diagnosis, discharge summary, and all other appropriate elements of the patient's record. A physician member to the Active Staff shall be responsible for completing the medical history and physical examination (with the exception noted in Section 4.5-3), for the care of any medical problem present at the time of admission or that may arise during hospitalization, and shall determine the risk and effect of the proposed surgical procedure on the total health status of the patient.

4.5-3. Services performed by dentists shall be under the general supervision of the Chairperson of the Department of Surgery.

4.6. Special Conditions for Podiatric Privileges

4.6-1. Podiatrists may be granted clinical privileges to admit patients to the Hospital for podiatric surgery. Patients admitted for podiatric care shall be admitted to the Department of Surgery and shall be the responsibility of the admitting podiatrist. A responsible physician member to the Active Staff shall be identified by the podiatrist before admission of his/her patient for surgery. All podiatric patients shall receive the same basic medical appraisal as patients admitted to other Departments.

4.6-2. Each podiatrist is responsible for the podiatric care of the patient, including the podiatric history and examination, diagnosis, operative report, discharge summary, and all other appropriate elements of the patient's record. A physician member to the Active Staff shall be responsible for completing the medical history and physical examination (with the exception noted in Section 4.6-3), for the care of any medical problem present at the time of admission or that may arise during hospitalization, and shall determine the risk and effect of the proposed surgical procedure on the total health status of the patient.

4.6-3. A podiatrist, if granted the clinical privilege to do so, may complete the history and physical examination for his/her patient and may assess the medical, surgical and anesthetic risks of the proposed operation or other procedure.

4.6-4. Services performed by podiatrists shall be under the general supervision of the chair of the Department of Surgery.

4.7. Temporary Clinical Privileges

4.7-1. Temporary clinical privileges may be granted for the circumstances and under the conditions set forth below for a limited period of time, not to exceed one hundred twenty (120) days. A practitioner shall exercise such clinical privileges under the supervision of the Chairperson of the Department to which he/she is assigned. Special requirements of consultation and reporting may be imposed by the Department Chairperson responsible for supervising a practitioner who has been granted temporary clinical privileges. A practitioner requesting temporary clinical privileges must acknowledge in writing that he/she has received or has access to, a copy of the Bylaws, Rules & Regulations, and applicable Hospital and Medical Staff policies, and that he/she agrees to be bound by such documents in all matters relating to the exercise of his/her temporary clinical privileges.

4.7-2. The Hospital Administrator may, upon recommendation of the MEC, grant temporary clinical privileges on a case-by-case basis in the following circumstances:

a) Pendency of a Completed Application. Temporary clinical privileges may be granted to an applicant for new or additional clinical privileges by the Administrator upon review and recommendation by the applicable Department Chairperson, and Credentials Committee while awaiting review and approval by the MEC and Governing Board, provided that the applicant has submitted a completed application without any negative or adverse information and there is verification of:

(i) Current licensure.

(ii) Relevant education, training, and experience.

(iii) Demonstrated current competence/ability to perform the privileges requested.

(iv) Receipt of professional references (to include information regarding current competence) and applicable database profiles (*e.g.* AMA/AOA).

(v) Satisfaction of other criteria required by the Bylaws/this Manual.

(vi) Completion of a query to the National Practitioner Data Bank and evaluation of information therefrom.

(vii) Completion of a query to the Office of the Inspector General.

(viii) Current Professional Liability Insurance coverage.

(ix) That the applicant has no current or previously successful challenge to his/her licensure or registration.

(x) That the applicant has not been subject to the involuntary termination of Medical Staff membership at another organization.

(xi) That the applicant has not been subject to the involuntary limitation, reduction, denial or loss of clinical privileges.

b) Urgent Patient Care Need. Temporary privileges may also be granted to a practitioner to meet an urgent patient care need by the Administrator upon review and recommendation by the applicable Department Chairperson, and Credentials Committee upon verification of: current licensure; education; demonstrated current competence relative to the privileges being requested; receipt of professional references (to include information regarding current competence) and applicable database profiles (*e.g.* AMA/AOA); and, completion of a query to the National Practitioner Data Bank and Office of Inspector General, and evaluation of information therefrom.

Temporary clinical privileges shall be granted only when the information available reasonably supports a favorable determination regarding the requesting applicant's qualifications with respect to the clinical privileges requested. Under no circumstances will temporary privileges be initially granted or renewed if the application is still pending because the applicant has not responded in a satisfactory manner to a request for clarification of a matter or for additional information.

4.8. Emergency Privileges

For the purposes of this Section, an "emergency" is defined as a situation in which there is an imminent risk of serious or permanent harm or death to a patient and any delay in administering treatment would add to that risk. In the case of an emergency, any practitioner, to the degree permitted by his/her license, regardless of Department, Medical Staff status or clinical privileges, shall be permitted to do, and shall be assisted by Hospital personnel in doing, everything possible to save the patient from serious or permanent harm or death. A practitioner exercising emergency privileges must obtain all consultative assistance deemed necessary and arrange for appropriate post-emergency care.

4.9. Disaster Privileges

4.9-1. Practitioners (volunteers) who do not possess clinical privileges at the Hospital may be granted disaster privileges when the emergency management plan has been activated and the hospital is unable to handle the immediate patient needs.

4.9-2. During disaster(s) in which the emergency management plan has been activated, the Hospital Administrator, President of the Medical Staff or their designee(s) may grant disaster privileges in their discretion on a case-by-case basis.

4.9-3. Disaster privileges upon presentation at a minimum of a valid government-issued photo identification issued by a state or federal agency (e.g. driver's license or passport) and at least one of the following:

a) A current picture hospital ID card that clearly identifies the individual as a resident physician or attending physician in Iowa.

b) A current license to practice in Iowa.

c) Primary source verification of Iowa license.

d) Identification indicating the individual is a member of a Disaster Medical Assistance Team (DMAT) or Medical Reserve Corp (MRC) or the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) or other recognized state or federal organization or group.

e) Identification indicating that the individual has been granted authority to render patient care, treatment and services in disaster circumstances (such authority having been granted by a federal, state or municipal entity).

f) Presentation by current hospital or medical staff member(s) with personal knowledge regarding the practitioner's identity as a currently licensed Iowa practitioner.

Practitioners with disaster privileges will be paired with a member of the Medical Staff, and will act only under the supervision of the member. Practitioners who are granted disaster privileges will be given a temporary numbered identification badge identifying them as having disaster privileges.

The credentials verification process for individuals who receive disaster privileges will begin as soon as the immediate situation is under control.

a) Primary source verification of licensure will begin as soon as the immediate situation is under control and will be completed within 72 hours from the time the volunteer practitioner presents to the organization.

b) The verification process will be the same as the process identified for granting temporary privileges to meet an important care need, and will be a high priority.

Disaster privileges will be immediately terminated in the event that any adverse information is received during the verification process or information that suggests the individual is not capable of rendering services. The practitioner's disaster privileges will be for the duration of the disaster only. They will automatically be cancelled at the end of the needed services.

A decision (based on information obtained regarding the professional practice of the volunteer) will be made within 72 hours related to the continuation of the disaster privileges initially granted.

4.10. Telemedicine Privileges

Practitioners who are responsible for the patient's care, treatment, and services via a telemedicine link shall be credentialed and privileged to do so by the Hospital in accordance with the Bylaws and this Manual, accreditation requirements, and applicable law. If the Hospital has a pressing clinical need and the practitioner can supply that service through a telemedicine link, the

practitioner may be evaluated for temporary privileges in accordance with the procedures set forth in Section 4.7.

Practitioners providing telemedicine services to Hospital patients shall be credentialed and privileged to do so through one of the following mechanisms:

a) The practitioner is credentialed and privileged by the Hospital in accordance with the applicable procedure set forth in the Bylaws and this Manual.

b) The practitioner is credentialed and privileged by the Hospital in accordance with the applicable procedure set forth in the Bylaws and this Manual with the exception that the credentialing information and/or privileging decision from the distant site may be relied upon by the Medical Staff and MRC in making its recommendations/decision provided that the Hospital has entered into a written agreement with the distant site and all of the following requirements are met:

(i) The distant site is a Medicare-certified hospital or a facility that qualifies as a "distant site telemedicine entity." A "distant site telemedicine entity" is defined as an entity that (1) provides telemedicine services, (2) is not a Medicare-certified hospital, and (3) provides contracted services in a manner that enables hospitals using its services to meet all applicable conditions of participation, particularly those requirements related to the credentialing and privileging of practitioners providing telemedicine services to the patients of the hospital.

(ii) When the distant site is a Medicare-certified hospital, the written agreement shall specify that it is the responsibility of the distant site hospital to meet the credentialing requirements of 42 C.F.R. 482.12 (a)(1)-(a)(7), as that provision may be amended from time to time, with regard to the distant site hospital practitioners providing telemedicine services.

(iii) When the distant site is a "distant site telemedicine entity" the written agreement shall specify that the distant site telemedicine entity is a contractor of services to the Hospital and, as such, furnishes the contracted services in a manner that permits the Hospital to comply with all applicable conditions of participation for the contracted services including, but not limited to, 42 C.F.R. 482.12 (a)(1)-(a)(7) with regard to the distant site telemedicine entity practitioners providing telemedicine services. The written agreement shall further specify that the distant site telemedicine entity's medical staff credentialing and privileging process and standards will, at minimum, meet the standards at 42 C.F.R. 482.12 (a)(1)-(a)(7) and at 42 C.F.R. 482.22 (a)(1)-(a)(2), as those provisions may be amended from time to time.

(iv) The individual distant site practitioner is privileged at the distant site for those services to be provided to Hospital patients via telemedicine link and the Hospital is provided with a current list of his/her privileges at the distant site.

(v) The individual distant site practitioner holds an appropriate license issued by the Iowa Medical Licensing or other appropriate licensing agency.

(vi) The Hospital maintains documentation of its internal review of the performance of each distant site practitioner and sends the distant site such performance information for use in the distant site's periodic appraisal of the distant site practitioner. At a minimum, this information must include:

a) All adverse events that result from the telemedicine services provided by the distant site practitioner to Hospital patients; and,

b) All complaints the Hospital receives about the distant site practitioner.

4.11. Termination of Temporary, Emergency or Disaster Privileges

4.11-1. Termination. The Hospital Administrator, President of the Medical Staff or their designees, may, at any time, terminate all or any portion of, a practitioner's temporary emergency, disaster or telemedicine privileges. In circumstances where an immediate danger exists, the practitioner's clinical privileges may be terminated by any person entitled to impose a summary suspension pursuant to the Corrective Action and Fair Hearing Plan.

4.11-2. Due Process Rights. A practitioner who has been granted temporary, emergency, disaster or telemedicine privileges is not a member of the Medical Staff and is not entitled to the procedural due process rights afforded to Medical Staff members and other practitioners as specified in the Corrective Action and Fair Hearing Plan. Additionally, practitioners are not entitled to the procedural due process rights set forth in the Corrective Action and Fair Hearing Plan should the practitioner's request for temporary, emergency, disaster or telemedicine privileges be refused, in whole or in part or because all or any portion of such clinical privileges are terminated, not renewed, restricted, suspended or otherwise limited, modified or monitored in any way.

4.11-3. Patient Care. In the event a practitioner's temporary, emergency, disaster or telemedicine privileges are revoked, the practitioner's patients then in the Hospital shall be assigned to another practitioner by the President of the Medical Staff or designee. The desires of the patient will be considered, where feasible, in choosing a substitute practitioner.

ARTICLE 5. RESIGNATION, TERMINATION, AND REAPPLICATION AFTER ADVERSE DECISION

5.1. Reapplication After Adverse Decision

A practitioner seeking Medical Staff appointment or reappointment and/or initial or a renewal of clinical privileges who has received a final adverse decision shall not be eligible to reapply for a period of two (2) years from the later of the date of the notice of the final adverse decision; the effective date of the resignation or application withdrawal; or the final court decision, as applicable, unless the decision, agreement or Bylaws provide otherwise. Any reapplication will be processed as an initial application, and the applicant shall submit such additional information

as the Medical Staff or the Governing Board may require in demonstration that the basis for the earlier adverse action no longer exists or is otherwise resolved.

5.2. Resignations and Terminations

5.2-1. Resignation of Medical Staff Membership and/or Clinical Privileges. Resignation of Medical Staff appointment and/or clinical privileges, and the reason for such resignation, shall be submitted to Medical Staff Affairs. Notification of the resignation shall be forwarded to all appropriate Hospital personnel and Medical Staff representatives.

5.2-2. Termination of Medical Staff Membership and/or Clinical Privileges. When a practitioner moves away from the area without submitting a forwarding address or the practitioner's written intentions with regard to his/her Medical Staff membership and/or clinical privileges are unknown during an extended absence, the practitioner's Medical Staff membership and/or clinical privileges shall be terminated after approval by the MEC and the Governing Board. If a forwarding address is known, the practitioner will be asked his/her intentions with regard to Medical Staff appointment and/or clinical privileges and, if the practitioner does not respond within thirty (30) days, the practitioner's name will be submitted to the MEC and Governing Board for approval of administrative termination. The Hospital Administrator will inform the practitioner of the approved termination by Special Notice.

ARTICLE 6. LEAVE OF ABSENCE

6.1. Request for Leave of Absence

At the discretion of the MEC for good cause shown, Medical Staff members may be granted a leave of absence from the Medical Staff by submitting a written request to the Vice President of Medical Affairs (VPMA) stating the reason and approximate period of time for the proposed leave, which may not exceed twelve (12) months or the last date of the current appointment/privilege period, whichever occurs first. Good cause may include, but are not limited to, activities or circumstances involving medical or educational reasons and sabbatical, charitable or military service.

6.2. Obligations During a Leave of Absence

During a leave of absence, the member is not entitled to exercise privileges at the Hospital, and has no appointment Prerogatives and responsibilities, with the exception that he/she must continue to pay Medical Staff dues, unless otherwise waived by the MEC. Before a leave of absence is granted, the member shall have made arrangements, acceptable to the MEC and MRC, for the care of his/her patients during the leave.

6.3. Reinstatement Following a Leave of Absence

6.3-1. Request for Reinstatement. Any member seeking reinstatement from a leave of absence must submit to the MEC, at least fifteen (15) days before termination of the leave of absence or at any earlier time, a written request for reinstatement of his/her membership and clinical privileges as well as such additional information as is reasonably necessary to reflect that the member is qualified for reinstatement or as may otherwise be requested by the MEC, including but not limited to:

a) A physician's report on the member's ability to resume practice and provide patient care at the generally recognized professional level of quality and efficiency if the member is returning from a medical leave of absence.

b) A written statement summarizing the educational activities undertaken by the member if the leave of absence was for educational reasons.

c) Proof of military status if the leave of absence was for military reasons.

6.3-2. Extension of Leave. For good cause and upon notice received not less than thirty (30) days before expiration of a leave, a member's leave may be extended by the MEC, with approval of the Governing Board, for an additional period not to exceed the final date of the member's current term or appointment and/or clinical privileges period.

6.3-3. Insurance Requirements during Leave. In order to qualify for reinstatement following a leave of absence, the member must maintain professional liability insurance coverage during the leave or purchase tail coverage for all periods during which the member held privileges at the Hospital. The member shall provide information to demonstrate satisfaction of continuing professional liability insurance coverage or tail coverage as required by this section and the Bylaws upon request for reinstatement.

6.3-4. Processing a Request for Reinstatement. When the member's request for reinstatement is deemed complete, the MEC shall, at its next regular meeting, take action on the request. If the MEC grants the request, the member may begin practicing as of the date of the MEC's decision. If the MEC denies the request, the member may have certain hearing and/or appellate review rights as more fully described in the Corrective Action and Fair Hearing Plan.

6.3-5. Failure to Request Reinstatement Following a Leave. If a member fails to request reinstatement upon the termination of a leave of absence, the MEC shall make a recommendation to the Governing Board as to how the failure to request reinstatement should be construed. If such failure is determined to be a voluntary resignation, it shall not give rise to any hearing and/or appellate review rights as set forth in the Corrective Action and Fair Hearing Plan.

ARTICLE 7. ADOPTION, AMENDMENT, REPEAL

This Credentials Manual may be adopted, amended or repealed as set forth in the Medical Staff Governance and Organization Manual.

ADOPTION AND APPROVAL

Adopted by the Medical Executive Committee on _____

_____
President of the Medical Staff

Adopted by the Board of Directors on _____

_____
Chairperson, Board of Directors