MEDICAL STAFF BYLAWS:

Credentialing Manual

May 28, 2020

Accredited by The Joint Commission
The definitions set forth in the Medical Staff Governance and Organization Manual apply to all Medical Staff governing documents unless otherwise indicated.

**ARTICLE 1: PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT OF MEMBERSHIP AND/OR PRIVILEGES**

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ARTICLE 1: PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT OF MEMBERSHIP AND/OR PRIVILEGES

Section 1.1 Pre-Application Procedures

1.1.1 Form Preparation

The Credentials Committee, with the assistance of Medical Staff Services, shall be responsible for reviewing and recommending any changes to application forms, including application request, appointment, reappointment, and updating forms. All forms and revisions thereof shall be reviewed and approved by the MEC and the Governing Board and shall conform to any applicable Montana statutes and regulations that mandate the use of particular forms or specific content.

1.1.2 Application Request Forms

Any individual seeking Medical Staff membership and/or clinical privileges must request in writing an application request form from Medical Staff Services and/or a System centralized verification resource and send 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. An application request form shall only be accepted from an individual if the form is completed and returned to Medical Staff Services within sixty (60) 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 shall be returned by Special Notice to the individual. If a completed application request form is not submitted to Medical Staff Services within sixty (60) days of the date the form was returned to the individual, the form shall be considered automatically withdrawn. Individuals who fail to return a completed application request form with the time required are not eligible to reapply for six (6) months from the date of withdrawal.

1.1.3 Receipt of Application Request Form

If Medical Staff Services determines that the pre-applicant has provided satisfactory and complete responses in the application request form, Medical Staff Services will forward an application packet to the pre-applicant. The pre-applicant shall 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, including the Ethical and Religious Directives for Catholic Health Care Services, the Hospital Corporate Bylaws, and the Hospital Corporate Compliance Plan. Any pre-applicant denied an application shall 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, including economic factors and/or need determinations.

Section 1.2 Application for Initial Appointment and/or Clinical Privileges
1.2.1 Application Form

Each application for appointment to the Medical Staff and/or clinical privileges shall be in writing, submitted on the prescribed form, and signed by the pre-applicant. Once a signed and completed application form has been received and accepted by Medical Staff Services, the pre-applicant becomes an applicant.

1.2.2 Content

The Hospital's application generally includes the following requests for information. The Hospital may supplement its application form content by general or specific requests for information.

(a) Acknowledgment and Agreement

A statement that the applicant has received or has had access to, the Hospital's Medical Staff Bylaws, Corporate Bylaws, and the Hospital's Corporate Compliance Plan, and has read them and agrees to be bound by all applicable provisions in all matters relating to consideration of his or her request for initial or continuing Medical Staff membership and/or clinical privileges.

(b) Qualifications

Detailed information concerning the applicant’s qualifications, demonstrated current competence and professional performance, including information regarding the qualifications specified in the Medical Staff Governance and Organization Manual and of any additional qualifications established by the Medical Staff or Governing Board for the particular Medical Staff category, and/or clinical privileges being requested.

(c) Requests

A request stating the Medical Staff category and clinical privileges for which the applicant desires to be considered.

(d) References

The names of at least two (2) practitioners 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 character, and ability to work with others.

(e) Professional Sanctions

Information regarding whether any of the following have ever been or are in the process of being denied, revoked, suspended, reduced, restricted, probationary, not renewed, or voluntarily relinquished or voluntarily not exercised shall be reported in detail:

(i) Medical Staff membership status and/or clinical privileges at any other
hospital or health care facility;

(ii) Membership/Fellowship in local, state or national professional organizations;

(iii) Board Certification or related Board Certification status;

(iv) License to practice any profession in any jurisdiction; and

(v) Any state Controlled Substance License or Drug Enforcement Administration Controlled Substances Registration Certificate (DEA).

(f) Additional Disclosures

The applicant shall disclose:

(i) Any and all malpractice suits, settlements and judgments to which he or she is or has been a party during the past five (5) years;

(ii) Any remedial, corrective or disciplinary action of any kind taken by any hospital, medical staff, professional organization, licensing body or governmental agency;

(iii) Any circumstance where employment, medical staff membership and/or clinical privileges, were reduced, suspended, diminished, revoked, refused, voluntarily not exercised, or limited at any hospital or other health care facility, whether voluntarily or involuntarily;

(iv) Any circumstance where he or she withdrew an application for appointment/reappointment, and/or clinical privileges, or resigned from medical staff or clinical privileges to avoid an investigation before action by a hospital's or health facility's medical staff or board;

(v) Any past disciplinary action due to inappropriate conduct, disruptive behavior, or unprofessional conduct (e.g., sexual harassment);

(vi) Any past disciplinary action, focused individual monitoring, review, or audits related to the quality of care or competency;

(vii) All other information residing in the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank;

(viii) All healthcare-related employment/appointments (work history);

(ix) All information related to the investigation, arrest, indictment, or conviction with regard to any felony or misdemeanor, excluding traffic violations. All applicants will be required to undergo a criminal background check;

(x) All information as to the applicant’s medical education and post-graduate
training; and

(xi) Any information requested on the supplemental form utilized as a part of the Medical Staff membership and/or clinical privileges application process.

(g) **Notification of Release of Immunity Provisions**

Statement notifying the applicant of the scope and extent of the authorization, confidentiality, immunity, and release provisions of Section 1.3 of this Credentialing Manual and Article 9 the Medical Staff Governance and Organization Manual.

(h) **Administrative Remedies**

A statement that the applicant agrees that if an adverse decision is made with respect to his or her Medical Staff membership status and/or clinical privileges, the applicant agrees to exhaust or waive the administrative remedies afforded by the Medical Staff Governance and Organization Manual and the Medical Staff Fair Hearing Plan before attempting to resort to formal legal action.

(i) **Financial Responsibility**

Evidence that the applicant has secured or currently maintains professional liability insurance in amounts or limits as prescribed by the Governing Board in consultation with the Medical Staff.

(j) **Obligation to Update**

The application and reapplication form includes a statement that the applicant acknowledges that he or she has the burden of providing any and all information necessary to process the application as determined in the discretion of the Credentials Committee, MEC or Governing Board; that he or she is solely responsible for supplementing his or her application during the application and reapplication process, in addition to the disclosure requirements set forth in this Credentialing Manual and the Medical Staff Governance and Organization Manual, to ensure the absolute accuracy of all statements and information contained therein as soon as this information becomes known but, in any event, before a final appointment or reappointment decision is made; and that any false or misleading information provided by a pre-applicant, applicant, Medical Staff member, or APP/AHP during the pre-application, application, appointment, reappointment, or renewal process may be treated as a voluntary relinquishment or otherwise serve as grounds for corrective action or termination of the credentialing process.

(k) **Consent to Shared Information Policy**

As a condition of membership and/or clinical privileges, the applicant agrees that any quality, peer review, and other related information that is collected as part of the appointment/reappointment or privileging process, as well as any peer review activities, may be shared with other health care organizations and entities, and
their designees, including without limitation those that are administratively and clinically affiliated with the Hospital and practitioner for purposes related to credentialing, privileging, managed care participation or other Holy Rosary Healthcare service line activities and any other health care facility or organizations at or for which the applicant seeks to practice.

Section 1.3  Effect of Application

By applying for appointment to the Medical Staff and/or clinical privileges, and in addition to any other conditions, commitments, or releases contained throughout the Medical Staff Bylaws, each applicant:

(a) Attests to the accuracy and completeness of all information on his or her application or accompanying documents and agrees that any inaccuracy, omission, or misrepresentation, whether intentional or not, maybe grounds for termination of the application process without the right to a fair hearing or appeal. Each applicant acknowledges that if a material inaccuracy, omission, or misstatement is discovered after an individual has been granted appointment and/or clinical privileges, the individual’s appointment and clinical privileges shall lapse effective immediately upon notification of the individual without the right to a fair hearing or appeal. All determinations regarding whether an accuracy, omission or misrepresentation is material in nature shall be made by the MEC in its sole discretion;

(b) Signifies willingness to appear for interviews in regard to his or her application;

(c) Authorizes Hospital and Medical Staff representatives to consult with others who have been associated with him/her and/or who may have information bearing on the applicant’s competence and qualifications;

(d) Consents to Hospital and Medical Staff representatives inspecting all records and documents that may be material to an evaluation of professional qualifications and competence to carry out the clinical privileges requested, of physical and mental health status and of professional ethical qualifications;

(e) Releases from liability extends absolute immunity to, and agrees not to sue all representatives of the Hospital and Medical Staff for their peer review and peer review committee activity, including otherwise privileged or confidential information, so long as such activity does not constitute willful and wanton misconduct, concerning the applicant’s competence, professional ethics, character, physical and mental health, emotional stability, and other qualifications for Medical Staff appointment and clinical privileges, and is performed in connection with the evaluation of and any decisions involving the applicant;

(f) Releases from any liability extends absolute immunity to and agree not to sue all
individuals and organizations who provide information pursuant to peer review and peer review committee activity, including otherwise privileged or confidential information, to Hospital and Medical Staff representatives, so long as such activity does not constitute willful and wanton misconduct, concerning the applicant’s competence, professional ethics, character, physical and mental health, emotional stability, and other qualifications for Medical Staff appointment and clinical privileges; and

(g) Authorizes Hospital and Medical Staff representatives to provide other hospitals, medical associations, the National Practitioner Data Bank, Healthcare Integrity and Protection Data Bank, licensing boards, Holy Rosary Healthcare Care affiliated entities (or its successor) other health care facilities or organizations of health professionals with any information relevant to such matters that the Hospital may have concerning him or her, and releases Hospital and Medical Staff representatives from liability for so doing.

Section 1.4 Processing the Application

All requests for Medical Staff membership and/or clinical privileges physicians, dentists, oral surgeons, podiatrists, advanced independent practitioners, and advanced dependent practitioners will be processed according to this Credentialing Manual.

Requests for clinical privileges or permission to provide patient care services by Independent and Dependent AHPs as defined in Section 3.2 of the Governance Manual will be processed and evaluated by the Hospital's Human Resources Department through its policies and procedures unless Hospital policy and the practitioner's professional license and scope of practice permits the practitioner to exercise clinical privileges or provide patient care services without direction or supervision.

1.4.1 Applicant's 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 Medical Staff Bylaws. All information required to be provided or disclosed, including supplemental requests by the Credentials Committee, MEC, or Governing Board, must be submitted within thirty (30) days of the request or when otherwise due by this
Credentialing Manual. If an applicant fails to meet this burden, the application will be deemed withdrawn, and the applicant will not be eligible to submit a new application for a period of one (1) year from the date the initial application was deemed to be withdrawn.

1.4.2 Verification of Information

The applicant shall return an application that contains all requested information to Medical Staff Services or a designated System credentialing verification organization resource (CVO), within thirty (30) days from the date the application was initially mailed; otherwise, the application shall be deemed automatically withdrawn. The Hospital and Medical Staff representatives, in conjunction with the CVO, shall, in a timely fashion, seek to collect and primary source verify the applicant's licensure history, medical education and postgraduate training, malpractice insurance history, board certification status, sanctions, and disciplinary actions, criminal history, employment/appointment history, professional references, and other qualification evidence submitted, including, but not limited to, National Practitioner Data Bank and Healthcare Integrity and Protection Data Bank information. Medical Staff Services will also request from the pertinent Licensing Board of the Montana Department of Labor and Industry all information concerning the licensure status and any disciplinary action taken against a practitioner’s license. An applicant shall be notified of any problems or omissions in obtaining the information required, and it shall then be the applicant's obligation to obtain or provide the required information. Upon receipt of the completed application, Medical Staff Services shall transmit the application and all other supporting materials to the Credentials Committee for review and action.

1.4.3 Credentials Committee Action

(a) Within sixty (60) days after the receiving the completed application, the Credentials Committee shall review the application, all supporting materials, and the recommendation; conduct a personal interview (directly or through a Committee representative) with the applicant, if it deems an interview is appropriate; and/or conduct further investigation of the applicant as warranted.

(b) Once the Credentials Committee has considered the licensure status, training/education, professional competence, character, judgment, experience, health status, ethical standing of the applicant, and other applicable qualifications, it shall transmit its written report and recommendations to the MEC. If an appointment to the Medical Staff and/or clinical privileges are recommended and provided all other conditions of appointment are satisfied, the report shall state the Medical Staff category, and any special condition(s), if any, to be attached to the appointment. The Credentials Committee may recommend that the MEC defer action on the application, stating the reason for such recommendation.
1.4.4 **Medical Executive Committee Action**

The MEC at its next regular meeting or such other appropriate time, after receipt of the written report and recommendations of the Credentials Committee, shall consider those reports and all such other relevant information available to it or otherwise requested. The MEC shall then determine whether to:

(a) Recommend to the Governing Board/CEO that the applicant be appointed to the Medical Staff and/or that specific clinical privileges be granted; or

(b) Recommend to the Governing Board/CEO that the applicant be denied for Medical Staff membership and/or that specified clinical privileges be denied; or

(c) Defer MEC action on the application for no more than sixty (60) days, at which time a recommendation to the Governing Board/CEO must be made.

The President of the Medical Staff or his or her designee shall present the MEC’s written report and recommendations for Medical Staff appointment and clinical privileges, including clinical privileges requests for Advanced Practitioners and Advanced Dependent AHPs, to the Governing Board for its consideration. The report shall state, as applicable, the Medical Staff category, and/or whether the applicant’s request for membership and/or clinical privileges is being recommended and any recommended special condition(s) if any.

1.4.5 **Governing Board Action**

Upon reviewing the application and all supporting material forwarded by the MEC, at its next regular meeting, the Governing Board shall, in whole or in part, adopt or not accept the recommendation of the MEC. Alternatively, it may refer the application back to the MEC for further consideration, stating the reasons for this action and setting a time limit within which any subsequent recommendation shall be made.

Whenever the Governing Body’s decision is contrary to or materially different from the MEC’s final recommendation, the Governing Body shall notify the MEC. In such circumstances, if the MEC or the Governing Body so requests, the Governing Body shall first submit the matter to a Joint Conference Committee which shall report its recommendation to the Governing Board within fourteen (14) business days of the action proposed by the Governing Board. Under such circumstances, the Governing Board shall consider the report of the subcommittee and then take its tentative final action. The Governing Body is responsible for the final decision, based on Medical Staff recommendations, regarding an individual’s reappointment and/or renewal or revision of individual Clinical Privileges. In rendering its final decision on an application for reappointment, the Governing Board shall recognize the primary role of the Medical Staff in reviewing the qualifications of Medical Staff applicants and members. The Governing Board’s decisions with respect to such recommendations shall be based on the information and recommendations submitted by the Medical Staff, and other relevant information, provided, however, that the recommendations of the Medical Staff shall be given their proper weight and authority given its expertise in these areas;
and provided further that while the Governing Board has the ultimate authority with respect to such decisions, the Board’s decision shall be guided by quality patient care and other relevant considerations.

1.4.6 Notice of Final Decision

(a) If the Governing Board’s action or CEO’s in the case of Dependent Practitioners is favorable to the applicant, it shall become effective as a final decision. Notice of final decisions shall be communicated to the President of the Medical Staff, and Medical Staff Services, who shall notify the applicant in writing.

(b) If the decision of the Governing Board is adverse to the applicant with respect to appointment and/or clinical privileges, the CEO shall send a Special Notice of the adverse decision to the applicant. The notice will explain the reasons for the adverse decision, including any reasons based in whole or in part on the applicant’s qualifications or any other factors. Initial applicants for appointment to the Medical Staff subject to an adverse determination are not entitled to a hearing or any other form of reconsideration, unless the decision is an adverse action, as that term is defined in the Medical Staff Fair Hearing Plan. Adverse actions regarding the granting or renewal of clinical privileges for APP/AHPs are addressed in Section 2.7.3 herein.

(c) Notice of the Governing Board’s final decision shall be communicated to the President of the Medical Staff and Medical Staff Services.

(d) A decision and notice of appointment to the applicant shall be provided within sixty (60) days of the Governing Board’s decision and shall include, as applicable, (1) the Medical Staff category to which the applicant is appointed; (2) the clinical privileges he or she may exercise; and (3) any special condition(s) attached to the appointment and/or clinical privileges.

1.4.7 Reapplication after Adverse Appointment or Privileges Decision

An applicant who has received a final adverse decision regarding appointment and/or clinical privileges shall not be eligible to reapply to the Medical Staff or for clinical privileges for a period of two (2) years from the date of the decision. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as the Medical Staff or the Governing Board may require.

Section 1.5 Reappointment/Renewal Process

1.5.1 Information Form for Reappointment

Medical Staff Services or a designated credentialing verification organization resource (CVO) shall, not less than one hundred twenty (120) days prior to the expiration date of a Medical Staff appointment 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 Services or CVO, as appropriate. Failure to return the form within the time required may be deemed a voluntary resignation from the Medical Staff and may 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.

1.5.2 Content of Reappointment Application Form

The content of the reappointment/renewal application form shall include, but not be limited to, the requested information set forth in Section 1.2.2 of this Credentialing Manual.

Section 1.6 Processing of Reappointment and/or Renewal of Clinical Privileges

1.6.1 Reappointment Burden

The practitioner shall have the same burden of producing adequate information and resolving doubts as provided in Section 1.4.1 of this Credentialing Manual.

1.6.2 Verification of Information

The Hospital and Medical Staff shall in a timely fashion, in conjunction with the Holy Rosary Healthcare Medical Staff Services Office, 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, Committee responsibilities, as applicable. The Hospital shall also request from the pertinent Licensing Board of the Montana Department of Labor and Industry 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, Medical Staff Services shall transmit the form and all other supporting materials to the Credentials Committee.

1.6.3 Credentials Committee, MEC and Governing Board Action

Thereafter, the procedures provided in Sections 1.4.3 through 1.4.7 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."

1.6.4 Basis for Recommendations
Each recommendation concerning the reappointment of a Medical Staff member and the clinical privileges to be granted upon reappointment, including renewal of clinical privileges for an APP/AHP, 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 and clinical privileges obligations, compliance with the Medical Staff Bylaws, the Hospital Corporate Compliance Plan, applicable Hospital policies, the Ethical and Religious Directives, 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 Medical Staff and Governing Board for the purpose of verifying clinical activity, clinical competence, and engagement in Medical Staff affairs.

Section 1.7 Requests for Modification of Membership Status or Clinical Privileges

A practitioner may, either in connection with reappointment or renewal or at any other time, request modification of Medical Staff category or clinical privileges. A requested change in Medical Staff category assignment shall be sent to the President of the Medical Staff or designee, whereas a requested change in clinical privileges shall be sent to the Credentials Committee. All requests for clinical privileges must be accompanied by evidence of the practitioner's education, training, experience, and competence to perform the specific clinical privileges requested. Such application shall be processed in substantially the same manner as provided in Section 1.6 of this Credentialing Manual for reappointment.

Section 1.8 Option to Expedite

1.8.1 Expedited Review

In the event, an applicant or reapplicant for Medical Staff membership and/or clinical privileges shows evidence or has demonstrated the basic qualifications set forth in the Medical Staff Governance and Organization Manual, has submitted a complete application or reapplication form and supporting documents, and otherwise meets all applicable criteria and any applicable regulatory and accrediting agencies’ standards for expedited review, Chairperson of Credentials Committee may initiate an expedited review process by assessing the application or reapplication and forwarding a recommendation directly to the President of the Medical, requesting that the application or reapplication be expedited. The President of the Medical Staff, in conjunction with two (2) members of the MEC, may then review the application or reapplication, and if unanimously recommending the application or reapplication for approval, may forward the application or reapplication to the Governing Board or designee to review the application or reapplication and take final action thereon.
1.8.2 Restrictions and Objections

An applicant or reapplicant is usually ineligible for the expedited process if at the time of appointment or granting of clinical privileges, or if since the time of the last reappointment, any of the following has occurred: the applicant or reapplicant submits an incomplete application or reapplication; there is a current challenge or a previously successful challenge to licensure or registration; the applicant or reapplicant has received an involuntary termination of medical staff membership at another organization; the applicant or reapplicant 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 or reapplicant in a professional liability action, or there is a reasonable concern about the applicant or reapplicant’s health status.

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

Section 1.9 Disability

Any practitioner who has been absent from his/her Hospital duties or has been unable to perform usual professional duties for more than thirty (30) days because of a physical, mental, emotional or other disability, shall upon request provide the President of the Medical Staff with a written report from his or her attending physician that addresses the practitioner’s health status and that includes a recommendation regarding the practitioner’s capacity to practice. A second opinion from an appropriate physician appointed by the MEC or applicable Medical Staff Committee may be required. If the MEC or the applicable Medical Staff Committee finds the circumstances surrounding a practitioner’s impairment or disability suggests that there is a limitation on the practitioner’s ability to properly or safely exercise clinical privileges, regardless of the practitioner’s absence from or presence at the Hospital, the MEC or applicable Medical Staff Committee shall report its findings to the MEC, which shall then determine whether further investigation or corrective action pursuant to this Plan should be initiated.
ARTICLE 2: CLINICAL PRIVILEGES

Section 2.1 Exercise of Privileges

Any practitioner providing direct clinical services at the Hospital shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted to him/her by the Governing Board. While only physicians, dentists, oral surgeons, and podiatrists are eligible for Medical Staff membership, APP/AHPs may also be granted clinical privileges in order to provide clinical services at the Hospital in accordance with this Article and the Medical Staff Governance and Organization Manual and applicable Hospital policy. All clinical privileges and services must be within the scope of the practitioner’s license, certificate, or other legal authority authorizing him/her to practice in Montana and consistent with any applicable restrictions. The care of all patients admitted by an APP/AHP, if permitted by their clinical privileges, must be under the care of a physician member of the Medical Staff.

Section 2.2 General Delineation of Clinical Privileges

2.2.1 Requests

(a) Each application for appointment and reappointment to the Medical Staff and/or for clinical privileges must contain a request for the specific clinical privileges desired by the practitioner. A request for a modification of clinical privileges must be supported by documentation of appropriate training and/or experience supportive of the request and must be consistent with all criteria that have been delineated and established by the Medical Staff and Governing Board.

(b) Any request for clinical privileges for which there are no approved requirements may be tabled for a period of up to one hundred twenty (120) days. During this time, the Credential Committee, and the MEC will create requirements and formulate the necessary criteria for clinical privileges under which the request may be processed for approval by the Governing Board. All requirements for clinical privileges will consist of baseline criteria specifying the minimum amount of education, training, experience, and evidence of competency required.

2.2.2 Basis for Clinical Privileges Determination

Requests for clinical privileges shall be evaluated based on the practitioner’s education, training, certifications, experience, demonstrated ability, judgment, compliance with Medical Staff and Hospital policies, and based on the capabilities of the Hospital. If available, the basis for clinical privileges determination shall also include clinical performance as observed or reviewed by the Hospital's performance distinction and/or quality improvement programs. In addition, other factors to be considered shall be the results of focused and ongoing performance distinction monitoring and evaluation activities, other quality assurance activities, and whether the applicant meets applicable patient contact requirements, all as may be required by the Medical Staff and Hospital Bylaws and related policies. A clinical privileges determination shall also be based on pertinent information concerning clinical performance obtained from other sources,
such as peers of the practitioner, and/or from other institutions, especially from health care settings where the practitioner exercises the clinical privileges that are requested. This information shall be maintained in the quality file established for each practitioner.

Section 2.3  **Special Conditions for Oral Surgery, Dental and Podiatric Clinical Privileges**

2.3.1 **Oral Surgery and Dental Clinical Privileges**

Requests for clinical privileges from oral surgeons and dentists shall be processed in the same manner as any other applicant or reapplicant. Privileges for surgical procedures performed by oral surgeons or dentists will require that all dental patients receive a basic medical evaluation (history and physical) by a physician member of the Medical Staff or APP with privileges to perform history and physicals. A designated physician member shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization and shall determine the risk and effect of the proposed procedure on the total health status of the patient. The oral surgeon or dentist will be responsible for the dental care of the patient, including the dental history and physical examination. Oral surgeons and dentists may issue orders within their licensed scope of practice, granted clinical privileges, and consistent with applicable Medical Staff policies.

2.3.2 **Podiatric Clinical Privileges**

Requests for clinical privileges from podiatrists shall be processed in the same manner as any other applicant or reapplicant. Privileges for procedures performed by podiatrists will require that all podiatric patients receive a basic medical evaluation (history and physical) by a physician member of the Medical Staff or APP with privileges to perform history and physicals. A designated physician member shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization and shall determine the risk and effect of the proposed procedure on the total health status of the patient. The podiatrist will be responsible for the podiatric care of the patient, including the podiatric history and physical examination. Podiatrists may issue orders within their licensed scope of practice, granted clinical privileges, and consistent with applicable Medical Staff policies.

Section 2.4  **Special Conditions for Advanced Practice Professionals and Allied Health Practitioners**

2.4.1 **Only those APP/AHP categories or professions approved by the Governing Board for providing services at the Hospital are eligible to apply for clinical privileges. APP/AHPs may, subject to any licensure requirements or other limitations, exercise independent judgment only within the scope of practice, areas of professional competence, granted clinical privileges, and applicable Hospital policies, provided, however, that the clinical privileges for certified registered nurse anesthetists, will be in accordance with CMS guidelines and Montana law. The clinical privileges of an APP/AHP shall terminate immediately, without the right to procedural rights, in the event that 1) the practitioner's employment by the Hospital or a required supervising physician member of the Medical Staff is terminated for any reason, or 2) any required supervision or collaborative agreement with a physician member of the Medical Staff is terminated for any reason. Provided, however, that the clinical privileges of an APP/AHP shall not**
terminate if timely arrangements are made for the Hospital to employ the APP/AHP or the APP/AHP’s supervision or collaborative agreement or permissible arrangement is appropriately replaced, as required.

2.4.2 Additional Requirements/Restrictions for AHPs

(a) Supervision by Employing or Supervising Member

(i) Advanced Dependent and Dependent AHPs may only exercise clinical privileges under the direct supervision of their employing or supervising member of the Medical Staff or as otherwise permitted by the practitioner's clinical privileges, Hospital policy, and applicable Montana law. Except as required by law or Governing Board-approved policy, "direct supervision" shall not require the actual physical presence of the employing or supervising member. All such practitioners must provide evidence of a current collaborative or supervision agreement with a physician member of the Medical Staff when required by the AHP's clinical privileges.

(ii) AHPs may only exercise clinical privileges on the condition that they remain employees of or are supervised by the designated collaborative or supervising member of the Medical Staff unless otherwise permitted by the practitioner's clinical privileges, Hospital policy, and applicable Montana law. All such practitioners must provide evidence when required of a current collaborative, supervision, or employment agreement with a physician member of the Medical Staff.

(b) Revocation or Termination of Collaborative/Supervising Member's Appointment and/or Clinical Privileges

(i) If the membership or clinical privileges of the employing or collaborative/supervising member is revoked or terminated, for any reason, the AHP’s clinical privileges shall automatically terminate.

(c) Responsibilities of Employing or Collaborative/Supervising Member

(i) The number of AHPs acting as employees of or under the collaboration/supervision of one (1) member of the Medical Staff, as well as the acts the AHP(s) may undertake, shall be consistent with applicable Montana law, Medical Staff policies or applicable policies of the Governing Board.

(ii) It shall be the responsibility of the collaborating or supervising member of the Medical Staff to countersign all medical record entries made by the AHP in accordance with applicable Hospital policies.

(iii) AHPs must have professional liability insurance in amounts required by the Governing Board that covers any activities of the AHP at the Hospital and to furnish evidence of such coverage to the Hospital. An AHP shall exercise clinical privileges only while such coverage is in effect.
2.4.3 Employed APP/AHPs

(a) Except as provided below, the employment of an APP/AHP by the Hospital shall be governed by the Hospital's employment policies and the terms of the individual's employment relationship. If the Hospital's employment policies or the terms of any applicable employment relationship are more restrictive, conflict with this Credentialing Manual, the employment policies or terms of the individual's employment relationship shall apply.

(i) Advanced Practice Professional / Advanced Dependent Practitioners/Independent Practitioners. A request for clinical privileges, on an initial basis or for renewal, submitted by an Advanced Practitioner, Advanced Dependent Practitioner, or Independent Practitioner who is seeking employment or who is employed by the Hospital shall be processed in accordance with this Credentialing Manual. If Hospital policy permits the practitioner to exercise clinical privileges without supervision or direction. A report regarding each practitioner's qualifications shall be made to the CEO or Human Resources, as appropriate for employment-related decisions.

(ii) Independent and Dependent Practitioners. A request for clinical privileges or permission to provide specified patient care services on an initial basis or for renewal from Independent Practitioners (if Hospital policy requires supervision or direction) or Dependent Practitioners who are seeking employment or is employed by the Hospital shall be evaluated by the Hospital's Human Resources Department through its policies and procedures.

(iii) Termination of Employment. If an APP/AHP's employment is terminated by the Hospital, for any reason, the individual's clinical privileges shall automatically expire without any procedural rights set forth in this Credentialing Manual.

(iv) Concerns. If concerns about a Hospital employed APP/AHP's clinical competence or professional conduct originates with the Medical Staff, the concern will be reviewed and addressed in accordance with Section 2.7 below after which will be reported to Human Resources.

Section 2.5 APP/AHP Corrective Action

2.5.1 No Entitlement to Medical Staff's Corrective Action and Fair Hearing Plan

APP/AHPs are not entitled to the hearing and appeals procedures set forth in the Medical Staff's Corrective Action and Fair Hearing Plan or any other Hospital or Medical staff policy or document.
2.5.2 **Investigation and Committee Meeting**

(a) When a question involving clinical competence or professional conduct of an APP/AHP is referred to or raised by the MEC, the MEC will review the matter and determine whether to conduct an investigation or to direct the matter to be handled pursuant to applicable Hospital policy.

(b) The MEC shall either investigate the matter itself or request the matter be investigated by a designee, which may include a standing committee, *ad hoc* committee, or an individual on its behalf ("Investigating Committee").

(c) The Investigating Committee will have the authority to review relevant documents, interview individuals, and retain external consultants or peer reviewers. It will also have available to it the full resources of the Medical Staff and Hospital.

(d) The APP/AHP will have an opportunity to meet with the Investigating Committee before it makes its report. Prior to this meeting, the APP/AHP will be provided a written description of the issues being investigated and the reasons related thereto, that as a result of such investigation his/her clinical privileges may be modified, restricted or revoked or other action taken related thereto and will be provided any documents that support the medical staff’s recommendation and a summary of any feedback from any individuals who have raised concerns about the individual. The APP/AHP will be invited to discuss, explain, or refute the questions that gave rise to the investigation. A summary of the interview will be prepared.

(e) The Investigating Committee will make a reasonable effort to complete the investigation and issue its report within thirty (30) days of the commencement of the investigation, provided that an external review is not necessary. When an external review is necessary, the Investigating Committee will make a reasonable effort to complete the investigation and issue its report within thirty (30) days of receiving the results of the outside review. These periods are intended to serve only as guidelines.

(f) At the conclusion of the investigation, the Investigating Committee will prepare a report with its findings, conclusions, and recommendations.

(g) Upon preparation and review of the report, the MEC may accept, modify or reject any recommendation it receives from the Investigating Committee, which may include taking no action, issuing a letter of reprimand, recommending additional training or education, recommendation, reduction, restriction, or termination of clinical privileges, or any other recommendation or action it determines to be appropriate under the circumstances.

2.5.3 **Appeal following Denial, Modification, Restriction or Revocation**

(a) In the event that an APP/AHP, excluding Hospital employees, is denied clinical
privileges at the Hospital or whose clinical privileges are modified, restricted or revoked, the APP/AHP, and when applicable, his or her employing or supervising member of the Medical Staff, shall have the right to appear personally before the Credentials or other designated or appointed Medical Staff committee to discuss the decision.

(b) If the APP/AHP desires to appear before the Credentials Committee, he or she must make such request:

(1) in writing; and

(2) within ten (10) days of the decision to deny, modify, revoke clinical privileges.

(c) Should the APP/AHP request an appearance in a timely manner, the APP/AHP will be informed of the general nature of the information supporting the decision to deny, modify, restrict or revoke prior to the scheduled meeting.

(d) At the meeting, the APP/AHP and, when applicable, his or her employing or supervising member, shall be invited to discuss the decision.

(e) Within ten (10) days following the meeting, the Credentials Committee shall notify the Governing Board of its recommendation.

(f) At its next scheduled regular meeting, the Governing Board shall make a final decision. The APP/AHP will be notified in writing in a timely fashion following the Governing Board's decision.

Section 2.6 History and Physical Examination Requirements

2.6.1 History and Physical Examinations Generally

Practitioners granted clinical privileges to perform a history and physical examination must complete and document the results of the history and physical examination no more than thirty (30) days before or twenty-four (24) hours after admission or registration of each patient, but prior to surgery or a procedure requiring anesthesia services.

When a history and physical examination is completed within thirty (30) days prior to admission or registration, a re-examination of the patient must be performed and any updates to the patient’s conditions must be documented in the patient's medical record within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

Additional requirements for the completion of history and physical examinations may be set forth in the Rules and Regulations, Medical Staff policy, and/or applicable Hospital policies.
Section 2.7  Telemedicine Clinical Privileges

2.7.1 Applicants seeking appointment to the Medical Staff and/or clinical privileges to perform telemedicine services may, but need not, be processed pursuant to the complete appointment and privileging procedures described in Section 1.4 above. Alternatively, in the case of applicants who intend to provide telemedicine services under a written agreement between the Hospital and a distant-site hospital or entity, the MEC may make recommendations to the Governing Board regarding such applicants in reliance upon the credentialing and privileging decision of the distant-site hospital or entity with whom the Hospital has an agreement for telemedicine services.

2.7.2 Applicants based at distant-site hospitals or entities who intend to provide telemedicine services under a written agreement with the Hospital may apply for such telemedicine clinical privileges and appointment to the Associate Staff provided each applicant meets the basic qualifications for appointment set forth in Section 1.2 of the Medical Staff Organization and Governance Manual and by submission of the same application or application with equivalent content as specified in this Credentialing Manual. All determinations regarding equivalent content will be made by the MEC and Governing Board.

2.7.3 Upon confirmation by Medical Staff Services that an applicant’s request for appointment and telemedicine privileges complies with the terms of the written agreement between the Hospital and the distant-site hospital or entity, including clinical privileges criteria adopted by the Medical Staff, the MEC may rely upon the credentialing and privileging decisions made by a distant-site hospital or telemedicine entity when making its recommendation for appointment and clinical privileges provided the agreement between the Hospital and distant-site hospital or entity ensures the following:

(a) The distant-site hospital is a Medicare-participating hospital or the distant-site telemedicine entity provides written assurances that its credentialing and privileging process and standards meet the Medicare Conditions of Participation for Hospitals;

(b) The practitioner is privileged at the distant-site hospital or distant-site telemedicine entity and a current list of equivalent privileges is provided;

(c) The distant-site practitioner holds a current license issued or recognized by the State of Montana; and

(d) That upon being granted membership and/or clinical privileges, the Hospital provides the distant-site hospital or entity evidence of an internal review of the practitioner's clinical performance for use in the practitioner's periodic appraisal and, at a minimum, the information must include all adverse events resulting from the telemedicine services provided by the distant-site practitioner as well as any registered complaints.
2.7.4 If a practitioner who has been granted clinical privileges to provide telemedicine services at the Hospital fails to utilize such clinical privileges or otherwise provide telemedicine services to Hospital patients at a satisfactory volume as determined by the MEC for the purpose of reliably assessing the quality and performance of the practitioner's telemedicine services, such clinical privileges shall cease and expire either six (6) months following the date practitioner last provided telemedicine services at the Hospital or when otherwise notified by the Medical Staff.

2.7.5 If the Hospital has not entered into a written agreement for telemedicine services with a distant-site hospital or entity but has a pressing clinical need for telemedicine services and a distant-site practitioner can supply such services via a telemedicine link, the Hospital may evaluate the use of temporary clinical privileges for a distant-site practitioner as addressed in Section 2.8 below. In such cases, the distant-site practitioner must be credentialed and privileged to provide telemedicine services in accordance with Hospital standards and procedures applicable to the approved telemedicine services.

Section 2.8 Temporary Clinical Privileges

2.8.1 Circumstances

The CEO, acting on behalf of the Governing Board, may grant specific temporary clinical privileges in only the following circumstances. Provided, however, unless otherwise provided by applicable Hospital policy, that temporary clinical privileges may not be granted unless an applicant successfully completes any Hospital sponsored training programs related to electronic medical record (EMR) and related clinical system implementation, pass any related program examination or opt-out examination, and submit required program documentation prior to review of request for temporary admitting and clinical privileges by the President of the Medical Staff.

(a) Pendency of Application

Upon receipt of a signed and completed application for Medical Staff appointment and request for specific clinical privileges and after receiving a favorable recommendation by the Credentials Committee, an appropriately licensed physician, dentist, oral surgeon, podiatrist, or APP/AHP may be granted temporary clinical privileges for an initial period of sixty (60) days, with one subsequent renewal not to exceed thirty (30) days. In exercising such temporary clinical privileges, the applicant shall act under the supervision of the respective Department Chairperson of the section for where their clinical privileges are assigned and in accordance with the conditions specified in Section 2.8.2 of this Credentialing Manual.

(b) Care of Specific Patients/Important Patient Care Need

Upon receipt of a written request for specific temporary clinical privileges to the President of the Medical Staff, a duly licensed physician, dentist, oral surgeon or podiatrist of documented competence who is not an applicant for Medical Staff membership may be granted temporary clinical privileges for the care of one or more specific patients. Such temporary clinical privileges shall only be granted...
under extraordinary circumstances, may be limited by the CEO to a specified number of patients, and shall be exercised in accordance with the conditions specified in Section 2.8.2 of this Credentialing Manual.

(c) Locum Tenens

As an extension of important patient care need, upon receipt of a written request for locum tenens, clinical privileges to the President of the Medical Staff, a duly licensed physician, dentist, oral surgeon or podiatrist of documented competence who will serve as a locum tenens for a Medical Staff member and who is on the active medical staff of another hospital may, without applying for Medical Staff membership, be granted locum tenens clinical privileges for an initial period of thirty (30) days.

Such temporary clinical privileges may be renewed for two (2) successive periods of thirty (30) days each but not to exceed his or her period of service as locum tenens, shall be limited to the treatment of the patients of the practitioner for whom he or she is serving as locum tenens and shall be exercised in accordance with the conditions specified in Section 2.8.2 of this Credentialing Manual. He or she shall not be entitled to admit his or her own patients to the Hospital.

2.8.2 Conditions

Temporary clinical privileges may be granted only where the individual requesting temporary clinical privileges meets the basic qualifications set forth in the Medical Staff Governance and Organization Manual. Any practitioner seeking temporary clinical privileges must have his or her qualifications appropriately verified and must be recommended by the President of the Medical Staff.

Special requirements of consultation and reporting may be imposed by MEC. Before temporary clinical privileges are granted, the practitioner must acknowledge in writing that he or she has received, or been given access to, and read the Medical Staff Bylaws, the Ethical and Religious Directives for Health Care Services, the Hospital Corporate Compliance Plan, and that he or she agrees to be bound by the terms thereof in all matters relating to temporary clinical privileges.

2.8.3 Suspension

On the discovery of any information or the occurrence of any event of nature which raises questions about a practitioner’s professional qualifications or ability to appropriately or safely exercise any or all of the temporary clinical privileges granted, these temporary clinical privileges may be summarily suspended consistent with the process identified in Section 1.2 of the Medical Staff Fair Hearing Plan. In the event of any such suspension, the practitioner’s patients than in the Hospital shall be assigned to a Medical Staff member(s) by the President of the Medical Staff. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner. The substitute practitioner(s) shall have the right to refuse to accept such patient assignments, in which case the Chairperson shall assign the patients to another substitute practitioner(s).

2.8.4 Rights of a Practitioner with Temporary Clinical Privileges
By applying for temporary clinical privileges, all practitioners acknowledge the expected short-term nature of such status and that such status does not confirm an expectation of appointment to the Medical Staff and expressly agree that if granted temporary clinical privileges, the practitioner shall not be entitled to the procedural rights afforded by Article 2 of the Medical Staff Fair Hearing Plan, if a request for temporary clinical privileges is refused, or if all or any portion of the temporary clinical privileges are terminated or otherwise restricted.

Section 2.9  Emergency Clinical Privileges

For the purpose of this Section, an "emergency" is defined as a condition in which serious or permanent harm would result to a patient or bystander or in which the life of a patient or bystander is in immediate danger and any delay in administering treatment would add to that danger. In the case of an emergency, any practitioner shall be permitted and assisted to do everything possible to save the life of a patient, using every facility of the Hospital necessary, including the calling of any consultation necessary or desirable, regardless of his or her Medical Staff status, or clinical privileges. The practitioner shall make every responsible effort to communicate promptly with the appropriate individuals concerning the need for emergency care and assistance by members of the Medical Staff with appropriate clinical privileges, shall promptly yield such care to qualified members of the Medical Staff when it becomes reasonably available and once the emergency has passed or assistance had been made available, shall defer to the President of the Medical Staff with respect to further care of the patient.

Section 2.10  Disaster Clinical Privileges

2.10.1  Circumstances

Any individual intending to provide services during a disaster event must be granted clinical privileges prior to providing patient care. Disaster privileges are considered temporary in nature. Applicants for disaster privileges are limited to physicians, dentists, oral surgeons, podiatrists, AIPs, Advanced Dependent, and Dependent AHPs and are not being considered for membership on the Medical Staff.

2.10.2  Conditions

(a) The CEO or President of the Medical Staff or their designee, in circumstances of disaster in which the Hospital's emergency operation plan has been activated, shall have the authority to grant disaster privileges to a physician, dentist, oral surgeon, podiatrist, or APP/AHP who is not a member of the Medical Staff subject to the following process and conditions.

(b) Decisions regarding the granting of disaster privileges are made on a case-by-case basis and the CEO or President of the Medical Staff or their designee is not required to grant privileges to any individual. Prior to granting such privileges, the CEO or President of the Medical Staff or their designee shall verify information regarding the individual upon presentation of a valid government-issued photo identification care and at least one (1) of the following:
(i) A current picture identification card from a healthcare organization that identifies the practitioner's professional designation;

(ii) A current license to practice;

(iii) Primary source verification of licensure;

(iv) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) or other recognized state or federal response organization or group;

(v) Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state, or municipal entity; or

(vi) Confirmation by a practitioner who is currently privileged by the Hospital with personal knowledge regarding the practitioner’s ability to act as a licensed independent practitioner during a disaster.

(c) If appropriate under the circumstances, the process established for verification of credentials and privileges under this Credentialing Manual and the Medical Staff Governance and Organization Manual for granting temporary privileges shall begin as soon as the immediate emergency is under control, but no later than seventy-two (72) hours. In extraordinary circumstances, verification of credentials may occur later than seventy-two (72) hours and as soon as possible. In such cases the Hospital shall document: 1) the reasons for any delay; 2) evidence of the practitioner's demonstrated ability to continue to adequate care, treatment and services; and 3) evidence of the Hospital's attempt to perform credentialing verification in a timely manner.

(d) The MEC or designee will oversee the performance of individuals granted disaster privileges by either direct observation, mentoring or medical record review as may be more fully described in the Hospital's emergency operation plan.

The CEO or designee will determine within seventy-two (72) hours of each practitioner's arrival whether granted disaster privileges should continue.