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**RULE 1 QUALIFICATIONS**

1.1 **QUALIFICATIONS.** The basic qualifications for Medical Staff membership are set forth in the Medical Staff Bylaws.

**RULE 2 PRACTITIONER FILES**

2.1 **GENERAL**

2.1.1 Three files will be developed and maintained for Medical Staff applicants and Members: a credentials file, Peer Review file and a health file (collectively, the “Practitioner Files”). The Practitioner Files of Medical Staff applicants and Members shall contain all relevant information available regarding the Practitioner that is needed for the Hospital and other System Members to evaluate the competence and professional conduct of, and quality and appropriateness of care provided by Medical Staff applicants and Members. The specific contents of the credentials file, Peer Review file and health file are addressed in the Policy entitled “Physicians/AHP File Documents and Retention Policy”, as such is amended from time to time (the “File Policy”). Files may be in paper and/or electronic format.

2.1.2 The Practitioner Files shall be retained in strict confidence in Medical Staff Services or other designated areas.

2.1.3 It is expressly understood that the contents of the Practitioner Files include records and proceedings of Medical Staff Professional Review committees that are responsible for evaluating the competence, professional conduct and quality and appropriateness of care provided by Practitioners to improve the quality of care provided in the Hospital. These committees include, without limitation, the Credentials Committee, the Peer Review Committee, the Medical Executive Committee, the Conference Committee, any investigation committee appointed from time to time, Department, Section or Service committees, Hearing Panels and the Governing Body. The contents of the Practitioner Files are intended to be privileged and confidential, and may be used and disclosed in accordance with Colorado law, Federal law (for National Practitioner Data Bank Reports), and the Medical Staff Rules and Policies.

2.1.4 This Rule 2 applies to files for Allied Health Practitioners.

2.2 **CONTENTS**

The Practitioner Files shall include the Practitioner’s application forms and all correspondence, and other documents pertaining to the Practitioner and his or her professional qualifications, competence, professional conduct, performance, health status and Medical Staff activities and responsibilities as further clarified in the File Policy.

2.3 **DISCLOSURE TO APPLICANT OR MEDICAL STAFF MEMBER**

2.3.1 A Medical Staff applicant or Member who wishes to review any portion of his or her Practitioner Files shall submit a written request that specifies the item(s) he or she wishes to see. Requests to review any portion of the Practitioner Files that conform to the restrictions set forth below may generally be granted, but may be denied in unusual circumstances by the President, the Chief Executive Officer, or either’s designee.

2.3.2 An applicant or Member may inspect only his or her own Practitioner Files (unless he or she is authorized to review another applicant’s or Member’s Practitioner Files in accordance with the provisions set forth in Rule 2.4 below) and may review only the following Practitioner File items as further clarified in the File Policy:

a. Documents or correspondence the applicant or Member personally prepared and submitted, e.g., his or her application or letters.

b. Documents or correspondence addressed and sent directly to the applicant or Member.

c. Public documents, such as copies of the applicant’s or Member’s license to practice medicine.

2.3.3 Copies of any item contained in the Practitioner Files shall not be made for an applicant or a Member unless:

a. Pursuant to Rule 2.3.2 above, the applicant or Member may inspect the item, and
b. The applicant or Member has reimbursed the Hospital for the costs (other than incidental costs) it incurred in making such copies.

c. Additional disclosures may be made in connection with any Professional Review Activities, upon approval by the President, CEO or their respective designees, with advice of legal counsel as appropriate, or in connection with a hearing, as provided in the Medical Staff Bylaws and Rules.

2.4 Disclosure to System Members, Medical Staff Officers and Medical Staff Committees or Their Designees

By applying for and maintaining Medical Staff membership, each Practitioner consents to the disclosure of Practitioner Files and other Professional Review information to other System Members where the Practitioner applies for or maintains Medical Staff membership or Privileges or other affiliation (such Practitioners are “Shared Practitioners”). Practitioner Files and other Professional Review information of Shared Practitioners may be disclosed, as appropriate, to System Members, Medical Staff Officers, Department, Service and Section leaders, Medical Staff committees and their Chairs, the Conference Committee, the Chief Medical Officer, to any of their designees and other persons, as further clarified in the File Policy. Disclosure to such persons or entities shall occur whenever necessary to enable them to carry out their responsibilities of evaluating and improving the quality of care rendered by the subject Shared Practitioner in the System. For example, the contents of the Practitioner Files of a Shared Practitioner may be disclosed to persons or committees that are responsible for recommending the Shared Practitioner’s appointment or reappointment to the Hospital’s or any System Member’s Medical Staff and what, if any, Privileges shall be granted; reviewed or revised, for precautionary suspensions, for investigating any request for corrective action, or recommending what, if any, corrective action should be taken, and for quality improvement and other Peer Review Activities, and for the resolution of potentially inconsistent recommendations by the Committees.

2.5 Disclosure to the Hospital Governing Body

2.5.1 The contents of the Practitioner Files may be disclosed to the Governing Body - or any individual Governing Body member - insofar as is necessary to enable the Governing Body member(s) to properly fulfill their legal responsibilities, as further clarified in the File Policy.

2.5.2 Disclosure should be limited to the member(s) or subcommittee(s) that are responsible for evaluating and analyzing such information.

a. Generally, any portion of a Practitioner File that is reviewed by Governing Body members should not be included in or maintained as a part of Governing Body records or minutes.

b. Governing Body actions shall refer, as appropriate, in summary fashion and by reference to any Practitioner File material.

c. All portions of Practitioner Files reviewed by the Governing Body shall be returned to and maintained by the Medical Staff Services or designated area.

2.6 Disclosure of Practitioner Files and Professional Review Information to Non-System Members

2.6.1 By applying for and maintaining Medical Staff membership, each Practitioner agrees to execute a release and consent to the disclosure of information in the Practitioner Files to non-System Member entities (i) where the Practitioner applies for or has been granted affiliation, (ii) that conduct Professional Review activities in the State of Colorado and (iii) become registered with the Colorado Department of Regulatory Agencies as “Authorized Entities” under the Colorado Professional Review Act (CPRA) following implementation of the registration process. CRS 12-36.5-101, et seq.

a. Prior to the disclosure of the contents of Practitioner Files or other information regarding a Practitioner to non-System Member entities within the State of Colorado, Medical Staff Service will determine whether the entity has registered as an “Authorized Entity” as defined in the CPRA following implementation of the registration process. The Practitioner will provide written consent to the disclosure of Practitioner Files or Professional Review information to the entity, and will agree to release the Hospital, its Medical Staff members, all persons, entities, and the System from any liability that might arise from the disclosure or use of the information.
2.6.2 Prior to the disclosure of the contents of Practitioner Files or other Professional Review information regarding a Practitioner to entities that are not Authorized Entities within the State of Colorado, the Practitioner will be asked to sign a release stating a general summary of the information that will be disclosed and agreeing to release all persons, entities, and the System from any liability that might arise from the disclosure or use of the information.

RULE 3 CATEGORY OF MEMBERSHIP

3.1 CATEGORIES

There are 5 categories of Medical Staff membership: Active, Courtesy, Affiliate, Emeritus, and Honorary and Retired.

3.2 PREROGATIVES AND RESPONSIBILITIES

3.2.1 The prerogatives available to a Medical Staff Member depending upon Medical Staff category are:

a. Admit patients consistent with approved Privileges (“Admit Patients”).

b. Exercise Privileges which have been approved (“Eligible for Privileges”).

c. Vote on any Medical Staff matters including Medical Staff Bylaws amendments, officer selection, and other matters presented at any general or special Medical Staff meetings and on matters presented at Service, Department or Section meetings (“Eligible to Vote”).

d. Serve as a Medical Staff Officer or as a Medical Executive Committee at large member (“Serve as Medical Staff Officer”).

e. Hold office in the Service, Department and Section to which he or she is assigned (“Hold Other Offices”).

f. Serve on Committees and vote on Committee matters (“Serve on Committees”).

g. Serve as chair of a Committee (“Serve as Committee Chair”).

h. Attend Medical Staff meetings and CME events (“Attend Medical Staff Meetings and CME Events”).

3.2.2 The responsibilities which Medical Staff Members will be expected to carry out in addition to the basic responsibilities set forth in the General Medical Staff Rules are to:

a. Participate equitably in Medical Staff functions, at the request of a Department/Service Chair or Section Chief or other Medical Staff Officer, including contributing to the Hospital’s medical education programs and contributing to the organizational and administrative Medical Staff activities, including Peer Review, proctoring, quality improvement, risk management, and utilization management (“Medical Staff Functions”).

b. Serving on the on-call roster and accepting responsibility for providing care to any patient requiring on-call coverage in his or her specialty and consulting with other Medical Staff Members consistent with his or her delineated Privileges and in accordance with the General Medical Staff Rules (“ER Call”).

c. Submit an application for initial Medical Staff membership and request for Privileges and pay a non-refundable application fee (“Must Submit Application and Pay Non-Refundable Application Fee”).

d. If the Member desires reappointment to the Medical Staff and renewed Privileges, every two years, the Member must submit an application for reappointment and request for Privileges, and pay a non-refundable reappointment fee (“May Submit Reapplication and Must Pay Non-refundable Reappointment Fee Every Two Years”).

e. Pay any non-refundable applicable late charges if the Member fails to submit a completed application for reappointment in a timely manner in accordance with Rule 4 (“Must Pay any Non-refundable Reappointment Late Fees”).
f. Pay non-refundable Medical Staff dues and assessments that are periodically approved by the Medical Executive Committee (“Must Pay Annual Non-refundable Dues and Assessments”).

3.2.3 Prerogatives and Obligations of Medical Staff Categories:

The prerogatives and obligations of each Medical Staff category are described in the table following.

### MEDICAL STAFF CATEGORIES

<table>
<thead>
<tr>
<th>PREROGATIVES</th>
<th>ACTIVE</th>
<th>COURTESY</th>
<th>HONORARY &amp; RETIRED</th>
<th>AFFILIATE</th>
<th>EMERITUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Contacts means patient care at ESJH and includes Admissions, Consultations &amp; Procedures (Inpatients &amp; Outpatients)</td>
<td>YES -- Regularly at least 12 per year at Saint Joseph (5 for allergy, dentistry, dermatology, rheumatology and psychiatry)</td>
<td>YES, Fewer than 12 per year</td>
<td>NO</td>
<td>Co-admit, assist in surgery, and write progress notes</td>
<td>NO</td>
</tr>
<tr>
<td>Admit Patients</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
<td>Co-admit only</td>
<td>NO</td>
</tr>
<tr>
<td>Eligible for Privileges</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
<td>YES, limited</td>
<td>NO</td>
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<tr>
<td>Eligible to Vote</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
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</tr>
<tr>
<td>Serve as Medical Staff Officer</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>Hold Other Offices</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>Serve as Committee Chair</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>Serve on Committees</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Attend Medical Staff meetings and CME Events</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
</tbody>
</table>

### RESPONSIBILITIES

<table>
<thead>
<tr>
<th>RESPONSIBILITIES</th>
<th>ACTIVE</th>
<th>COURTESY</th>
<th>HONORARY &amp; RETIRED</th>
<th>AFFILIATE</th>
<th>EMERITUS</th>
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</thead>
<tbody>
<tr>
<td>Medical Staff Functions</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>Must Submit Application and Pay Non-refundable Application Fee</td>
<td>YES,</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Must Pay Annual Non-refundable Dues and Assessments</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>May Submit Reapplication and Must Pay Non-refundable Reappointment Fee Every Two Years</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Must Pay any Non-refundable Reappointment Late Fees</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>E.R. Call</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>Malpractice Insurance</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

Active: Regularly admit/treat patients at Exempla Saint Joseph Hospital; Medical Staff leadership position.

Courtesy: Occasionally admit/treat patients.

Honorary&Retired: Members of the Medical Staff retired from active practice or persons of outstanding reputation whom the Medical Staff wishes to honor.

Affiliate: Practitioners who do not qualify for full privileges in a specialty but who are qualified to exercise co-admitting, assisting and other limited privileges.

Emeritus: Practitioners who are no longer practicing at Exempla Saint Joseph Hospital, have been on the Medical Staff for at least 10 years, and have contributed to the hospital and the community.

3.3 QUALIFICATIONS FOR MEDICAL STAFF CATEGORY

3.3.1 Assignment and Transfer in Medical Staff Category
a. Medical Staff Members shall be assigned to the category of Medical Staff membership based upon the qualifications identified below. Active Staff Members who fail to achieve the minimum activity for 2 consecutive years shall be deemed to have requested transfer to the appropriate category and, accordingly, shall be automatically transferred to the appropriate category. Action shall be initiated to evaluate and possibly terminate the privileges and membership of any Staff Member who has failed to have any activity. A Courtesy Member who has exceeded the maximum activity permitted for 2 consecutive years shall be deemed to have requested transfer to the appropriate category. The Medical Executive Committee shall approve these assignments and transfers, which shall then be evaluated in accordance with the Medical Staff Bylaws and these Rules. The transfers shall be done at the time of reappointment.

b. In assigning Practitioners to the proper Medical Staff category, the Medical Staff shall also consider whether the Practitioner participated in other aspects of the Hospital’s activities by, for example, serving on committees or in leadership positions. The Governing Body (on recommendation of the Medical Executive Committee) may rescind an automatic transfer, but only if the Practitioner clearly demonstrates that unusual circumstances unlikely to occur again in his or her practice caused the failure to meet the minimum or maximum requirements.

3.3.2 Active Staff

The Active Staff also known as the Organized Medical Staff shall consist of the Members who are regularly involved in caring for patients (12 or more patient encounters per 12 month period).

The Active Staff also known as the Organized Medical Staff shall consist of the Members who:

a. Are regularly involved in caring for patients or demonstrate by way of other substantial involvement in Medical Staff or Hospital activities a genuine concern and interest in the Hospital. Regular involvement in patient care shall mean Admissions, Consultations, & Procedures (Inpatients & Outpatients) on at least 12 cases each Medical Staff Year for all Practitioners except allergists, dentists, dermatologists, psychiatrists, and rheumatologists who must be involved in at least 5 cases in order to maintain Active Staff status. Service as a Medical Staff Officer, Service, Department or Section leader or Committee member may also be considered in classifying members.

3.3.3 Courtesy Staff

The Courtesy Staff shall consist of the Members who:

a. Admit, refer, or otherwise provide services for no more than 12 patients during each Medical Staff Year at the Hospital.

b. Prior to reappointment, provide evidence of current clinical performance at the hospital where they practice in such form as the Member’s Department, Section (if any) or the Credentials Committee, or the Medical Executive Committee may require in order to evaluate their current ability to exercise the requested Privileges.

3.3.4 Affiliate Staff

The Affiliate Staff shall consist of Members who have not completed full training in their specialty and/or do not meet board certification or eligibility for board examination requirements or who have not met all minimum experience requirements to qualify for full Privileges, but who nevertheless appear likely to provide a distinct service to the Hospital, the Medical Staff and the patients. Affiliate Staff Members may be granted privileges to co-admit patients, assist in surgery, and write progress notes, depending upon the Member’s training and experience. Affiliate Staff Members are not required to have a covering physician.

3.3.5 Honorary and Retired Staff

The Honorary and Retired Staff shall consist of Practitioners who are not practicing at the Hospital but who the Medical Staff and the Governing Body wish to honor by virtue of their outstanding reputations, noteworthy contributions to the health and medical sciences, or their previous long standing service to the Hospital or the System, and Members who have retired.
3.3.6 Emeritus Staff

The Emeritus Staff shall consist of Practitioners who are no longer practicing at the Hospital but who were previously members of the Medical Staff of the Hospital or the System for at least 10 years and who wish to remain in contact with the Medical Staff and the Hospital. The practitioners have contributed to the Hospital and the Medical Staff.

3.3.7 Interns, Residents, and Fellows

Interns, Residents and Fellows in training in the System shall not hold appointments to the Medical Staff and shall not be granted specific Privileges in the training programs. Rather, they shall be permitted to perform only those clinical duties set out in training protocols developed by the Directors of Education, curriculum requirements, and/or affiliation agreements approved by the System. The only exception to this is that the 4th year Internal Medicine Chief Resident may apply for and be granted Medical Staff membership.

RULE 4 PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

4.1 Applicant’s Burden

An applicant for appointment, reappointment, change in Medical Staff category, and/or for the granting, renewal or revision of Privileges shall have the burden of producing accurate and adequate information for a thorough evaluation of the applicant’s qualifications and suitability for the requested status or Privileges, resolving any reasonable doubts about these matters and satisfying requests for information. This burden may include submission to a medical or psychological examination at the applicants’ sole cost, as provided in the Medical Staff Bylaws or Rules. An applicant’s failure to meet the burden of proving his/her qualifications and suitability for the requested status or Privileges shall be grounds for administrative rejection or denial of an application or request, as applicable, in accordance with these Credentialing and Privileging Rules.

4.2 Administrative Rejection of Application or Request Form

If, at any time, the information received indicates that the applicant does not meet the basic qualifications for membership set forth in the Medical Staff Bylaws, or the objective eligibility requirements for Privileges requested as set forth in the appropriate Privilege Forms (such as completing a fellowship or performing a minimum number of specialized procedures), the application or request will not be processed. Also, an application or request for Privileges that contains a significant misrepresentation will not be processed. The applicant will be notified in writing that he or she is not eligible to apply for Medical Staff membership or to request Privileges, as appropriate, that his or her application or request will not be processed, the basis for the administrative rejection, and that he or she is not entitled to a hearing or appeal under the Medical Staff Bylaws or the Peer Review, Fair Hearing and Appeal Rules. Applicants who do not otherwise meet the objective eligibility requirements for Privileges requested may be eligible to participate in the voluntary proctoring procedures under the Medical Staff Proctoring Policy, as amended from time to time and which is incorporated herein; provided, however, that neither the proctoring nor an administrative rejection following the proctoring based on the applicant’s failure to meet the objective eligibility requirements entitles the applicant to a hearing or appeal under the Medical Staff Bylaws or the Peer Review, Fair Hearing and Appeal Rules.

4.3 Basis for Appointment, Reappointment and Revision

Recommendations for appointment and reappointment to the Medical Staff and for granting, renewal and revision of Privileges shall be based upon the applicant’s or Member’s professional performance and professional conduct at this Hospital and in other settings, whether the applicant or Member meets the qualifications and can carry out all of the responsibilities specified in the Medical Staff Bylaws and the Rules, and upon the System’s patient care needs and ability to provide adequate support services and facilities for the applicant.

4.4 Application Form

4.4.1 Provision and Return of Application

Each Practitioner who expresses formal interest in a recognized and appropriate category of membership and Privileges shall be provided an approved application form for Medical Staff membership, supplemental documentation and a request form for Privileges. The provision of an application, supplemental documentation or Privilege request form in no way guarantees or implies a favorable recommendation or
4.2 Application Form

The application, supplemental documentation, and agreements and authorization forms, including the Medical Staff Expectations, which are approved by the Medical Executive Committee and the Governing Body, shall be considered part of these Rules. The application shall (i) request information pertinent to the applicant’s qualifications, (ii) document the applicant’s agreement to abide by the Medical Staff and System Bylaws, Rules and policies (including the standards and procedures for evaluating applicants contained therein), (iii) document the applicant’s agreement to release all persons and entities from any liability that might arise from their investigating and/or acting on the application, (iv) document the applicant’s agreement to abide by the Medical Staff Expectations, and (v) document the applicant’s agreement to abide by the Ethical and Religious Directives for Catholic Health Care Services, as all are amended from time to time.

4.5 HEALTH CONCERNS

4.5.1 Obtaining Health Information

a. For purposes of these Rules, “health concern” means a physical or mental condition, including past or present dependence on drugs or alcohol.

b. The approved application forms includes health related questions. Medical Staff Services will detach the forms that contain health related questions from the other portions of the application and retain them in a separate confidential file before the application is forwarded for review. The application form may include a request for information pertaining to the applicant’s ability to exercise the Privileges requested and the responsibilities of Medical Staff membership safely and competently. An application will not be deemed complete until the health related forms have been received.

c. When Medical Staff Services verifies information and obtains references, it may ask for any information concerning the applicant’s health status on a separate health status questionnaire. Medical Staff Services will detach the health status questionnaire from the other portions of the application and retain the health questionnaire in a separate confidential file.

d. If no health concern is identified, the application is processed in the usual manner.

4.5.2 Review of Health Status Information

a. The Hospital and the Medical Staff are committed to providing quality patient care. The Hospital and the Medical Staff also care about Medical Staff Members and Practitioners who exercise Privileges at the Hospital. A health concern disclosed or learned during the application process shall be evaluated to determine whether the Practitioner can safely and competently carry out the responsibilities of Medical Staff membership and exercise the Privileges requested in a manner consistent with Hospital’s quality of care and professional conduct standards.

b. To the extent practicable, the review of Practitioner health concerns by the Service Chair, Department Chair or Section Chief, Credentials Committee, and Governing Body shall be separate from their determination whether the Practitioner is otherwise qualified for Medical Staff membership and the Privileges requested. However, a Practitioner shall not be granted full Medical Staff membership or Privileges until such health status review is complete.

c. A Practitioner may request that the Medical Staff postpone the review of health related forms until the Governing Body has made a conditional offer of Medical Staff membership and Privileges.

d. If a health concern is identified on the health related forms or otherwise during the application process, this matter shall be referred to either the Service Chair, Department Chair, Section Chief, President and/or Chief Medical Officer (or their designees) or a Medical Staff committee appointed to review health concerns (collectively, the “Reviewers”). The Reviewers shall review
the health related forms and any other information relevant to the Practitioner’s health concern. This may include one or all of the following:

1. **Medical Examination**: To ascertain whether the Practitioner has a physical or mental disability that might interfere with his or her ability to safely and effectively carry out the responsibilities of Medical Staff membership and exercise Privileges.

2. **Interview**: To ascertain the Practitioner’s views on his or her health concern and to assess whether reasonable accommodations may be appropriate. The Reviewers shall document the results of such interview.

e. If a reasonable accommodation is requested, the Reviewers shall consult with the Chief Medical Officer and/or Hospital’s Human Resources Department to determine the reasonableness of any requested accommodation. The Hospital shall ultimately determine whether to provide any requested accommodation.

1. The Reviewers shall not disclose health status information to the Credentials Committee (or, in the case of temporary Privileges, the Medical Staff representatives who review temporary Privilege requests and the Chief Executive Officer) until this committee has assessed whether the Practitioner is otherwise qualified for Medical Staff membership and/or to exercise the Privileges requested and is prepared to make a recommendation to the Medical Executive Committee.

2. If the Credentials Committee determines that the Practitioner is otherwise qualified, the health status information obtained by or prepared by the Reviewers shall be disclosed to the Credentials Committee. Thereafter, the Credentials Committee shall assess whether the Practitioner can safely and effectively carry out the responsibilities of Medical Staff membership and exercise Privileges at Hospital in a manner that meets the Hospital’s and Medical Staff’s quality of care and professional standards.

3. If accommodations are not appropriate, it may be necessary to deny or modify a Practitioner’s Privileges, and the Practitioner shall have the hearing and appellate review rights as described in the Medical Staff Bylaws and the Peer Review, Fair Hearing and Appeal Rules.

4. Any information regarding health concerns for a Shared Practitioner will be communicated with the other System Members to promote a consistent approach to any concerns regarding the Shared Practitioner’s ability to safely and effectively carry out the responsibilities of Medical Staff membership and exercise Privileges at the System Members.

### 4.6 Effect of Application

4.6.1 By applying for or by accepting appointment or reappointment to the Medical Staff, the applicant:

a. Signifies his or her willingness to appear for interviews regarding his or her application for appointment.

b. Authorizes Medical Staff and System representatives to consult with other hospitals, persons or entities who have been associated with him or her and/or who may have information bearing on his or her competence and qualifications or that is otherwise relevant to the pending review and authorizes such persons to provide all information that is requested orally and in writing.

c. Consents to the inspection and copying, by System representatives, of the Practitioner File and all Professional Review records and documents that may be relevant or lead to the discovery of information that is relevant to the pending review, regardless of who possesses these records, and directs individuals who have custody of such records and documents to permit inspection and/or copying.

d. Certifies that he or she will report any subsequent changes in the information submitted on the application form to the Credentials Committee and the Chief Executive Officer within thirty (30) days of the change. Without limiting the foregoing, the applicant agrees to monitor the status of
his/her board certification status and to notify Medical Staff Services of any changes to this status within thirty (30) days of the change.

e. Releases from any and all liability the Medical Staff and the System and its representatives for their acts performed in connection with evaluating the applicant.

f. Releases from any and all liability all individuals and organizations who provide information concerning the applicant, including otherwise privileged or confidential information, to System representatives.

g. Authorizes and consents to System representatives providing other hospitals, professional societies, licensing boards, and other organizations concerned with provider performance and the quality of patient care with relevant information the System may have concerning him or her, and releases the System and System representatives from liability for so doing.

h. Agrees that the System and Medical Staff may share the Practitioner File or any other information with a representative or agent from any System Member, including information obtained from other sources, and releases each person and each entity who received the information and each person and each entity who disclosed the information from any and all liability, including any claims of violations of any federal or state law, including the laws forbidding restraints of trade, that might arise from the sharing of the information and likewise agrees that the System and any and all System Members may act upon such information.

i. Agrees that the System and Medical Staff may share the contents of the Practitioner File and other Professional Review information with a representative or agent from any other entities that conduct Professional Review Activities in the State of Colorado and become registered with the Colorado Department of Regulatory Agencies as “Authorized Entities” under the Colorado Professional Review Act following implementation of the registration process. The Practitioner agrees to release each person and each entity who received the information and each person and each entity who disclosed the information from any and all liability, including any claims of violations of any federal or state law, including the laws forbidding restraints of trade, that might arise from the sharing of the information and will execute any written release requested by the hearing entity or by the System.

j. Consents to undergo and to release the results of a medical, psychiatric, or psychological examination by a Practitioner acceptable to the Credentials Committee or Medical Executive Committee, at the applicant’s expense, if deemed necessary by the Credentials Committee or Medical Executive Committee.

k. Signifies his or her willingness to abide by all the conditions of membership, as stated on the appointment application form, on the reappointment application form, and in the Medical Staff Bylaws and these Rules.

4.6.2 For purposes of this Rule, the term “System representative” includes the System Member’s Governing Body, its individual Directors and committee members; the Chief Executive Officer, the Chief Medical Officer, the Medical Staff, all Medical Staff, Service, Department, and Section officers and leaders and/or committee members having responsibility for collecting information regarding or evaluating the applicant’s credentials; and any authorized representative or agent of any of the foregoing.

4.7 VERIFICATION OF INFORMATION

4.7.1 Completion of Application and Verification

The applicant shall fill out and deliver an application form, including all signatures and attachments and payments, to Medical Staff Services which shall seek to verify the information submitted. The application will be deemed complete when all necessary payments, verifications and information have been obtained, including without limitation the following:

a. Payment of dues and nonrefundable application fees and assessments which are periodically approved by the Medical Executive Committee.

b. Valid E-mail address.
c. Information to verify that the applicant is the same individual identified in the application.

d. Current Colorado license and any licensing board disciplinary records.

e. Specialty board certification status.

f. National Practitioner Data Bank information.

g. Office of Inspector General program exclusion list status.

h. Criminal background check.

i. DEA certificate if appropriate.

j. Verification of relevant work history.

k. Current malpractice liability insurance.

l. Peer reference letters (at least one from the same professional discipline as the applicant).

m. Influenza vaccination status for applicants to the Active and Courtesy Staff (except for Practitioners who limit their practice to telemedicine), if the Practitioner applies during flu season (November 1 through March 31).

n. Education, training, experience continuing education, including CME relevant to the applicant’s specialty (past verifications of education, training, and experience done within the system may be used).

o. Documentation of current clinical activity required by the applicable privileging forms.

p. Any additional information deemed significant to a full and fair evaluation by the Credentials Committee, the Medical Executive Committee, the Governing Body, or an ad hoc or subcommittee appointed to review the applicant.

If any of the foregoing documents and information is not delivered to Medical Staff Services or Medical Staff Services cannot verify any required information, the application will be deemed incomplete. Once the application is complete, Medical Staff Services shall then provide the application and all supporting materials to the Chair of each Department or Service in which the applicant seeks Privileges.

4.7.2 Incomplete Application

a. If Medical Staff Services is unable to obtain or verify any information regarding an applicant, or the application is otherwise incomplete, Medical Staff Services may delay further processing of the incomplete application, or may begin processing the application based only on the available information, provided that the application is still considered incomplete and the missing information will be considered upon receipt. Additionally, if the Credentials Committee, the Medical Executive Committee, the Governing Body or an ad hoc or subcommittee deems additional information to be significant to a full and fair evaluation of the applicant and this additional information is not delivered to Medical Staff Services, the Committee may suspend further processing of the incomplete application. Medical Staff Services, the Credentials Committee Chair or the President will promptly notify their counterpart at another System Member if any Shared Practitioner’s application is deemed incomplete. If any other System Member deems a Shared Practitioner’s application to be incomplete, the Shared Practitioner’s application at the Hospital is automatically deemed incomplete, pending receipt of the missing information.

b. If the processing of the application is delayed for more than 30 days and if the missing information is reasonably deemed significant to a full and fair evaluation of the applicant’s qualifications and conduct, the affected Practitioner shall be so informed in writing. He or she shall then be given the opportunity to withdraw his or her application, or to provide or arrange for the provision of the missing information or verification within 30 days. If the applicant does not provide or arrange for the provision of such information or verification within 30 days, he or she shall be deemed to have voluntarily withdrawn his or her application. An applicant whose application is deemed withdrawn under this Rule 4.7 is not entitled to a hearing or appeal under the Medical Staff
Bylaws or the Peer Review, Fair Hearing and Appeal Rules. If a Shared Practitioner’s application is deemed withdrawn at another System Member for failure to provide or arrange for the provision of information, the application is automatically deemed withdrawn at Hospital, and the Shared Practitioner is not entitled to a hearing or appeal under the Medical Staff Bylaws or the Peer Review, Fair Hearing and Appeal Rules.

c. Any application deemed incomplete and withdrawn under this Rule may, thereafter, be reconsidered only if all missing information is submitted, and all other information has been updated as appropriate.

d. If an application for reappointment is deemed incomplete but the application is not deemed to have been automatically withdrawn (for example, the Practitioner executed all releases and missing information is being collected by an unaffiliated hospital or the missing information is part of an ongoing internal peer review process), the Credentials Committee and Medical Executive Committee may, but are not required to, recommend reappointment and renewal of Privileges for short period of time (e.g., two months) to allow for receipt of the missing information. If a Shared Practitioner is subject to reappointment and renewal of Privilege for a short period of time at another System Member in order to receive missing information, the Shared Practitioner’s reappointment and renewal of Privileges shall be for the shortest period recommended by any of the System Members in accordance with Sections 4.9.1, 4.10.5 and 4.10.7.

4.8 ACTION ON THE APPLICATION

4.8.1 Department and Section Action

Upon receipt, the Department Chair or Section Chief (if the Department has Sections) shall review the application, supporting documentation, and other relevant information available to him or her. The Department Chair or Section Chief may personally interview the applicant. The Department Chair or Section Chief shall send the Credentials Committee and the Medical Executive Committee a written or electronically entered report and recommendations as to Medical Staff appointment, Department and Section affiliations, and Privileges.

4.8.2 Credentials Committee Action

The Credentials Committee or a subcommittee thereof shall review the application, supporting documentation, Department Chair and Section Chief recommendations, and may review other relevant information available to it. The Credentials Committee or a subcommittee thereof may personally interview the applicant. The Credentials Committee shall send the Medical Executive Committee a report and recommendations as to Medical Staff appointment, Department and Section affiliations, and Privileges.

The Credentials Committee Chair will notify his/her counterpart at any System Member if the Credentials Committee anticipates making any recommendation other than full membership and all Privileges requested for a two year period for a Shared Practitioner (other than minor variations to align the appointment with the Shared Practitioner’s birth month). The Credentials Committee Chair may call a meeting of the Conference Committee before a recommendation is made to the Medical Executive Committee in the event of possibly inconsistent recommendations by the System Members’ Credentials Committees for a Shared Practitioner. The Credentials Committee report and recommendation should be postponed until after the Conference Committee meeting to promote consistent quality of care and professional standards among the System Members.

4.8.3 Medical Executive Committee Action

a. Preliminary Recommendation: At its next regular meeting after receiving the Credentials Committee and Department Chair and Section Chief reports and recommendations, the Medical Executive Committee shall consider all relevant information available to it. The Medical Executive Committee shall then formulate a preliminary recommendation. If the preliminary recommendation is favorable, the Medical Executive Committee shall then assess the applicant’s health status, and determine whether the applicant is able to perform, with or without reasonable accommodation, the necessary functions of a Member of the Medical Staff. The Medical Executive Committee may request additional evaluations of applicants in instances where there is
doubt about an applicant’s ability to perform the Privileges requested. Without limiting the foregoing, the Medical Executive Committee may require additional proctoring of any Privileges that are used so infrequently as to make it difficult or unreliable to assess current competency without additional proctoring, and if such proctoring requirements are imposed solely for lack of activity, the initial proctoring requirement itself is not reportable to the National Practitioner Data Bank and shall not result in any hearing or appeal rights under the Bylaws or the Peer Review, Fair Hearing and Appeal Rules.

b. Final Recommendation: Thereafter, a final recommendation shall be formulated, and the Medical Executive Committee shall forward to the Governing Body a report and recommendations, as follows:

1. Favorable Recommendation: Favorable recommendations shall be promptly forwarded to the Governing Body, with the Department affiliations, Privileges to be granted, and any special conditions to be attached to the appointment.

2. Adverse Recommendation: When the recommendation is adverse in whole or in part, the President shall immediately inform the Practitioner by Special Notice, and he or she shall be entitled to the hearing and appeal rights provided in the Peer Review, Fair Hearing and Appeal Rules. The Governing Body shall be generally informed of, but shall not receive detailed information and shall not take action on, the pending adverse recommendation until the applicant has exhausted or waived his or her procedural rights.

For the purposes of this Rule, an “adverse recommendation” by the Medical Executive Committee is as defined in the Peer Review, Fair Hearing and Appeal Rules.

3. Deferral: The Credentials Committee, Department Chair or Section Chief, and/or Medical Executive Committee may defer its recommendation in order to obtain or clarify information, or in other special circumstances; provided that the Practitioner’s appointment will not be allowed to lapse during the deferral period. A deferral must be followed up within a reasonable time, ordinarily not to exceed 60 days with a recommendation regarding appointment and Privileges, or for rejection for Medical Staff membership.

c. Recommendation: Initial appointment recommendations shall be written or electronically entered and shall specify whether the applicant’s appointment should be granted; granted with modified membership category, Department affiliation, and/or Privileges; or denied. The reason for any adverse recommendation shall be described. The Medical Executive Committee may require additional proctoring of any Privileges that are used so infrequently as to make it difficult or unreliable to assess current competency without additional proctoring, and if such proctoring requirements are imposed solely for lack of activity, the initial proctoring requirement itself is not reportable to the National Practitioner Data Bank and shall not result in any hearing or appeal rights under the Bylaws or the Peer Review, Fair Hearing and Appeal Rules.

The President will notify his/her counterpart at any System Member as soon as possible if the Medical Executive Committee anticipates making any recommendation other than full membership and all Privileges requested for a two year period for a Shared Practitioner (other than minor variations to align the appointment with the Practitioner’s birth month). The President may call a meeting of the Conference Committee before a recommendation is made to the Governing Body in the event of possibly inconsistent recommendations by the System Members’ Medical Executive Committees for a Shared Practitioner. The Medical Executive Committee recommendation should be postponed until after the Conference Committee meeting to promote consistent quality of care and professional standards among the System Members.

4.8.4 Governing Body Action

a. On Favorable Medical Executive Committee Recommendation: The Governing Body shall adopt, reject, or modify a favorable recommendation of the Medical Executive Committee, or shall refer the recommendation back to the Medical Executive Committee for further consideration, stating the reasons for the referral and setting a time limit within which the Medical Executive Committee
shall respond. If the Governing Body’s action is a ground for a hearing under the Peer Review, Fair Hearing and Appeal Rules, the Chief Executive Officer shall promptly inform the applicant by Special Notice, and he or she shall be entitled to the hearing and appeal rights provided in the Peer Review, Fair Hearing and Appeal Rules.

b. **Without Benefit of Medical Executive Committee Recommendation:** If the Governing Body does not receive a Medical Executive Committee recommendation within the time specified below, it may, after giving the Medical Executive Committee written notice and a reasonable time to act, take action on its own initiative. If such recommendation is favorable, it shall become effective as the final decision of the Governing Body. If the recommendation is a ground for a hearing under the Peer Review, Fair Hearing and Appeal Rules, the Chief Executive Officer shall give the applicant Special Notice of the tentative adverse recommendation and of the applicant’s right to request a hearing. The applicant shall be entitled to the hearing and appeal rights provided in the Peer Review, Fair Hearing and Appeal Rules before any final adverse action is taken.

c. **After Procedural Rights:** In the case of an adverse Medical Executive Committee recommendation or an adverse Governing Body decision pursuant to Rule 4.8.3(b) or 4.8.4(b), the Governing Body shall take final action in the matter only after the applicant has exhausted or has waived his or her procedural rights under the Peer Review, Fair Hearing and Appeal Rules. Action thus taken shall be the conclusive decision of the Governing Body, except that the Governing Body may defer final determination by referring the matter back for reconsideration. Any such referral shall state the reasons therefor, shall set a reasonable time limit within which reply to the Governing Body shall be made, and may include a directive that additional hearings be conducted to clarify issues which are in doubt. After receiving the new recommendation and any new evidence, the Governing Body shall make a final decision.

d. **Conflict Resolution:** The Governing Body shall give great weight to the actions and recommendations of the Medical Executive Committee, and in no event shall act in an arbitrary and capricious manner.

### 4.8.5 Notice of Final Decision

The Chief Executive Officer shall give notice of the Governing Body’s final decision to the Medical Executive Committee and to the applicant. If the decision is adverse, the notice to the applicant shall be by Special Notice. A decision and notice to applicant shall include:

a. The Medical Staff category to which the applicant is appointed;
b. The Department and Section, if any, to which the Practitioner is assigned;
c. The Privileges the Practitioner may exercise;
d. Any special conditions attached to the appointment, and
e. Appointment/reappointment period.

### 4.8.6 Guidelines for Time of Processing

All individuals and groups shall act on applications in a timely and good faith manner. Except when additional information must be secured or for other good cause, each application should be processed within the following time guidelines:

<table>
<thead>
<tr>
<th>REVIEWER</th>
<th>TIME FRAMES FOR REVIEW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Credentials Verification Office</td>
<td>45 days after all necessary documentation is received.</td>
</tr>
<tr>
<td>Medical Staff Services</td>
<td>45 days after all necessary documentation is received.</td>
</tr>
<tr>
<td>Department Chair or Section Chief</td>
<td>45 days after receiving application from Medical Staff Services.</td>
</tr>
<tr>
<td>Credentials Committee</td>
<td>45 days after receiving report from the Department Chair.</td>
</tr>
</tbody>
</table>
**REVIEWER** | **TIME FRAMES FOR REVIEW**
---|---
Medical Executive Committee | 45 days after receiving the report from the Credentials Committee
Governing Body | 45 days after receiving application from Medical Executive Committee report, except when the hearing and appeal rights under the Peer Review, Fair Hearing and Appeal Rules apply.

These time periods are guidelines and are not directives that create any rights for a Practitioner to have an application processed within these precise periods. The processing may be delayed or discontinued in the event of an incomplete application, as noted above. If action at a particular step in the process is delayed without good cause, the next higher authority may immediately proceed to consider the application upon its own initiative or at the direction of the President or the Chief Executive Officer. If at the time of Credentials Committee review any of the following documents have exceeded 180 days from the date of receipt by Medical Staff Services, current documents must be obtained: NPDB report, OIG query, peer references and any agreements, consents and/or releases to be signed by the applicant that are associated with application and/or supplemental documentation.

**4.9 DURATION OF APPOINTMENT AND PRIVILEGES**

4.9.1 Appointment to the Medical Staff and the initial grant of Privileges may be for less than two years, but shall not exceed two years. A Practitioner is not entitled to a hearing or appeal under the Medical Staff Bylaws or the Peer Review, Fair Hearing and Appeal Rules because an appointment or the grant of Privileges is for less than two years for any reason. Appointment to the Medical Staff and the grant of Privileges for a Shared Practitioner shall be for the shortest period recommended by any of the System Members. The initial granting of Privileges shall be subject to a provisional period of at least 12 months, not to exceed 24 months, except for those appointed to the Affiliate Staff. Provisional appointments shall be at least 12 months and shall not exceed 24 months. The initial granting of Privileges at the time of initial appointment or when new Privileges are requested will be subject to Focused Professional Practice Evaluation according to Policies as such are amended from time to time. Medical Staff Services will strive to have subsequent appointments coincide with the Member’s birth date. The initial appointment shall expire on the last day of the last month of the two year initial appointment period unless the Practitioner is reappointed sooner.

4.9.2 Reappointments to any Medical Staff category and renewal or revision of Privileges may be for less than two years but shall not exceed two years. Medical Staff Services will strive to have reappointments coincide with the Member’s birthday. A Practitioner is not entitled to a hearing or appeal under the Medical Staff Bylaws or the Peer Review, Fair Hearing and Appeal Rules because an appointment or the grant of Privileges is for less than two years for any reason.

4.9.3 Appointments/reappointments shall begin on the first day of the month after the Governing Body meets and shall expire on the last day of the month in which the appointment or reappointment expires (the last day of the month outlined on the applicant’s Governing Body letter, or the last day of the last month of the two year appointment period or shorter appointment period, as applicable).

**4.10 Reappointment Process**

4.10.1 Schedule for Reappointment

At least 120 days prior to the expiration date of each Medical Staff Member’s appointment, Medical Staff Services shall provide the Member with a reappointment form. Completed reappointment forms shall be returned to Medical Staff Services at least 90 days prior to the expiration date. Failure, without good cause, to return the form shall result in automatic suspension or resignation as described in Rule 4.10.9.

4.10.2 Content of Reappointment Packet

a. The reappointment packet shall be approved by the Medical Executive Committee and the Governing Body, and once approved shall be considered part of these Rules. The packet shall seek information concerning the changes in the applicant’s qualifications since his or her last review. If recertification is required to maintain certification in the Practitioner’s specialty,
documented proof that this has been completed is required for reappointment. Specifically, the packet shall request an update of all of the information and certifications requested in the appointment application form, with the exception of that information which cannot change over time, such as information regarding the Member’s premedical and medical education, date of birth, and so forth. The packet shall also require information as to whether the applicant requests any revisions in his or her Medical Staff status and/or in his or her Privileges, including any reduction, deletion, or additional Privileges. Requests for additional Privileges must be supported by the type and nature of evidence that would be necessary for such Privileges to be granted in an initial application.

b. If the Medical Staff Member’s level of clinical activity at this Hospital is not sufficient to permit the Medical Staff and Governing Body to conduct a reappraisal and to evaluate his or her competence to exercise the Privileges requested, additional peer references may be obtained and the Medical Staff Member shall have the burden of providing evidence of clinical performance at his or her principal institution in whatever form as the Medical Staff may require. If available, Ongoing Professional Practice Evaluation information according to Policies as such are amended from time to time will be considered at the time of reappointment.

c. In addition to completing the information requested on the reappointment form and paying any reappointment application fee, the Medical Staff Member must have paid his or her annual dues.

4.10.3 Verification and Collection of Information

The Medical Staff shall, in timely fashion, seek to verify the additional information made available on each reappointment application and to collect any other materials or information for reappraisal deemed pertinent by the Medical Executive Committee, the Credentials Committee, Chief Medical Officer, or Chair of any Department or Section Chief (if the Department has Sections) to which the Member belongs. The information shall address, without limitation:

a. Patterns of care and utilization as demonstrated in the findings of quality and performance improvement, evidence based practice, risk management, resource management activities and, when available and applicable.

b. Participation in relevant continuing education activities.

c. Clinical activity (patient care contacts).

d. Voluntary or involuntary relinquishment or termination in licensure, registration, Medical Staff membership or Privileges at any facility.

e. Sanctions imposed or pending and other problems.

f. Health status including completion of a physical examination or psychiatric evaluation by a physician who is mutually accepted by the affected Practitioner and Medical Staff (at the Practitioner’s sole cost), when requested by the Credentials Committee or Medical Executive Committee and subject to the standards set forth in Rule 4.5 pertaining to health concerns.

g. Timely and accurate completion and preparation of medical records.

h. Cooperativeness and general demeanor in relationships with other Practitioners, System personnel, and patients.

i. Professional liability claim experience, including being named as a party in any professional liability claims and the disposition of any pending claims.

j. Compliance with all applicable Medical Staff and System Bylaws, Rules, and policies.

k. Peer references from at least one Practitioner who is the same professional discipline as the Member and is familiar with the Member’s current qualifications by virtue of having recently worked with the Member or having recently reviewed the Member’s cases. Additional peer references may be used for the renewal of Privileges when there is insufficient Peer Review data available regarding the Member.
l. Any other pertinent information including the Medical Staff Member’s activities at other hospitals and his or her medical practice outside the System.

m. Information concerning the Member from the state licensing board and the National Practitioner Data Bank.

n. Additional education, training, and experience since last reappointment.

o. Status with the Office of Inspector General (OIG) program exclusion list.

p. Influenza vaccination status for Active and Courtesy members (except for members who limit their practice to telemedicine), if the reappointment application is processed during flu season (November 1 through March 31).

q. A valid email address.

r. Payment of nonrefundable fees and assessments, which are periodically approved by the Medical Executive Committee.

Medical Staff Services shall provide the completed reappointment application form and supporting materials to the Chair of each Department to which the Medical Staff Member belongs, or to the Section Chief (if the Department has Sections) and to the Chair of any other Department or Section in which the Member has or requests Privileges and to the Credentials Committee. Medical Staff Services may exchange all information collected regarding a Shared Practitioner with other System Members where the Shared Practitioner has applied for or been granted Privileges.

4.10.4 Department and Section Action

The Department Chair or Section Chief (if the Department has Sections) shall review the application and all other relevant available information. He or she shall provide to the Credentials Committee and to the Medical Executive Committee his or her written or electronically entered recommendations, which are prepared in accordance with Rule 4.8.

4.10.5 Credentials Committee

The Credentials Committee shall review the application, the Department Chair or Section Chief’s recommendation, and all other relevant available information. The Credentials Committee shall provide to the Medical Executive Committee recommendations, which are prepared in accordance with Rule 4.8.

The Credentials Committee Chair will notify his/her counterpart at any System Member if the Credentials Committee anticipates making any recommendation other than reappointment and grant of all Privileges requested for a two year period for a Shared Practitioner (other than minor variations to align the appointment with the Practitioner’s birth month). The Credentials Committee Chair may call a meeting of the Conference Committee before a recommendation is made to the Medical Executive Committee in the event of possibly inconsistent recommendations by the System Members’ Credentials Committees for a Shared Practitioner to promote consistent quality of care and professional standards among the System Members. The Credentials Committee report and recommendation should be postponed until after the Conference Committee meeting to promote consistent quality of care and professional standards among the System Members. The Credentials Committee may recommend reappointment of the Shared Practitioner and renewal of Privileges for a short period of time (e.g., two months) to allow the Conference Committee to proceed and for reconsideration by the Credentials Committee following the Conference Committee meeting; provided that the reappointment and renewal for a Shared Practitioner shall automatically be for the shortest period recommended by any System Member.

4.10.6 Medical Executive Committee Action

a. The Medical Executive Committee shall review the Credentials Committee and Department Chair or Section Chief’s recommendations and all other relevant information available to it and shall forward to the Governing Body its favorable recommendations, which are prepared in accordance with Rule 4.8.

b. When the Medical Executive Committee recommends adverse action, as defined in the Peer Review, Fair Hearing and Appeal Rules, either with respect to reappointment or Privileges, the
President shall give the applicant Special Notice of the adverse recommendation and of the applicant’s right to request a hearing in the manner specified in the Peer Review, Fair Hearing and Appeal Rules. The applicant shall be entitled to the hearing and appeal rights as specified under the Peer Review, Fair Hearing and Appeal Rules. The Governing Body shall be informed of, but not take action on, the pending recommendation until the applicant has exhausted or waived his or her procedural rights.

c. Thereafter the procedures specified for applicants in Rule 4.8.4 (Governing Body Action), Rule 4.8.5 (Notice of Final Decision) and in the Rule 4.13 (Waiting Period After Adverse Action), shall be followed. The Medical Executive Committee may also defer action; however, any deferral must be followed up within a reasonable time, ordinarily not to exceed 60 days with a recommendation.

4.10.7 Reappointment Recommendations

Reappointment recommendations shall be written or electronically entered and shall specify whether the applicant’s appointment should be renewed; renewed with modified membership category, Service, Department or Section affiliation, and/or Privileges; or terminated. The reason for any adverse recommendation shall be described. The Medical Staff may require additional proctoring of any Privileges that are used so infrequently as to make it difficult or unreliable to assess current competency without additional proctoring, and if such proctoring requirements are imposed solely for lack of activity, the initial proctoring requirement itself is not reportable to the National Practitioner Data Bank and shall not result in any hearing or appeal rights under the Medical Staff Bylaws or the Peer Review, Fair Hearing and Appeal Rules.

The President will notify his/her counterpart at any System Member if the Medical Executive Committee anticipates making any recommendation other than reappointment and grant of all Privileges requested for a two year period for a Shared Practitioner (other than minor variations to align the appointment with the Practitioner’s birth month). The President may call a meeting of the Conference Committee before a recommendation is made to the Governing Body in the event of possibly inconsistent recommendations by the System Members’ Medical Executive Committees for a Shared Practitioner to promote consistent quality of care and professional standards among the System Members. The Medical Executive Committee may recommend reappointment of the Shared Practitioner and renewal of Privileges for a short period of time (e.g., two months) to allow the Conference Committee to proceed and for reconsideration by the Medical Executive Committee following the Conference Committee meeting; provided that the reappointment and renewal for a Shared Practitioner shall automatically be for the shortest period recommended by any System Member.

4.10.8 Basis for Reappointment

Reappointment recommendations (including Privilege recommendations) shall be based upon a reappraisal of the Member, including whether the Member has met all of the qualifications and carried out all of the responsibilities set forth in the Medical Staff and System Bylaws, Rules and policies.

4.10.9 Late Submission of a Reappointment Application

Submission of a reappointment application beyond the deadline will result in the assessment of a $200 late fee. Submission of reappointment applications will be tracked as follows:

a. At least 120 days from expiration of current privileges, the reappointment packet is sent by mail or email.

b. Approximately 30 days after the reappointment packet was sent the completed reappointment packet is due in the Credentials Verification Office (“CVO”). If it has not been received, the CVO will mail a certified letter or send an email warning of possible assessment of a late fee and warning of impending automatic resignation and relinquishment.

c. Approximately 45 days after reappointment packet was sent, Medical Staff Services will contact, call or email any provider who has failed to return a completed packet and remind them that a late fee will be assessed if the completed reappointment packet has not been received within the next 15 days.
d. 50 days after reappointment packet was sent a late fee will be assed for all providers who have not returned the completed reappointment packet to the CVO.

e. Reappointment applications received less than 45 days from expiration of current Privileges may not be processed due to insufficient time to obtain required documentation necessary for Department and Credentials Committee review and will result in voluntary resignation as outlined below in “Failure to File a Reappointment Application.” A special assessment may apply to a reappointment application that is received late depending on when a reappointment application is received and if the application is complete and can be processed and reviewed by the Department prior to the date of the next Credentials Committee meeting.

4.10.10 Failure to File a Reappointment Application

a. If a Member submits an application for reappointment on or after the actual date of expiration, the Member shall be deemed to have automatically voluntarily resigned from the Medical Staff and to have relinquished his/her Privileges on the date the Member’s appointment expired. The former Member will be processed as a new applicant without seniority.

b. If a Member is deemed to have automatically voluntarily resigned or relinquished Privileges under this Rule, the Member shall not be entitled to any hearing and appellate review under the Bylaws or the Peer Review, Fair Hearing and Appeal Rules.

4.11 Leave of Absence

4.11.1 Leave of Absence - General

A Member may request to the Credentials Committee and be granted a leave of absence by the Medical Executive Committee in accordance with the Medical Staff Bylaws and these Rules. All requests for a leave of absence shall be submitted in writing to the Medical Executive Committee, specifying the reason for the leave of absence and the proposed period of leave. A leave of absence may be for medical reasons (see Rule 8), military service obligations, educational purposes, personal reasons (e.g., to pursue a volunteer endeavor such as contributing work to “Doctors Without Borders/USA”), or family reasons (e.g., maternity leave). A leave of absence may be approved for up to two years; provided, however, the Member must submit a complete and timely reappointment application during the leave of absence and must be granted reinstatement upon expiration of the leave of absence prior to resuming the exercise of Privileges at the Hospital as set forth below. A leave of absence is not a relinquishment or limitation of membership or Privileges. During the leave of absence, however, the Member shall not exercise Privileges at the Hospital, and membership rights and responsibilities shall be inactive, but the obligation to pay dues, if any, shall continue unless waived by the Medical Executive Committee.

4.11.2 Early Reappointment to Approval of Leave of Absence

If a Member is planning to take an extended leave of absence, he or she may apply for early reappointment. Early reappointment allows for early processing of a reappointment application, in advance of the time frame under Rule 4.9, if the Member’s appointment might otherwise expire during the leave of absence. To seek early reappointment, the Member must submit a completed reapplication form, a written request for early reappointment and a request for a leave of absence to Medical Staff Services at least ninety days prior to the anticipated commencement of the leave of absence. Thereafter, the early reappointment application shall be processed in the same manner as other reappointment applications under Rule 4.10. The Member may be granted reappointment for any period up to two years, notwithstanding the customary expiration schedule set forth in Rule 4.9.2. If an early reappointment application is not fully processed prior commencement of the Member’s leave of absence, this shall not be deemed a denial of reappointment or any Privileges, and shall not entitle the Practitioner to a hearing or appeal under the Peer Review, Hearing and Appeal Rules.

4.11.3 Approval of Leave of Absence and Notice

The Medical Executive Committee shall approve all requests for a leave of absence. If a Member’s departure date for a military service leave is prior to the next Medical Executive Committee meeting, the President and the Chief Executive Officer may approve the leave of absence as the Medical Executive Committee’s designee. The Medical Executive Committee (or its designee) shall notify the Member in
writing if his or her request for a leave of absence is approved. The Notice of Approved Leave of Absence shall address the following:

a. The reason for the leave of absence;
b. The approved period for the leave of absence (not to exceed two years);
c. That the Member must submit a complete and timely reappointment application during the leave of absence if his or her then-current appointment would otherwise expire during the leave, and the date such reappointment application is due;
d. That the Member must submit a timely written request for reinstatement, and the anticipated date such request is due;
e. Any known preconditions for a reinstatement evaluation (e.g., a report on clinical activity, a report from an educational program, a report from CPHP, a written authorization to return to work from the Member’s treating physician);
f. If the Member is entitled to expedited reinstatement, the conditions for such expedited reinstatement (see Rule 4.11.4 (a) below);
g. That a leave of absence is not a relinquishment of Medical Staff membership or Privileges;
h. That the Member may not exercise Privileges at the Hospital or other Medical Staff rights and responsibilities (e.g., call coverage) during the leave of absence;
i. Whether the Member is obligated to pay dues during the leave of absence; and
j. Any other conditions applicable to the leave of absence.

The Medical Executive Committee may include a copy of this Rule 4.11 (and, for a medical leave of absence, a copy of Rule 8) with the Notice of Approved Leave of Absence.

4.11.4 Reinstatement and Special Conditions

a. Expedited Reinstatement.

If the Medical Executive Committee determines that a Credentials Committee recommendation for reinstatement following a leave of absence is not necessary, the Medical Executive Committee may authorize expedited reinstatement as stated in the Notice of Approved Leave of Absence. For example, expedited reinstatement may be appropriate for a maternity leave, a 120-day personal leave to engage in volunteer activities, or an educational leave that does not warrant a review of the Member’s professional qualifications or competence to exercise the Privileges previously granted. A Member is not entitled to expedited reinstatement if his or her appointment expires under Rule 4.10.9 for failure to file a timely reappointment application during the leave. Expedited reinstatement may not be appropriate for certain extended leaves of absence, medical leaves of absence that warrant Credentials Committee review (see Rule 8), and educational leaves of absence that warrant Credentials Committee review of the Member’s professional qualifications and competence to exercise those Privileges previously granted. As a condition of expedited reinstatement, the Member may be required to execute an attestation that no changes have occurred in the status of any of the professional qualifications listed in the Medical Staff Bylaws, the Member’s application form or the privileging forms during the leave, and to provide any other information deemed relevant by the Medical Executive Committee (e.g., a return to work authorization from the Member’s personal physician). The Credentials Chair (or his/her designee) shall review such attestation and any additional information provided.

b. Reinstatement Request.

Unless an expedited reinstatement is specifically authorized in the Notice of Approved Leave of Absence and so long as the Member’s appointment has not expired under Rule 4.10.9 for failure to file a timely reappointment application, the Member may request reinstatement of membership
and Privileges by submitting a written notice to Medical Staff Services at least ninety (90) days prior to the expiration of the approved leave period. If a Member has not submitted a timely request for reinstatement, Medical Staff Services shall notify the Member at least sixty (60) days prior to expiration of the approved leave period. The Member shall have an additional five (5) business days from receipt of the notice to submit a request for reinstatement. If a Member fails to request reinstatement in a timely manner, the Member shall be deemed to have voluntarily relinquished appointment and Privileges effective at the end of the approved leave period.

The written request for reinstatement shall include an attestation that no changes have occurred in the status of any of the professional qualifications listed in the Medical Staff Bylaws, the Member’s application form or the privileging forms, or if changes have occurred, a detailed description of the nature of the changes. The request for reinstatement shall also include any information identified as a precondition of reinstatement. The Member shall submit a summary of relevant professional activities during the leave, which may include, but is not limited to the scope and nature of professional practice during the leave period and any professional training completed.

c. Approval of Reinstatement.

The Credentials Committee shall review the request for reinstatement (except for expedited reinstatements) and all relevant available information, and shall provide the Medical Executive Committee a recommendation regarding reinstatement. Reinstatement may be subject to certain monitoring and/or proctoring conditions as determined by the Medical Executive Committee, based on the Credentials Committee’s recommendation and evaluation of the nature of activities during the leave.

d. Special Conditions for Medical Leave

If the leave of absence was for medical reasons and the Member was not granted expedited reinstatement, additional health status information shall be submitted to the Credentials Committee in accordance with Rule 8.

e. Special Conditions for Educational Leave

Any additional Privileges that may be desired upon the successful conclusion of additional education and training must be requested in accordance with Rule 6.

4.11.5 Denial of Reinstatement

An adverse decision regarding reinstatement by the Medical Executive Committee shall be treated as denial of reappointment and renewal of Privileges under the Peer Review, Fair Hearing and Appeal Rules. The denial of reinstatement and renewal shall not be deemed effective until the Member has exhausted or waived his or her hearing and appeal rights.

4.11.6 Reappointment During Leave

Reappointment applications must be completed and submitted in a timely and complete manner during any leave of absence in accordance with Rule 4.10. Reappointment and renewal of Privileges during a leave of absence may be subject to the condition that the Member remains on leave until he or she is reinstated. If a Member fails to apply for reappointment in a timely and complete manner, his or her membership and Privileges shall expire in accordance with Rule 4.10.9. Thereafter, the Member may apply for membership and Privileges as a new applicant under Rule 4.

4.12 REVISING PRIVILEGES

A Medical Staff Member who wishes to relinquish or limit particular Privileges shall send written notice to the President and the appropriate Department Chair or Section Chief (if the Department has Sections) identifying the particular Privileges to be relinquished or limited. A copy of this notice shall be forwarded to Medical Staff Services for inclusion in the Member’s credentials file. A Medical Staff Member who wishes to increase the scope of Privileges shall complete the appropriate form, which shall be processed in the same manner as an initial request for Privileges under Rules 4 and 6.
4.13  WAITING PERIOD AFTER ADVERSE ACTION

4.13.1 Who Is Affected

a. A waiting period of 24 months shall apply to the following Practitioners:

1. An applicant who (i) has received a final adverse decision regarding appointment or (ii) withdrew his or her application or request for membership or Privileges following an adverse recommendation by the Medical Executive Committee or the Governing Body;

2. A former Member who has (i) received a final adverse decision resulting in termination of Medical Staff membership and/or Privileges or (ii) resigned from the Medical Staff or relinquished Privileges while an investigation was pending or following the Medical Executive Committee or Governing Body issuing an adverse recommendation; or

3. A Member who has received a final adverse decision resulting in (i) termination or restriction of his or her Privileges or (ii) denial of his or her request for additional Privileges.

b. Ordinarily the waiting period shall be 24 months. However, for Practitioners whose adverse action included a specified period or conditions of retraining or additional experience, the Medical Executive Committee may exercise its discretion to allow earlier reapplication upon completion of the specified conditions. Similarly, the Medical Executive Committee may exercise its discretion, with approval of the Governing Body, to waive the 24-month period in other circumstances where it reasonably appears, by objective measures that changed circumstances warrant earlier consideration of an application.

c. An action is considered adverse only if it is based on the type of occurrences, which might give rise to corrective action. An action is not considered adverse if it is based upon reasons that do not pertain to medical or professional conduct, such as actions based on a failure to maintain a practice in the area (which can be cured by moving), to pay dues (which can be cured by paying dues), or to maintain professional liability insurance (which can be cured by obtaining the insurance). The waiting period will also not be required when Medical Staff membership is terminated because of failure to complete medical records in a timely manner, as such termination is not considered an adverse action.

4.13.2 Date When the Action Becomes Final

The action is considered final on the latest date on which the application or request was withdrawn, a Member’s resignation became effective, or upon completion or waiver of all Medical Staff and Hospital hearings and appellate reviews.

4.13.3 Effect of the Waiting Period

Except as otherwise allowed (per Rule 4.13.1), Practitioners subject to waiting periods cannot reapply for Medical Staff membership or the Privileges affected by the adverse action for at least 24 months after the action became final. After the waiting period, the Practitioner may reapply. The application will be processed like an initial application or request, plus the Practitioner shall document that the basis for the adverse action no longer exists, that he or she has corrected any problems that prompted the adverse action, and/or he or she has complied with any specific training or other conditions that were imposed.

4.14  CONFIDENTIALITY; IMPARTIALITY

To maintain confidentiality and to assure the unbiased performance of appointment and reappointment functions, participants in the credentialing process shall limit their discussion of the matters involved to the formal avenues provided in the Medical Staff Bylaws and Rules for processing applications for appointment and reappointment.

4.15  SYSTEMWIDE COOPERATION

4.15.1 General Rules for Systemwide Cooperation for Appointments, Reappointments and Corrective Action.

Practitioners and AHPs desiring to exercise Privileges through more than one System Member are subject to the following provisions regarding Systemwide appointments and reappointments, reporting of Peer Review information and adverse actions.
4.15.2 System Application Form

A single application form shall be developed for all participating System Members to use, and the applicant shall indicate those System Members in which he or she desires to exercise Privileges together with the Departments and Sections (if any) to which the applicant will apply and the Privileges desired.

a. An applicant requesting appointment and Privileges with an affiliated medical group or entity must first demonstrate a contractual or employment relationship with such medical group or entity.

b. An applicant requesting Privileges in a facility or Department or Section subject to an exclusive or semi-exclusive contracting arrangement must first demonstrate a contractual or employment relationship with the party holding the exclusive contract.

c. In addition to the provisions of subparagraphs (a) and (b) above, Privileges at any System Member shall be limited by the scope of Privileges normally available at that System Member.

4.15.3 System Review and Investigation

a. A review and investigation shall be conducted in accordance with the processes set forth in each Exempla System Member’s Medical Staff Bylaws, Rules and Policies; provided, however, that each System Member will share the results of its review and investigation, including any suspension (precautionary or summary) or other corrective action, on a confidential basis, with other System Members in order to further quality of care and patient safety whenever a Practitioner applies for or maintains Medical Staff membership, privileges or affiliation with another System Member. The Medical Staff may delegate review or investigatory responsibility to one or more participants in the processes, including other System Members or a committee consisting of representatives of one or more System Members.

b. The results of the review or investigation for purposes of credentialing shall be reported to the Credentials Committee for processing in the manner described above. The results of routine Peer Review and formal investigations will be reported to the System Members’ Credentials Committees and Medical Executive Committees. The Credentials Committee shall make its recommendations to the Medical Executive Committee. Each System Member shall collaborate to make a consistent recommendation for appointment and/or Privileges or corrective action in accordance with each System Member’s Bylaws, Rules and other applicable credentialing policies and procedures.

c. Notwithstanding the foregoing, the System Members may elect to proceed with Systemwide Peer Review and corrective action in accordance with the Peer Review, Fair Hearing and Appeal Rules or Joint Hearings and Appeals for System Members in accordance with the Peer Review, Fair Hearing and Appeal Rules.

RULE 5 PROFESSIONAL LIABILITY INSURANCE

5.1 General

5.1.1 Each Practitioner granted Privileges (including temporary Privileges) shall maintain professional liability insurance in not less than the minimum amounts specified below and with a carrier approved to market insurance in the State of Colorado.

5.1.2 The minimum amounts of coverage shall be $1,000,000 per occurrence, $3,000,000 aggregate, or such greater amount as may be required by law or established by the Governing Body, except that Members, such as full time faculty of the University of Colorado Health Sciences Center may have less coverage if they qualify for governmental immunity under Colorado state or federal law.

5.1.3 The insurance shall apply to all patients the Practitioner treats and to all procedures the Practitioner has Privileges to perform in the Hospital.

5.2 Proof of Insurance

5.2.1 Proof of insurance coverage must be provided. The proof shall be maintained in each Practitioner’s credentials file. Information about insurance coverage must be provided at the time of appointment and
reappointment and upon request from any Medical Staff Committee, officer, or Service, Department, or Section leader.

5.2.2 At the time of initial appointment and reappointment, each applicant or Member must provide information on any professional liability claims filed against him or her, any malpractice claims reported to his or her insurance carrier, any letters of intent to sue he or she received, any claims pending, any judgment entered against him or her, and any settlement made where there was a monetary payment. In addition, the applicant or Member must state whether he or she was denied professional liability insurance, had his or her policy canceled, had limitations placed on his or her Scope of Practice, or has been notified of any intent to deny, cancel, or limit coverage.

5.3 **REPORTING CHANGES**

Each Member shall report any reduction, restriction, cancellation, or termination of the required professional liability insurance or change in insurance carrier as soon as reasonably possible to the Credentials Committee and Chief Executive Officer, through a notice sent to Medical Staff Services.

5.4 **FAILURE TO MAINTAIN PROFESSIONAL LIABILITY INSURANCE**

The automatic suspension procedure set forth in the Medical Staff Rules shall be followed in the event a Practitioner fails to maintain insurance in the required amount.

5.5 **AVAILABILITY OF INFORMATION**

Upon receipt of a request from a Medical Staff Member, Medical Staff Services may supply information to the Member regarding another Member’s insurance coverage.

**RULE 6 PRIVILEGES**

6.1 **DELINEATION OF PRIVILEGES IN GENERAL**

6.1.1 Requests

a. Each application for appointment and reappointment to the Medical Staff must contain a request for the specific Privileges desired by the applicant. A request for a revision of Privileges must be supported by documentation of training and/or experience supportive of the request.

b. Each Department and Section will be responsible for developing criteria for granting, renewing and revising Privileges, and including those criteria in the Department and Section’s Privilege Forms, which shall be a part of these Rules and subject to approval by the Credentials Committee, Medical Executive Committee and Governing Body.

6.1.2 Bases for Privilege Determinations

Requests for granting, renewing or revising Privileges shall be evaluated on the basis of the Practitioner’s education, training, experience, demonstrated professional competence and judgment, clinical performance, the documented results of patient care and other quality improvement review and monitoring, performance of a sufficient number of procedures each year to develop and maintain the Practitioner’s skills and knowledge, peer references and compliance with any specific criteria applicable to the Privileges. Privilege determinations shall also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a Practitioner exercises Privileges.

6.1.3 Telemedicine Privileges

Telemedicine involves the use of electronic communication or other communication technologies to provide or support clinical care at a distance. Each Service, Department and Section will be responsible for recommending whether clinical services are appropriately delivered through telemedicine, subject to approval by the Credentials Committee, the Medical Executive Committee and the Governing Body. Criteria for granting telemedicine Privileges shall be developed in accordance with Rule 6.1.1 above. Requests for Privileges to prescribe, render a diagnosis, or otherwise provide clinical care through telemedicine shall be evaluated in the same manner as other requests for Privileges under these Rules.
6.1.4 Privileges to Perform Histories and Physicals

Privileges granted to Physicians and oral surgeons shall have been deemed to include Privileges to perform histories and physicals (“H&Ps”) in accordance with Rule 6.2.1 and the Clinical Rules, as such are amended from time to time. Privileges granted to dentists, podiatrists and clinical psychologists shall not be deemed to include Privileges to perform H&Ps, provided, however, that dentists, podiatrists and clinical psychologists may perform that portion of an H&P relating to dentistry, podiatry or psychology, as applicable. The Privileges to perform H&Ps for oral surgeons are limited to patients admitted for oral surgery.

6.1.5 Continuously Maintain Qualifications

Practitioners shall continuously maintain qualifications for Privileges granted, renewed or revised throughout the term of appointment or reappointment. A Practitioner will be granted a 60 day grace period to provide evidence of current Board Certification or other required certification providing the Practitioner has completed or submitted all requirements for the certification and is only awaiting confirmation of successfully attaining the certification.

6.1.6 Requests for New Technology, Procedure or Test

Requests for Privileges representing new technology, procedure or diagnostic test at the hospital will be evaluated according to hospital policy. The effective date of such Privileges granted will be the date of the hospital’s implementation of the new technology, procedure or test.

6.2 CONDITIONS FOR PRIVILEGES OF LIMITED LICENSE PRACTITIONERS

6.2.1 Admissions

a. Dentist, oral surgeon, podiatrist and clinical psychologist Members may admit patients only if a Physician Member assumes responsibility for the care of the patient’s medical problems present at the time of admission or which may arise during hospitalization which are outside of the limited license Practitioner’s lawful scope of practice. Clinical psychologists may admit patients only if a psychiatrist co-admits the patient.

b. When evidence of appropriate training and experience is documented, an oral surgeon may perform the history or physical on his or her own patient. Otherwise, a Physician Member must conduct or directly supervise the admitting history and physical examination (except the portion related to dentistry, podiatry, or clinical psychology).

6.2.2 Medical Appraisal

All patients admitted for care in a Hospital by a dentist, oral surgeon, or podiatrist shall receive the same basic medical appraisal as patients admitted to other services, and a Physician Member or a limited license Practitioner with appropriate Privileges shall determine the risk and effect of any proposed treatment or surgical procedure on the general health status of the patient. When a dispute exists regarding proposed treatment between a Physician Member and a limited license Practitioner based upon medical or surgical factors outside of the scope of licensure of the limited license Practitioner, the treatment will be suspended insofar as possible while the dispute is resolved by the appropriate Department(s) or Section.

6.3 TEMPORARY PRIVILEGES

6.3.1 Circumstances

Under certain circumstances, temporary privileges may be granted for a limited period of time. There are two circumstances in which temporary privileges may be granted.

Temporary Privileges may be granted:

a. To fulfill an important patient care, treatment, and service need which may include but is not limited to:

(i) Providing care, treatment, and services for up to 4 specific patients in any 12 consecutive months to fulfill;
(ii) For Practitioners providing care, treatment, or services, under the sponsorship of a Practitioner on the Medical Staff, for a period of up to 120 days.

b. When a new applicant with a completed application that raises no concerns is awaiting review and approval of the Medical Executive Committee and the Governing Body. Temporary privileges for new applicants shall automatically expire in 120 days.

6.3.2 Application or Request Form

a. Practitioners seeking temporary Privileges or Scope of Practice to care for specific patients must complete a request form for temporary Privileges.

b. Practitioners seeking temporary Privileges or Scope of Practice during the pendency of a completed application must have submitted a completed application.

6.3.3 Level of Review for Temporary Privileges

The Medical Staff must review the qualifications of any Practitioner who requests temporary Privileges and assure that the available information supports the granting of the temporary Privileges. The nature of the Medical Staff review of an application for temporary Privileges may vary, depending upon the reason for temporary Privileges and the specific Privileges the Practitioners requests.

Two levels of review for temporary Privileges apply:

a. **Level One**: Level One is the minimum Medical Staff review that must be completed for each Practitioner who has requested temporary Privileges to fulfill an important patient care, treatment and service need. It consists of the following steps:

1. **Application**: Completion of an Application for Temporary Privileges or Scope of Practice to meet an important patient care, treatment, and service need. In the application, the Practitioner must document the important patient care, treatment and service need and provide information regarding his or her qualifications and also certify his or her agreement to abide by the Medical Staff Bylaws and the Rules. The application fee will not be charged for those applicants seeking to fulfill an important patient care need.

2. **Verification of Licensure**: The Practitioner must submit a copy of his or her license. Medical Staff Services will verify that the license is valid and unrestricted with the Colorado Medical Board or the out-of-state licensing board, if the applicant qualifies to practice with an out-of-state license.

3. **Verification of Professional Liability Insurance**: The Practitioner must identify his or her insurer and provide a certificate of coverage.

4. **Querying the National Practitioner Data Bank**: Medical Staff Services will query the National Practitioner Data Bank and the persons authorized to grant temporary Privileges will review the results.

5. **Obtain Copy of Federal DEA**: If the Practitioner seeks Privileges, which include prescribing controlled substances, Medical Staff Services will obtain a copy of his or her federal DEA license.

6. **Verify Hospital Affiliation**: Medical Staff Services must communicate with the equivalent of Medical Staff Services of one or more hospitals where the applicant primarily practices or has recently practiced.

7. **Querying the Office of Inspector General Exclusion List**: Medical Staff Services will query the Office of the Inspector General Exclusion List and the persons authorized to grant temporary Privileges will review the results.

8. **Verification of relevant education and training**: Primary source verification of education/training will be obtained.
9. **Verification of current competence** as evidenced by a minimum of one reference from a professional peer who has personal knowledge of and is directly familiar with the applicant’s professional competency.

b. **Level Two**: A Level Two review must be completed by the Medical Staff for temporary Privileges during the pendency of a completed application. The same review conducted in accordance with Rule 4.7 (Verification of Information), Rule 4.8.1 (Department and Section Action) and Rule 4.8.2 (Credentials Committee Action); provided, however, the Credentials Committee may delegate its duties under Rule 4.8.2 to one or more Credentials Committee members. It consists of the following steps

1. **Application**: Submission and processing of a completed application.
2. **Verification of Licensure**: The Practitioner must submit a copy of his or her license. Medical Staff Services will verify that the license is valid and unrestricted with the Colorado Medical Board or the out-of-state licensing board, if the applicant qualifies to practice with an out-of-state license.
3. **Verification of Professional Liability Insurance**: The Practitioner must identify his or her insurer and provide a certificate of coverage.
4. **Querying the National Practitioner Data Bank**: Medical Staff Services will query the National Practitioner Data Bank and the persons authorized to grant temporary Privileges will review the results.
5. **Obtain Copy of Federal DEA**: If the Practitioner seeks Privileges, which include prescribing controlled substances, Medical Staff Services will obtain a copy of his or her federal DEA license.
6. **Verify Hospital Affiliation**: Medical Staff Services must communicate with the equivalent of Medical Staff Services of one or more hospitals where the applicant primarily practices or has recently practiced.
7. **Querying the Office of Inspector General Exclusion List**: Medical Staff Services will query the Office of the Inspector General Exclusion List and the persons authorized to grant temporary Privileges will review the results.
8. **Verification of relevant education and training**.
9. **Verification of current competence** as evidenced by a minimum of one reference from a professional peer who has personal knowledge of and is directly familiar with the applicant’s professional competency.
10. Verification of no current or previously successful challenge to licensure or registration.
11. Verification of no subjection to involuntary termination of medical staff membership or AHP at another organization.
12. Verification of no subjection to involuntary limitation, reduction, denial, or loss of clinical privileges.

6.3.4 **Granting Temporary Privileges**

a. Temporary Privileges may be granted by the Chief Executive Officer or his or her designee (or for the care of a specific patient, such designee shall include the Administrator on Call), on the recommendation of the Medical Staff President or his or her designee which may include the Department Chair or Section Chief where the Privileges will be exercised, or either’s designee.

b. Temporary Privileges shall automatically terminate at the end of the designated period or service, unless earlier terminated.

c. Members whose membership was automatically terminated for a failure to complete medical records shall not be eligible for temporary Privileges except in an emergency.
6.3.5 Denial or Termination

a. There is no right to temporary Privileges. Accordingly, temporary Privileges should not be granted unless the available information supports, with reasonable certainty, a favorable determination regarding the requesting Practitioner’s qualifications, ability, and judgment to exercise the Privileges requested in accordance with the Medical Staff Bylaws and these Rules, and only after the appropriate level of review under this Rule 6.3.

b. Temporary Privileges may be automatically terminated, suspended or adversely affected in accordance with these Rules. A Practitioner shall be entitled to the procedural rights afforded by the Medical Staff Bylaws and the Rules in accordance with the Peer Review, Fair Hearing and Appeal Rules hereof. A Practitioner shall not be entitled to more than one hearing on any matter.

c. Whenever temporary Privileges are terminated, suspended, revoked or expire, the appropriate Department Chair or Section Chief or, in the Chair’s or Chief’s absence, the President shall assign a Member to assume responsibility for the care of the Practitioner’s patient(s). The wishes of the patient and affected Practitioner shall be considered in the choice of a replacement Member.

6.3.6 General Conditions

a. Practitioners granted temporary Privileges shall be subject to quality improvement review.

b. Practitioners requesting or receiving temporary Privileges shall be bound by the Medical Staff Bylaws and the Rules.

c. AHPs may request and be granted temporary Privileges in accordance with this Rule 6.3; provided however, AHPs shall be entitled only to the procedural rights set forth in the AHP Rules.

6.4 DISASTER PRIVILEGING

6.4.1 In a state of emergency, defined as a circumstance under which the hospital’s Emergency Management Plan has been implemented and where the immediate needs of patients cannot be met Practitioners or Allied Health Practitioners who volunteer to assist the Hospital will be privileged on an emergency basis, as needed to care for the Hospital’s patients. The Medical Director of the Hospital Emergency Incident Command System (HEICS) has the authority to emergently privilege appropriate Practitioners or Allied Health Practitioners. These decisions are to be made in accordance with the needs of the organization and its patients, and consistent with the qualifications of its volunteers. Volunteers considered eligible to act as licensed independent practitioners in the hospital must at a minimum present a valid government-issued photo identification issued by a state or federal agency and at least one of the following: 1) A current picture hospital ID card. 2) A current license to practice 3) Primary source verification of the license; 4) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), MRC, ESAR-VHP, or other recognized state or federal organizations or groups; 5) 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 or; 6) Identification by current hospital or Medical Staff Member(s) with personal knowledge regarding the Practitioner’s or AHP’s identity. A log will be maintained recording the volunteer’s ability to act as a licensed independent practitioner during a disaster. An ID badge will be issued to each emergently privileged Volunteer Practitioner.

6.4.2 The verification process is a high priority and as time, power, and technology permits, the Medical Staff will obtain primary source verification of the Volunteer Practitioner’s licensure as soon as the immediate situation is under control, not to exceed 72 hours from the time the volunteer practitioner has been granted disaster Privileges. In the event primary source verification cannot be completed in 72 hours (e.g. no means of communication or lack of resources) primary source verification will be completed as soon as possible. In this extraordinary circumstances

6.4.3 Whenever possible, the Volunteer Practitioner will be paired with a currently privileged member of the ESJH Medical Staff or a credentialed Allied Health Professional who has similar credentials/licensure. Whenever possible, the Volunteer Practitioner granted disaster Privileges should act only under the direct supervision and mentoring of an ESJH Medical Staff Member or AHP with like credentials. If a member of the ESJH Medical Staff or AHP with like credentials is not available to be paired with the Volunteer
Practitioner, another member of the ESJH Medical Staff or AHP will perform direct observation and mentoring of the Volunteer Practitioner.

6.4.4 The HEICS Medical Staff Director shall make a decision regarding continuation of the disaster Privileges granted within 72 hours of the initial granting of disaster Privileges. This determination shall be based upon information obtained regarding the professional practice of the Volunteer Practitioner. A Volunteer Practitioner’s disaster Privileges will be immediately rescinded by the HEICS Medical Staff Director in the event any information is received that suggests the person is not capable of rendering services in an emergency. There will be no appeal rights in the event a Volunteer Practitioner’s disaster Privileges are denied or terminated, regardless of the reason for action.

6.4.5 The assignments of Volunteer Practitioners granted disaster Privileges should be made in accordance with the Hospital’s disaster plan. Generally, the HEICS Medical Staff Director or his/her designee will help make assignments.

6.4.6 Disaster Privileges will end when they are determined to be no longer necessary by the HEICS Medical Staff Director, in consultation with the HEICS Operations Section Chief, the HEICS Medical Care Director, and the HEICS Incident Commander. Previously issued ID badges will be collected. Emergency staff members should be debriefed as time permits.

RULE 7 AUTOMATIC SUSPENSION, LIMITATION OR TERMINATION

In the following instances, the Member’s Privileges or membership may be suspended, limited or terminated as described:

7.1 MEMBERSHIP OR PRIVILEGES MAY BE SUSPENDED, LIMITED OR TERMINATED

7.1.1 Licensure

   a. Revocation, Suspension, Expiration, Surrender or Relinquishment: When a Member’s license or other legal credential authorizing practice in this state is revoked, suspended, expired, surrendered or relinquished without an application pending for renewal, Medical Staff membership and Privileges shall be automatically suspended as of the date such action becomes effective. The suspension shall continue at least until the license or certificate is reinstated, and the Practitioner submits complete information concerning the licensure or certification action to the Medical Executive Committee.

   b. Restriction: When a Member’s license or other legal credential authorizing practice in this state is limited or restricted by the applicable licensing or certifying authority, any Privileges which are within the scope of such limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

   c. Probation: When a Member is placed on probation by the applicable licensing or certifying authority, his or her membership status and Privileges shall automatically become subject to probation under similar terms as of the date such action becomes effective and throughout its term.

7.1.2 DEA Certificate

   a. Revocation, Suspension, and Expiration: When a Member’s DEA certificate is revoked, limited, suspended, or expired, the Member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate as of the date such action becomes effective and throughout its term.

   b. Probation: When a Member’s DEA certificate is subject to probation, the Member’s right to prescribe such medications at the Hospital shall automatically become subject to probation under similar terms as of the date such action becomes effective and throughout its term.

7.1.3 Failure to Satisfy Special Appearance Requirement

   A Member who fails without good cause to appear and satisfy the requirements of the Medical Staff Bylaws, Article 10, Section 10.8 shall automatically be suspended from exercising all or such portion of Privileges as the Medical Executive Committee specifies. The suspension shall continue until the
Practitioner arranges for and satisfies the special appearance requirement, unless sooner automatically terminated as set forth below.

7.1.4 Medical Records

Medical Staff Members are required to complete medical records within the time prescribed by the Clinical Rules. Failure to timely complete medical records shall result in an automatic suspension after Notice is given as provided in the Clinical Rules. Such suspension shall apply to the Medical Staff Member’s right to admit, treat, or provide services to any patients in the Hospital. The suspension shall continue until all incomplete medical records are completed.

7.1.5 Cancellation or Limitation of Professional Liability Insurance

Failure to maintain professional liability insurance as required under the Medical Staff Bylaws and these Rules shall result in automatic suspension of Member’s Privileges. Failure to maintain professional liability insurance for certain procedures shall result in the automatic suspension of the Privilege to perform those procedures. Suspension shall be effective until appropriate coverage is reinstated, including coverage of any acts or potential liabilities that may have occurred or arisen during the period of any lapse in coverage.

7.1.6 Exclusion, Failure to Comply With Government and Other Third Party Payor Requirements

Exclusion or suspension from participation in any federal health program, including the Medicare and Medicaid programs, shall result in automatic suspension of a Member’s Privileges. The Medical Executive Committee shall be empowered to determine that compliance with certain specific third party payor, government agency, and Professional Review organization rules or policies is essential to Hospital and/or Medical Staff operations and that compliance with such requirements can be objectively determined. Failure to comply with such requirements shall be grounds for automatic suspension. The suspension shall be effective until the Practitioner complies with such requirements.

7.1.7 Failure to Pay Dues or Assessments

For failure to pay dues or assessments within 30 days after written warning of delinquency, a Practitioner’s Medical Staff membership and Privileges shall be automatically suspended and shall remain so suspended until the Practitioner pays the delinquent dues or assessments.

7.1.8 Attestation

If, through the application process, a Practitioner attests that he/she is in full compliance with the privileging criteria for certain Privileges requested, the Practitioner’s subsequent failure to verify compliance with such criteria within thirty (30) days of a written request shall result in automatic suspension of the affected Privileges. The Practitioner’s failure to present such verification within thirty (30) days of notice of automatic suspension shall result in automatic termination of the affected Privileges.

7.1.9 Criteria for Membership and Privileges

a. If a Practitioner fails to continuously maintain the basic qualifications for Medical Staff membership in accordance with the Medical Staff Bylaws (other than licensure, which is addressed above), the Practitioner’s membership shall be automatically suspended as of the date such action becomes effective. The suspension shall continue at least until the qualification is fully reinstated, and the Practitioner submits complete information verifying such reinstatement to the Medical Executive Committee. A Practitioner will be granted a 60 day grace period to provide evidence of current Board Certification or other required certification providing the Practitioner has completed or submitted all requirements for the certification and is only awaiting confirmation of successfully attaining the certification.

b. If a Practitioner fails to continuously maintain any objective qualification for Privileges granted, the affected Privileges shall be automatically suspended as of the date the Practitioner fails to satisfy the qualification. The suspension shall continue at least until the qualification is fully reinstated and the Practitioner submits information verifying such reinstatement to the Medical Executive Committee.

c. If, through the application process, a Practitioner is required to attest that he/she is in full compliance with the privileging criteria for certain Privileges requested (without primary source
verification) the Practitioner’s subsequent failure to verify compliance with such criteria within thirty (30) days of a written request shall result in automatic suspension of the affected Privileges. The Practitioner’s failure to present such verification within thirty (30) days of notice of automatic suspension shall result in automatic termination of the affected Privileges.

7.1.10 Violation of Influenza Vaccination Requirements
If a Practitioner who is required to obtain an influenza vaccination fails to verify or obtain a seasonal influenza vaccination or to wear a mask if entitled to an exemption as provided in the System Influenza Vaccination Policy, the Practitioner will be suspended automatically during flu season (November 1 through March 31) or until the Practitioner complies with the Policy.

7.1.11 Precautionary or Summary Suspension of Privileges at System Member
If Practitioner’s Privileges at another System Member are suspended as a precaution or summarily suspended at the other System Member, the Shared Practitioner’s same Privileges are automatically suspended at the Hospital, subject to review in accordance with the Peer Review, Fair Hearing and Appeal Rules, and Conference Committee review, if applicable. A Shared Practitioner whose Privileges are suspended at another System Member is not eligible to apply for any of the suspended Privileges until such time, if ever, that the suspension is terminated and the Privileges are fully reinstated.

7.1.12 Automatic Termination
If a Practitioner remains suspended under an automatic suspension provision for more than 6 months, his or her membership (or the affected Privileges, if the suspension is a partial suspension) shall be automatically terminated. If a Practitioner is suspended 3 times in a 12 month period for failing to complete Medical Records, his or her membership shall be automatically terminated. Thereafter, reinstatement to the Medical Staff shall require application and compliance with the appointment procedures for initial applicants.

7.1.13 Executive Committee Deliberation and Procedural Rights
a. After action is effective as described in Rule 7.1.1 (licensure revocation, suspension, expiration, surrender, relinquishment, restriction, or probation), Rule 7.1.2 (DEA certificate revocation, suspension, expiration, or probation), Rule 7.1.3 (failure to satisfy a special appearance), Rule 7.1.9 (criteria for membership and Privileges), or Rule 7.1.10 (influenza vaccination), the Medical Executive Committee may recommend such further corrective action as it deems appropriate following the procedure generally set forth in the Peer Review, Fair Hearing and Appeal Rules. There is no need for the Medical Executive Committee to consider further corrective action based on automatic suspensions described in Rule 7.1.4 (medical records), Rule 7.1.5 (cancellation on limitation of professional liability insurance), Rule 7.1.6 (exclusion, failure to comply with government and other third party payor requirements), Rule 7.1.8 (attestation), Rule 7.1.7 (failure to pay dues or assessments), or Rule 7.1.10 (influenza vaccination). The Medical Executive Committee review and any subsequent hearings and reviews shall not address the propriety of the underlying government, licensure, certification or DEA action, but instead shall address what corrective action, if any, should be taken by the Hospital.

b. Practitioners whose Privileges are automatically suspended and/or who have been deemed to have automatically terminated their Medical Staff membership shall be entitled to a hearing only if the suspension or termination is required by law to be reported to the National Practitioner Data Bank.

7.1.14 Notice of Automatic Suspension or Termination
Special Notice of an automatic suspension or termination shall be given to the affected Practitioner, and regular Notice of the suspension shall be given to the Credentials Committee, the Medical Executive Committee, and Governing Body, but such Notice shall not be required for the suspension to become effective. Patients affected by an automatic suspension or termination shall be assigned to another Member by the Department chair or President. The wishes of the patient and affected Practitioner shall be considered, when feasible, in choosing a substitute Member.

**RULE 8. PRACTITIONER HEALTH CONCERNS**
8.1 **General**

8.1.1 The Hospital and the Medical Staff are committed to providing quality patient care. The Hospital and the Medical Staff also care about Medical Staff Members and Practitioners who exercise Privileges at the Hospital.

8.1.2 Practitioner health concerns may result from physical, psychiatric or emotional conditions, and can compromise patient safety, quality care or safe and effective Hospital operations.

8.1.3 The Medical Staff desires to identify and manage matters of individual Practitioner health concerns through a process that promotes rehabilitation and confidentiality and is separate from the corrective action process, where appropriate.

8.1.4 The Medical Staff intends to be firm, yet compassionate, when dealing with a Practitioner with a suspected or existing health concern. The Medical Staff’s first obligation, however, is to protect patients from harm. Nothing in this Rule shall preclude the Medical Staff from initiating corrective action or precautionary suspension, as may be necessary for patient safety, quality of care, or safe and effective Hospital operations in accordance with the Peer Review, Fair Hearing and Appeal Rules.

8.1.5 Practitioners are encouraged to self-report health concerns. All Practitioners and Hospital employees are encouraged to promptly report suspected and existing Practitioner health concerns.

8.1.6 Throughout this process, all parties should avoid speculation, premature conclusions, gossip, and any discussions of the matter with anyone other than those described in this Rule.

8.2 **Self Reporting**

8.2.1 The Medical Staff encourages Practitioners to self-report health concerns so that appropriate steps may be taken to promote rehabilitation, to help the Practitioner practice in a safe and effective manner, and to protect patients. A Practitioner may self-report a health concern to the Service Chair, Section Chief, Department Chair or Vice Chair, Medical Staff President or Chief Medical Officer. If the Department Chair or Vice Chair or Section Chief receives the report, he or she shall either refer the matter to or assist the Service Chair, Medical Staff President and/or Chief Medical Officer in accordance with the processes under this Rule 8.

8.2.2 Practitioners who self-report a health concern will be promptly referred to suitable program or provider for diagnosis, treatment and rehabilitation, such as the Colorado Physicians’ Health Program (CPHP), if appropriate. Limited License Practitioners shall be referred to a resource appropriate to their specialty. Rehabilitation will be under the supervision of CPHP or another suitable program or provider. The Practitioner may be required to consent in writing to the release of information initially and as part of an ongoing monitoring process.

8.2.3 Practitioners who self-report a health concern may be encouraged to seek a voluntary leave of absence in accordance with the Medical Staff Bylaws and these Rules and/or to voluntarily refrain from exercising certain Privileges while the Practitioner seeks diagnosis, treatment and rehabilitation (at least initially) until it is demonstrated he or she can practice safely and effectively.

8.2.4 If the Practitioner does not fully and voluntarily cooperate under this Rule 8.2, the matter may be addressed in accordance with Rule 8.3 below or the Peer Review, Fair Hearing and Appeal Rules. Reinstatement and monitoring of a Practitioner who self-reports shall be in accordance with Rule 8.4, unless the Practitioner has been granted expedited reinstatement under Rule 4.11.

8.3 **Report and Review of Suspected Health Concern**

8.3.1 All Practitioners and Hospital employees who suspect that a Practitioner has a health concern that may affect his or her practice at the Hospital should promptly report his or her concerns to the Service Chair, Section Chief, Department Chair or Vice Chair, Medical Staff President and/or Chief Medical Officer. The report may be made orally, in writing or by electronically. The report should be factual and describe the incident(s) that prompted the concern. When feasible, at least a second witness should be identified. If the report is made orally, the Medical Staff leader should document the report in the Practitioner’s Confidential File. If the report is made to the Department Chair or Vice Chair or Section Chief, he or she shall either
refer the matter to or assist the Service Chair, Medical Staff President and/or Chief Medical Officer in accordance with the processes under this Rule.

8.3.2 The Service Chair, Medical Staff President and/or Chief Medical Officer, with the assistance of the Section Chief or Department Chair or Vice Chair, if appropriate, shall act expeditiously to review the concern. This review should include discussing the incident(s) with the person who submitted the report.

8.3.3 If the Department Chair, Medical Staff President and/or Chief Medical Officer concludes that the suspected health concern warrants further review, one or more of these Medical Staff leaders, the Section Chief, Medical Staff President and/or Chief Medical Officer, with the assistance of the Service Chair or Department Chair or Vice Chair if appropriate, may conduct such further review or may designate an ad hoc committee to conduct such further review (collectively, the “Reviewers”). As part of this further review, the Practitioner may be interviewed, may be asked to participate in an evaluation by CPHP or other suitable program or provider, and may be required to consent in writing to the release of information initially and as part of any ongoing monitoring process. The Reviewers shall make a report of the further review.

8.3.4 If, at any stage, the review suggests the Practitioner is or may be suffering from a health concern that may affect his or her practice at the Hospital, the Department Chair or Vice Chair, Section Chief, Medical Staff President and/or Chief Medical Officer shall request an interview with the Practitioner. At the interview:

a. The Practitioner should be informed about the review and the conclusion that the Practitioner is believed to be suffering from a health concern that may affect his or her practice. The Practitioner shall not be told who filed the report, but should be informed of the nature of the concern.

b. Depending on the severity of the problem and the nature of the health concern, the Practitioner may be encouraged to seek diagnosis, treatment and rehabilitation. Practitioners will be referred to CPHP or another suitable program or provider at his or her sole cost.

c. The Practitioner may be encouraged to seek a voluntary leave of absence in accordance with the Medical Staff Bylaws and Rule 4.11 while he or she seeks diagnosis, treatment and rehabilitation (at least initially) until it is demonstrated he or she can practice safely and effectively.

d. The Practitioner may be asked to voluntarily refrain from exercising some or all of his/her Privileges while he or she seeks diagnosis, treatment and rehabilitation (at least initially) until it is demonstrated he or she can practice safely and effectively.

8.3.5 The Service Chair, Section Chief, Department Chair or Vice Chair, Medical Staff President and/or Chief Medical Officer may ask the Practitioner to submit to an on-the-spot alcohol or drug screening test if the Practitioner is suspected of being under the influence of alcohol or drugs while on the Hospital premises for purposes of providing patient care.

8.3.6 The review may be closed at any time it appears there is no Practitioner health concern.

8.3.7 Reinstatement and monitoring of the Practitioner who was the subject of the further review shall be in accordance with Rule 8.4.

8.4 REINSTATEMENT AND MONITORING

8.4.1 For a Practitioner who self-reports or is otherwise determined to have a health concern that may affect his or her practice at the Hospital, information shall be forwarded to the Credentials Committee (or a subcommittee or ad hoc committee) for purposes of considering requests for reinstatement following a leave of absence (other than expedited reinstatement under Rule 4.11), appointment if membership and Privileges have expired during a leave of absence, monitoring, and reasonable accommodation if required by law. Such information shall include the following: a copy or a summary of the original complaint or self-report, a copy of the Reviewers’ report(s), and a description of the actions taken by the Service Chair, Section Chief, Department Chair or Vice Chair, the Medical Staff President and/or the Chief Medical Officer, any reports from CPHP or other program or provider, and information concerning the Practitioner’s activities, including whether the Practitioner took a voluntary leave of absence or agreed to refrain from exercising certain Privileges.
Upon sufficient proof that a Practitioner has been evaluated by and/or participated in a rehabilitation or treatment program or other provider acceptable to the Credentials Committee or its designee, a Practitioner who was granted a medical leave of absence may be eligible for reinstatement or appointment if his/her membership or Privileges expired, subject to evaluation of his or her fitness to return to practice. A request for reinstatement following a leave of absence shall be submitted in accordance with Rule 4.11.4(b). The Credentials Committee reviews all relevant information and shall make a recommendation to the Medical Executive Committee. Appointments shall be addressed in accordance with Rule 4. The Medical Executive Committee shall consider the recommendations of the Credentials Committee concerning reinstatement or appointment, monitoring and reasonable accommodation if required by law.

Prior to recommending reinstatement or appointment of a Practitioner who took a medical leave of absence, determining appropriate monitoring, or considering any request for reasonable accommodation if required by law, the Credentials Committee must obtain a letter from CPHP or other program or provider acceptable to the Credentials Committee or its designee addressing the relevant health concerns, which should include the Practitioner’s condition, compliance, the need for monitoring, continued treatment needs and whether the Practitioner can safely and competently exercise Privileges. The Practitioner may be required to consent in writing to the release of this information initially and as part of an ongoing monitoring process. The Credentials Committee may consult with the Hospital’s human resources department on a confidential basis concerning the standards for reasonable accommodation.

The Credentials Committee shall determine what, if any, monitoring should be required when the Practitioner returns to practice or exercises full Privileges. The Practitioner may be required to provide periodic reports from his or her treatment program or provider that address relevant concerns, including that his or her ability to practice safely and competently is not impaired. The Practitioner’s exercise of Privileges in the Hospital may be monitored by the Credentials Committee or its designee. If the Practitioner has a health concern relating to substance abuse, the Practitioner must, as a condition of reinstatement or appointment, agree to submit to random alcohol or drug screening tests at the request of the Service Chair, Section Chief, Department Chair or Vice Chair, Medical Staff President or Chief Medical Officer.

The Medical Staff desires to encourage self-reporting and voluntary cooperation through a process that promotes rehabilitation and confidentiality and is separate from the corrective action process. If at any stage, the Practitioner does not voluntarily and fully cooperate in the processes set forth in this Rule 8 in a timely manner and the Practitioner’s health concern presents a risk to patient safety, quality care, or safe and effective Hospital operations, the matter may be referred to the Medical Executive Committee in accordance with the Peer Review, Fair Hearing and Appeal Rules. If the failure to take action may result in imminent danger to the health and/or safety of any patient or other person or the safe and/or effective operation of the Hospital, precautionary suspension under the Peer Review, Fair Hearing and Appeal Rules may be invoked. The Practitioner’s rights, if any, to a hearing and appeal shall be as described in the Peer Review, Fair Hearing and Appeal Rules.

A copy or a summary of the original complaint or self-report, a copy of the Reviewers’ report(s), and a description of the actions taken by the Service Chair, Section Chief, Department Chair or Vice Chair, the Medical Staff President and/or the Chief Medical Officer shall be included in the Practitioner’s Confidential File.

If the review reveals that there is no merit to the complaint, this conclusion should be fully documented and kept with the original report in the Practitioner’s Confidential File.

If the review reveals there may be some merit to the report, but not enough to warrant immediate action, the Service Chair, Medical Staff President and/or the Chief Medical Officer, with the assistance of the Section Chief or Department Chair or Vice Chair should meet personally with the Practitioner to discuss the concerns, but no further action is warranted. A summary of the report, further review and meeting should be added to the Practitioner’s Confidential File.
8.6.4 Minutes of the Credentials Committee relating to health concerns shall be maintained in a Confidential File, separate from minutes which do not concern the Practitioner’s health concern.

8.6.5 Reports from CPHP or other treatment programs or providers should be included in the Practitioner’s Confidential File.

8.6.6 The Medical Staff President or Chief Medical Officer shall inform the individual who filed the complaint that follow-up action was taken.

8.6.7 All requests for information concerning the impaired Practitioner shall be forwarded to the Medical Staff President or Chief Medical Officer.

8.6.8 All matters of suspected or confirmed Practitioner health concerns are intended to be confidential, except as required by law, ethical obligations, patient safety, legal reporting obligations, and the fulfillment of Medical Staff processes, including reinstatement, monitoring, corrective action and precautionary suspension in accordance with the Peer Review, Fair Hearing and Appeal Rules. Practitioner health concern information may be shared with a System Member for purposes of Medical Staff processes, provided that the System Member shall maintain confidentiality of such information in the same manner as the Hospital. Nothing in these Rules shall prohibit any individual or entity from fulfilling his/her individual reporting obligations under applicable laws. Reports and other records concerning the identification and management of Practitioner health concerns shall be maintained in the Practitioner’s Confidential File.

8.7 **Education and Prevention**

The Medical Staff shall periodically arrange for educational materials and programs for the Medical Staff Members and other Hospital staff that addresses Practitioner health. These materials and programs should emphasize prevention, diagnosis and treatment of physical, psychiatric and emotional conditions.
Approved by:

Medical Executive Committee
By _________________________________
Print _________________________________
Medical Staff President

Date:

Exempla Board of Directors
By _________________________________
Secretary, Board of Directors

Date: