SUBMITTAL TO THE RIVERSIDE UNIVERSITY HEALTH SYSTEM MEDICAL CENTER GOVERNING BOARD COUNTY OF RIVERSIDE, STATE OF CALIFORNIA

ITEM: 18.2
(ID # 29056)
MEETING DATE:
Tuesday, October 21, 2025

FROM : RUHS-MEDICAL CENTER

SUBJECT: RIVERSIDE UNIVERSITY HEALTH SYSTEM-MEDICAL CENTER: Ratify and Approve Medical Staff Appointments, Reappointments, Clinical Privileges, Proctoring, Change of Status, Additional Privileges, Withdrawal of Privileges, Leave of Absences, Resignations/Withdrawals, Automatic Termination, and Policies, Plans and Procedures, as Recommended by the Medical Executive Committee on January 9, 2025, February 13, 2025, March 13, 2025, April 10, 2025, May 08, 2025 and June 12, 2025, All Districts. [$0].

RECOMMENDED MOTION: That the Board of Supervisors:

1. Ratify and approve medical staff appointments, reappointments, clinical privileges proctoring, change of status, additional privileges, withdrawal of privileges, leave of absence, resignations/withdrawals, automatic termination, and policies, plans and procedures as recommended by the Medical Executive Committee on January 9, 2025, February 13, 2025, March 13, 2025, April 10, 2025, May 08, 2025 and June 12, 2025.

ACTION:Policy

Jennifer Cruikshank
Jennifer Cruikshank, Chief Executive Officer – Health System 10/6/2025

MINUTES OF THE GOVERNING BOARD

On motion of Supervisor Washington, seconded by Supervisor Perez and duly carried by unanimous vote, IT WAS ORDERED that the above matter is approved as recommended.

Ayes:	Medina, Spiegel, Washington, Perez, and Gutierrez
Nays:	None
Absent:	None
Date:	October 21, 2025
xc:	RUHS-MC

Kimberly A. Rector
Clerk of the Board
By: _____ Deputy

SUBMITTAL TO THE RIVERSIDE UNIVERSITY HEALTH SYSTEM MEDICAL CENTER GOVERNING BOARD OF DIRECTORS COUNTY OF RIVERSIDE, STATE OF CALIFORNIA

FINANCIAL DATA	Current Fiscal Year:	Next Fiscal Year:	Total Cost:	Ongoing Cost
COST	$0	$0	$0	$0
NET COUNTY COST	$0	$0	$0	$0
SOURCE OF FUNDS: Hospital Enterprise Fund - 40050			Budget Adjustment: No	
			For Fiscal Year: FY24/25	

C.E.O. RECOMMENDATION: Approve

BACKGROUND:

Summary

The Riverside University Health System Medical Center (RUHS-MC) is a licensed and accredited acute care hospital serving the needs of County residents since 1893. As an acute care hospital, RUHS-MC is required by the State of California and its Department of Public Health to have a "governing body" separate from its administrative leaders and medical staff leadership.

On March 11, 2025, Agenda Item Number 18.3, the Board of Supervisors approved the recommended motion to ratify and approve medical staff appointments, reappointments, clinical privileges proctoring, change of status, additional privileges, withdrawal of privileges, leave of absence, resignations/withdrawals, automatic termination, and policies, plans and procedures as recommended by the Medical Executive Committee on July 11, 2024, August 8, 2024, September 12, 2024, October 10, 2024, November 14, 2024 and December 12, 2024.

This item requires Board approval in accordance with the requirements of the State of California which state that an acute care hospital shall have a "governing body" separate from its administrative leaders and medical staff leadership. The Board of Supervisors has declared itself to be the "governing body" for the RUHS Medical Center (Motion, February 23, 1988, 3-35). Furthermore, on April 12, 1998, the Board determined that it would hold regularly scheduled meetings, acting as the Medical Center governing board, to "review hospital policy, quality of care, medical staff credentialing, institutional planning and continuing education matters" pursuant to Resolution No. 88-166.

Pursuant to the duties of the hospital Medical Executive Committee to make recommendations directly to the Governing Board pertaining to recommendations regarding medical staff initial appointments, reappointments, and clinical privileges for eligible individuals, the Medical Executive Committee met monthly between January 2025 through June 2025, in consideration of its bi-annual submission to the Board.

During the meetings on January 9, 2025, February 13, 2025, March 13, 2025, April 10, 2025, May 08, 2025, and June 12, 2025, the Medical Executive Committee recommended the following RUHS-MC Medical Staff recommendations to the Board of Supervisors for review and action:

SUBMITTAL TO THE RIVERSIDE UNIVERSITY HEALTH SYSTEM MEDICAL CENTER GOVERNING BOARD OF DIRECTORS COUNTY OF RIVERSIDE, STATE OF CALIFORNIA

A.

Approval of Medical Staff Initial Appointments, Reappointments and Clinical Privileges, FPPE/Reciprocal* Complete Remain on Provisional, Final FPPE/Reciprocal* Advancement of Staff Category, FPPE–Final Proctoring for Allied Health Professionals, FPPE Partial Proctoring Complete Request for Extension, FPPE–Final Proctoring for Additional Privileges, Additional Privileges/Withdrawn Privileges, Change in Staff Reappointment Dates, Change in Staff Category, Automatic Termination, Voluntary Resignations/Withdrawals*.

The attached RUHS-MC Chief Executive Officer approvals provide information related to these topics. Their presentation and review by the Board not only helps the RUHS-MC to meet regulatory requirements, but also to be transparent about its operations, successes, and challenges.

ATTACHMENTS:

ATTACHMENT A	RUHS-MC CEO APPROVALS FOR MEDICAL STAFF ATTESTATION APPOINTMENT, REAPPOINTMENTS, AND CLINICAL PRIVILEGES (January 1, 2025, through June 30, 2025)
ATTACHMENT B	ANESTHESIA PRIVELEGE FORM 2.13.25
ATTACHMENT C	APP-PLASTIC SURGERY NP_CLINICAL PRIVELEGES 3.13.25
ATTACHMENT D	GENERAL SURGERY PRIVELEGE FORM 3.13.25
ATTACHMENT E	MEDICAL STAFF BYLAWS R&R 25-26 FINAL

Jacqueline Ruiz

Jacqueline Ruiz, Principal Analyst 10/14/2025

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 1/9/2025
MEC DATE: 1/9/2025
BOARD DATE: 1/9/2025

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

Date: January 9, 2025

To: File

From: Medical Staff Executive Committee

Subject: Medical Staff Attestation Appointment, Reappointments and Clinical Privileges

INITIAL APPOINTMENT – January 9, 2025 – December 31, 2026

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	BOARD STATUS
Acosta De Gonzalez, Maria I., MD	Provisional	OB-GYN	OB-GYN	Eligible
Bailey, James M., NP **Temps Granted on 12/1/2024**	AHP-Provisional	Nurse Practitioner	Emergency Medicine	ANCC
Chung, Julia A., MD	Provisional	Psychiatry	Psychiatry	Psychiatry Psychosomatic Medicine
Davis, Carolyn C., NP	AHP-Provisional	Nurse Practitioner	Clinical Neurological Sciences	ANCC
Jones, Junelle, CRNA	AHP-Provisional	Nurse Anesthetist	Anesthesia	CRNA
Nguyen, Frank, PA	AHP-Provisional	Physician Assistant	Emergency Medicine	NCCPA
Rimka, Rebecca J., NP **Temps Granted on 12/1/2024**	AHP-Provisional	Nurse Practitioner	Emergency Medicine	ANCC
Smith, Alden F., MD	Provisional	Head & Neck/Otolaryngology	Surgery/Head & Neck/Otolaryngology	Otolaryngology
Yen, Timothy, MD	Provisional	Gastroenterology	Medicine/ Gastroenterology	Internal Medicine Gastroenterology

REAPPOINTMENTS – February 1, 2025 – January 31, 2027

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	BOARD STATUS
Allen, Jonathan L., MD	Active	Orthopedic Surgery	Orthopedic Surgery	Orthopedic Surgery
Bannout, Firas, MD	Active	Neurology	Medicine/ Neurology	Neurology Clinical Neurophysiology Epilepsy
Bharadwaj, Aditya S., MD	Active	Cardiology	Medicine/ Cardiology	Cardiovascular Disease Interventional Cardiology
Drinhaus, Rolf R., MD	Active	Orthopedic Surgery	Orthopedic Surgery	Orthopedic Surgery
Granados, Kenneth, PA	Active	Psychiatry	Psychiatry	
Greas, Michael R., MD	Active	Pathology	Pathology	Pathology & Clinical Pathology
Hayton, William A., MD	Active	Psychiatry	Psychiatry	Psychiatry
Hopkins, Gail E., MD	Active	Orthopedic Surgery	Orthopedic Surgery	Orthopedic Surgery
Jerez-Aguilar, Brenda, NP	Allied Health Professional	Nurse Practitioner	Family Medicine	AANP

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 1/9/2025
MEC DATE: 1/9/2025
BOARD DATE: 1/9/2025

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

Jodhka, Upinder, MD	Active	Pediatric Cardiology	Pediatrics	Pediatrics Pediatric Cardiology
Kamson, Olayinka A., MD **Pending:** • Occ. Health Clearance • Reappointment Moodles	Active	Psychiatry	Psychiatry	N/A Grandfathered
Leung, Geoffrey W., MD	Administrative	Family Medicine	Family Medicine	Family Medicine
Martorell-Bendezu, Lily, MD	Active	Neonatal-Perinatal	Pediatrics	Pediatrics Neonatal-Perinatal Medicine
Minasian, Tanya, DO **Status change from Active to Courtesy due to low patient volume** **Additional Privilege:** • Fluoroscopy	Courtesy	Pediatric Neurosurgery	Clinical Neurological Sciences	Neurosurgery
Ochoa, William G., MD	Active	Internal Medicine	Medicine	Internal Medicine
Oei, Grace C., MD	Active	Pediatric Critical Care	Pediatrics	Pediatrics Pediatric Critical Care
Robison, Richard A., MD **Status change from Active to Courtesy due to low patient volume** **Additional Privilege:** • Fluoroscopy	Courtesy	Pediatric Neurosurgery	Clinical Neurological Sciences	Neurological Surgery Pediatric Neurological Surgery
Schlechter, John A., DO	Active	Orthopedic Surgery	Orthopedic Surgery	Orthopedic Surgery Orthopedic Sports Medicine
Steinmann, John C., DO	Active	Orthopedic Surgery	Orthopedic Surgery	Orthopedic Surgery
Sutjita, Made, MD	Active	Infectious Disease	Medicine	Internal Medicine Infectious Disease
To, Duc D., MD	Active	Internal Medicine	Medicine	Internal Medicine
Trupp, Diana L., MD	Active	Neonatal-Perinatal	Pediatrics	Pediatrics Neonatal-Perinatal Medicine
Umugbe, Oghenesume D., MD	Active	Psychiatry	Psychiatry	Psychiatry Child & Adolescent Psychiatry
Vu, Ivy, NP	Allied Health Professional	Family Medicine	Family Medicine	AANP
Wang, Bing, MD	Active	Pathology	Pathology	Pathology & Clinical Pathology

FPPE/RECIPROCAL* COMPLETE REMAIN ON PROVISIONAL

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 1/9/2025
MEC DATE: 1/9/2025
BOARD DATE: 1/9/2025

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Camara, Justin R., MD	Provisional	Interventional Radiology	Radiology/Interventional Radiology	Remain on Provisional until eligible for advancement
Kamassah, Mawusi E., MD	Provisional	Anesthesiology	Anesthesia	Remain on Provisional until eligible for advancement
Muraki, Alan S., MD	Provisional	Diagnostic Radiology	Radiology/TeleRadiology	Remain on Provisional until eligible for advancement
Sharma, Karan, DO	Provisional	Anesthesiology	Anesthesia	Remain on Provisional until eligible for advancement

FINAL FPPE/RECIPROCAL* ADVANCEMENT OF STAFF CATEGORY

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Dreger, Nicholas J., MD	Provisional	Pediatric Cardiology	Pediatrics/Cardiology	Advance to Active Status
Rajpoot, Ravi, MD	Provisional	Diagnostic Radiology	Radiology	Advance to Active Status
Sharbidre, Kedar G., MD	Provisional	Diagnostic Radiology	Radiology/TeleRadiology	Advance to Active Status

FPPE FINAL PROCTORING FOR ALLIED HEALTH PROFESSIONALS

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Li, Chun W., NP	AHP-Provisional	Nurse Practitioner	Anesthesia	Complete
Sanborn, Michele	AHP-Provisional	Nurse Practitioner	Surgery/Critical Care	Complete

FPPE FINAL PROCTORING FOR ADDITIONAL PRIVILEGES

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Health, Doris, NP	Allied Health Professional	Nurse Practitioner	Anesthesia	Pain Management

FPPE PARTIAL PROCTORING COMPLETE REQUEST FOR EXTENSION

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
None				

ADDITIONAL PRIVILEGES/WITHDRAWN PRIVILEGES

NAME	STATUS	SPECIALTY	DEPARTMENT/ DVISION	COMMENTS
None				•

CHANGE IN STAFF CATEGORY

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Truong-N, Khoa T., MD	Provisional	Anesthesiology/Pain Management	Anesthesia	Advance to Active Status

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 1/9/2025
MEC DATE: 1/9/2025
BOARD DATE: 1/9/2025

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

VOLUNTARY RESIGNATIONS/WITHDRAWALS*

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	REASON/EFFECTIVE
Agbisit, Michael A., NP	AHP	Nurse Practitioner	Anesthesia	Voluntary, Effective 12/11/2024
Bock, Alexandra M., CRNA	AHP	Nurse Anesthetist	Anesthesia	Voluntary, Effective 11/13/2024
Edwards, Mark S., MD	Active	Neurology	Medicine/Neurology	Voluntary, Effective 12/6/2024
Johnson, Craig M., CRNA	AHP	Nurse Anesthetist	Anesthesia	Voluntary, Effective 11/26/2024
Thomas, Mark E., DO	Active	Emergency Medicine	Emergency Medicine	Voluntary, Effective 12/31/2024 (Retired)

End of Report

I hereby:
1) Attest that the medical center's Medical Executive Committee meeting on October 10, 2024, recommended approval of the appointment, reappointments, proctoring, change of status, withdraw of privileges, automatic terminations, resignation/withdrawals and privilege forms.
2) Approve the listed changes as recommended by the Medical Executive Committee; and
3) Recommend that the Board of Supervisors ratify the listed changes as recommended by the Medical Executive Committee.

_____
Jennifer Cruikshank
Chief Executive Officer – RUHS Medical Center

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 1/24/2025
MEC DATE: 2/13/2025
BOARD DATE: 2/13/2025

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

Date: February 13, 2025

To: File

From: Medical Staff Executive Committee

Subject: Medical Staff Attestation Appointment, Reappointments and Clinical Privileges

INITIAL APPOINTMENT – February 13, 2025 – January 31, 2027

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	BOARD STATUS
Benanti, Michael J., DO	Provisional	Diagnostic Radiology	Radiology	Diagnostic Radiology
Chareonsook, Janet, MD	Provisional	Psychiatry	Psychiatry	
Dehoff, George W., MD	Provisional	Diagnostic Radiology	Radiology	Diagnostic Radiology
Luisiri, Phot, MD	Provisional	Rheumatology	Medicine/ Rheumatology	Rheumatology
Villarreal, Brenda I., PA	AHP-Provisional	Physician Assistant	Emergency Medicine	NCCPA
West, Anna M., MD	Provisional	Interventional Radiology	Radiology	Eligible
Widder, Jared R., DO	Provisional	Ophthalmology	Ophthalmology	Eligible

REAPPOINTMENTS – March 1, 2025 – February 28, 2027

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	BOARD STATUS
Bang, Sunny, MD **Withdraw of Privileges:** • Moderate Sedation (for Pain Medicine in Anesthesia only)	Emergency Medicine/ Pain Medicine	Emergency Medicine Anesthesia	Emergency Medicine/ Anesthesiology	Emergency Medicine Pain Medicine
Bhuller, Amardip S. MD • **Reappointment Term 9/30/2025**	LOA	Plastic Surgery	Surgery/Plastics	Surgery/Plastic Surgery
Downing, Stephanie R., MD **Yellow Flag**: Chair Recommendation	Active	Surgery	Surgery/Surgery Critical Care	Surgery/Surgical Critical care
Finley, John M., DO	Active	Rheumatology	Medicine	Internal Medicine Rheumatology
Gomez, Nephtali R., MD **Pending:** • Clinical Activity • Moodle's • Occupational Health Clearance	Active	Surgery	Surgery	Surgery

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 1/24/2025
MEC DATE: 2/13/2025
BOARD DATE: 2/13/2025

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

• Low Volume Status change from Active to Courtesy				
Grant, Sophia R., MD	Active	Pediatrics	Pediatrics	Pediatrics Child Abuse Pediatrics
Ioffe, Yevgeniya J., MD	Courtesy	Ob-Gyn	Ob-Gyn	Ob-Gyn/Gynecology Oncology
James, Janessa A., MD	Active	Pediatrics	Pediatrics	Pediatrics
Le, Anh Vu MD	Active	Pediatrics	Pediatrics	Pediatrics
Lopata, Lindsay R., MD **Status changed from Active to Courtesy due to low patient volume**	Courtesy	Anesthesiology	Anesthesia	Anesthesiology
Lopez, Merrick R., MD	Active	Critical Care Medicine	Pediatrics/Critical Care Medicine	Pediatrics Pediatric Critical Care
Lushanko, Cailey G., CRNA	AHP	Nurse Anesthetist	Anesthesia	NBCRNA
Mariano, Sharlette, FNP	AHP	Family Nurse Practitioner	Clinical Neurological Sciences	AANP
Mattison, Katherine M., NP	AHP	Nurse Practitioner	Medicine/ Hematology Oncology	AANP
Mehta, Khyati MD	Active	Gastroenterology	Pediatrics	Pediatrics Pediatric Gastroenterology
Mirshahidi, Hamid R., MD	Courtesy	Hematology/ Oncology	Medicine/ Hematology Oncology	Hematology Medical Oncology
Parks, Kelly C., DPM	Active	Podiatry	Orthopedic Surgery/Podiatry	Podiatric Medicine Foot Surgery Reconstructive Rearfoot
Prieto, Carina M., NP	AHP	Nurse Practitioner	Clinical Neurological Sciences	AACN AANP
Satterfield, Grace L., CRNA	AHP	Nurse Anesthetist	Anesthesia	NBCRNA
Scalzitti, Heidi, MD	Active	Internal Medicine	Medicine	Internal Medicine
Serrano, Ryan M. MD	Active	Cardiology	Pediatrics	Pediatrics Pediatric Cardiology
Shimmon, Ariel N., CRNA	AHP	Nurse Anesthetist	Anesthesia	NBCRNA
Shukla, Medha, MD	Active	Gastroenterology	Pediatrics	Pediatrics
Stump, Robert P., MD **Pending:** • PALS	Active	Anesthesiology	Anesthesia	Anesthesiology Pain Medicine
Tagge, Edward, MD	Active	Pediatric Surgery	Surgery	Surgery, Pediatric Surgery, Surgical Critical Care
Teruya, Theodore H., MD	Active	Surgery	Surgery	Vascular Surgery
Van Putten, Douglas J., MD **Additional Privilege:** • Participate in Teaching Program	Active	Ophthalmology	Ophthalmology	Ophthalmology
White, Steven C., MD	Active	Diagnostic Radiology	Radiology	Diagnostic Radiology

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 1/24/2025
MEC DATE: 2/13/2025
BOARD DATE: 2/13/2025

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

Yang, Eric, PA	AHP-Provisional	Physician Assistant	Surgery/Critical Care	NCCPA
Zaheer, Salman MD **Yellow Flag:** 1 Self-Reported claim -ongoing pending details	Courtesy	Thoracic Surgery	Surgery	Thoracic Surgery

FPPE/RECIPROCAL* COMPLETE REMAIN ON PROVISIONAL

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Anyu, Tse F., Do	Provisional	Diagnostic Radiology	Radiology/TeleRadiology	Remain on Provisional until eligible for advancement
Camacho-Santos, Armando, MD	Provisional	Internal Medicine	Medicine	Remain on Provisional until eligible for advancement
Haase, Tyler C., MD	Provisional	Internal Medicine	Medicine	Remain on Provisional until eligible for advancement
Lewsadder, Charles W., DO	Provisional	Emergency Medicine	Emergency Medicine	Remain on Provisional until eligible for advancement
Shiah, Kevin P., DO	Provisional	Internal Medicine	Medicine	Remain on Provisional until eligible for advancement
Stone, Melissa L., MD	Provisional	Diagnostic Radiology	Radiology/TeleRadiology	Remain on Provisional until eligible for advancement
Thomas, Sneha E., MD	Provisional	Internal Medicine/ Vascular Medicine	Medicine	Remain on Provisional until eligible for advancement
Zamir, Syed S., MD	Provisional	Diagnostic Radiology	Radiology/TeleRadiology	Remain on Provisional until eligible for advancement

FINAL FPPE/RECIPROCAL* ADVANCEMENT OF STAFF CATEGORY

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
None				

FPPE FINAL PROCTORING FOR ALLIED HEALTH PROFESSIONALS

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Bu, Liming, PA	AHP-Provisional	Physician Assistant	Clinical Neurological Sciences	Complete

FPPE FINAL PROCTORING FOR ADDITIONAL PRIVILEGES

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Bang, Sunny, MD	Active	Pain Medicine	Anesthesia	• Pain Medicine
Skoretz, Lynetta E., MD	Active	Internal Medicine	Medicine	• Internal Medicine Core • PCU

FPPE PARTIAL PROCTORING COMPLETE

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 1/24/2025
MEC DATE: 2/13/2025
BOARD DATE: 2/13/2025

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

Alkotob, Umron R., DO	Provisional	Emergency Medicine	Emergency Medicine	**Pending Proctoring:** • 2 Moderate Sedation • 5 TEE
Lu, Jackson, DO	Provisional	Emergency Medicine	Emergency Medicine	**Pending Proctoring:** • 5 TEE
Saldana, Mario A., MD	Provisional	Internal Medicine	Medicine	**Pending Proctoring:** • 5 PCU • 5 ACCU

ADDITIONAL PRIVILEGES/WITHDRAWN PRIVILEGES

NAME	STATUS	SPECIALTY	DEPARTMENT/ DVISION	COMMENTS
Bu, Liming, PA	AHP-Provisional	Physician Assistant	Clinical Neurological Sciences	Withdraw of Privilege: • Obtaining Informed Consent
Camacho-Santos, Armando, MD	Provisional	Internal Medicine	Medicine	Withdraw of Privilege: • Ambulatory
Haase, Tyler C., MD	Provisional	Internal Medicine	Medicine	Withdraw of Privilege: • Ambulatory
Minahan Jr., Thomas F., DO	Active	Emergency Medicine	Emergency Medicine	Withdraw of Privilege: • TEE
Shiah, Kevin P., DO	Provisional	Internal Medicine	Medicine	Withdraw of Privilege: • Ambulatory

CHANGE IN STAFF CATEGORY

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Dadani, Farhan, MD	Provisional	Internal Medicine	Medicine	Advance to Active Status
Patil, Shakuntala S., MD	Provisional	Nephrology	Medicine/Nephrology	Advance to Active Status
Tama, Maher, MD	Provisional	Gastroenterology	Medicine/ Gastroenterology	Advance to Active Status

CHANGE IN STAFF REAPPOINTMENT DATES TO ALIGN WITH CHC

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
None				

MODIFICATION OF PRIVILEGES

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Harris, Kurt, PA	AHP	Physician Assistant	Emergency Medicine	From PA Privilege Form to new APP Privilege Form

NAME CHANGE

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 1/24/2025
MEC DATE: 2/13/2025
BOARD DATE: 2/13/2025

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	CHANGE TO:
None				

AUTOMATIC TERMINATION, PER BYLAWS 3.8-3 (FAILURE TO COMPLETE PROCTORING)

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
None				

AUTOMATIC TERMINATION, PER BYLAWS 3.5-b (FAILURE TO MEET MEMBERSHIP/PRVILEGE CRITERIA)

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
None				

AUTOMATIC TERMINATION, PER BYLAWS 6.4-9 (FAILURE TO FILE COMPLETE REAPPOINTMENT)

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Miranda, Ivana, CRNA	AHP	Nurse Anesthetist	Anesthesia	Effective 3/1/2023

VOLUNTARY RESIGNATIONS/WITHDRAWALS*

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	REASON/EFFECTIVE
Contreras Rojas, Leslie P., PA	AHP	Physician Assistant	Emergency Medicine	Resignation Effective 12/27/2024
Hong, Linda J., MD	Courtesy	Ob-Gyn	Ob-Gyn	Resignation Effective 02/28/2025
Nguyen, Nina N., CRNA	AHP	Nurse Anesthetist	Anesthesia	Effective 01/16/2025

End of Report

I hereby:
1) Attest that the medical center's Medical Executive Committee meeting on October 10, 2024, recommended approval of the appointment, reappointments, proctoring, change of status, withdraw of privileges, automatic terminations, resignation/withdrawals and privilege forms.
2) Approve the listed changes as recommended by the Medical Executive Committee; and
3) Recommend that the Board of Supervisors ratify the listed changes as recommended by the Medical Executive Committee.

_____
Jennifer Cruikshank
Chief Executive Officer – RUHS Medical Center

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 2/28/2025
MEC DATE: 3/13/2025
BOARD DATE: 3/13/2025

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

Date: March 13, 2025

To: File

From: Medical Staff Executive Committee

Subject: Medical Staff Attestation Appointment, Reappointments and Clinical Privileges

INITIAL APPOINTMENT – March 13, 2025 – February 28, 2027

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	BOARD STATUS
Costilla, Magen A., NP	AHP-Provisional	Nurse Practitioner	Emergency Medicine	AANP
Fiman, Keith H., MD	Provisional	Gastroenterology	Medicine/ Gastroenterology	Internal Medicine Gastroenterology
Hamedani, Elnaz, DPM	Provisional	Podiatry	Orthopedic Surgery/ Podiatry	Eligible
Hasan, Bushra Z., FNP	AHP-Provisional	Nurse Practitioner	Emergency Medicine	ANCC
Leong, Fah S., MD	Provisional	Radiology	Radiology/Teleradiology	Diagnostic Radiology
Maxwell, Anne, MD	Provisional	Head & Neck/Otolaryngology	Surgery/Head & Neck Otolaryngology	Otolaryngology/ Neurotology
Na, Danny, NP	AHP – Provisional	Nurse Practitioner	Psychiatry	ANCC
Navar, Lianna MD	Provisional	Family Medicine	Family Medicine	Family Medicine
Salcedo, Regine V.T., NP	AHP-Provisional	Nurse Practitioner	Radiology/Neuro IR	AANP
Sutherland-Stolting, Amina I., MD	Provisional	Psychiatry	Psychiatry	Child & Adolescent Psychiatry Psychiatry
Wang, Jing Zhou, MD	Provisional	Gastroenterology	Medicine/ Gastroenterology	Internal Medicine Gastroenterology

REAPPOINTMENTS – April 1, 2025 – March 31, 2027

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	BOARD STATUS
Alkhairy, Tahir M., MD	Telehealth	Diagnostic Radiology	Radiology /Teleradiology	Diagnostic Radiology
Chan, Eric H., MD	Active	Ophthalmology	Ophthalmology	Ophthalmology
Edwards, Sara, MD	Active	Critical Care	Surgery/Critical Care	Surgery Critical Care
Friedler, Eli E., MD	Active	Psychiatry	Psychiatry	Child & Adolescent Psychiatry Psychiatry
Hasen, Alexandra L., PA	AHP	Physician Assistant	Emergency Medicine	NCCPA
Kang, Ilho, MD	Active	Internal Medicine	Medicine	Internal Medicine

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 2/28/2025
MEC DATE: 3/13/2025
BOARD DATE: 3/13/2025

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

Kheradpour, Albert MD	Active	Pediatric Hematology/Oncology	Pediatrics Hematology/Oncology	Pediatrics Pediatric Hematology/Oncology
Labha, Joel A., DO	Active	Emergency Medicine	Emergency Medicine	Emergency Medicine
Lodriguito, Ida Z., MD	Active	Psychiatry	Psychiatry	N/A
Michelson, David J., MD	Active	Pediatric Neurology	Pediatrics / Neurology	Pediatrics Neurology with Special Qualifications in Child Neurology
Razzouk, Akram Y., MD	Active	Psychiatry	Psychiatry	Psychiatry
Sethman, Lindsey, FNP	AHP	Nurse Practitioner	Clinical Neurological Sciences	AANP
Solaimani, Pejman, MD	Active	Gastroenterology	Medicine/ Gastroenterology	Internal Medicine Gastroenterology
Truong-N, Khoa T.,MD	Active	Anesthesia	Anesthesia	Anesthesiology
Walia, Jaswinder K., MD	Adminstrative	Psychiatry	Psychiatry	Psychiatry Psychosomatic Medicine

FPPE/RECIPROCAL* COMPLETE REMAIN ON PROVISIONAL

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Arfeen, Safa, MD	Provisional	Ophthalmology	Ophthalmology	Remain on Provisional until eligible for advancement
Cervantes, Richard J., MD	Provisional	Anesthesiology	Anesthesia	Remain on Provisional until eligible for advancement
Dhillon, Rummit K., DO	Provisional	Dermatology	Medicine/Dermatology	Remain on Provisional until eligible for advancement
Ghosh, Pradipta, MD	Provisional	Rheumatology	Medicine/Rheumatology	Remain on Provisional until eligible for advancement
Lee, Brigette M., MD	Provisional	Dermatology	Medicine/Dermatology	Remain on Provisional until eligible for advancement
May, William N., MD	Provisional	Ophthalmology	Ophthalmology	Remain on Provisional until eligible for advancement
Patel, Raj A., DO	Provisional	Emergency Medicine	Emergency Medicine	Remain on Provisional until eligible for advancement
Rao, Veena A., MD	Provisional	Rheumatology	Medicine/Rheumatology	Remain on Provisional until eligible for advancement

FINAL FPPE/RECIPROCAL* ADVANCEMENT OF STAFF CATEGORY

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 2/28/2025
MEC DATE: 3/13/2025
BOARD DATE: 3/13/2025

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

Saunders, Jeffrey A., MD	Provisional	Teleradiology	Radiology/TeleRadiology	Advance to Active Status

FPPE FINAL PROCTORING FOR ALLIED HEALTH PROFESSIONALS

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
None				

FPPE FINAL PROCTORING FOR ADDITIONAL PRIVILEGES - NONE

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
None				•

FPPE PARTIAL PROCTORING COMPLETE - NONE

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
None				

ADDITIONAL PRIVILEGES/WITHDRAWN PRIVILEGES - NONE

NAME	STATUS	SPECIALTY	DEPARTMENT/ DVISION	COMMENTS
Ghosh, Pradipta, MD	Provisional	Rheumatology	Medicine/ Rheumatology	Withdraw of Privileges: • Internal Medicine • Ambulatory
Rao, Veena A., MD	Provisional	Rheumatology	Medicine/ Rheumatology	Withdraw of Privileges: • Internal Medicine • Ambulatory

CHANGE IN STAFF CATEGORY - NONE

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
None				

CHANGE IN STAFF REAPPOINTMENT DATES TO ALIGN WITH CHC

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
None				

MODIFICATION OF PRIVILEGES

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Acevedo, Vivian, PA	AHP	Physician Assistant	Emergency Medicine	To new APP Emergency Medicine Privilege Form
Chow, Nathan H., PA	AHP	Physician Assistant	Emergency Medicine	To new APP Emergency Medicine Privilege Form
Harris, Kurt, PA	AHP	Physician Assistant	Emergency Medicine	To new APP Emergency Medicine Privilege Form

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 2/28/2025
MEC DATE: 3/13/2025
BOARD DATE: 3/13/2025

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

Hasen, Alexandra L., PA	AHP	Physician Assistant	Emergency Medicine	To new APP Emergency Medicine Privilege Form
Learman, Cameron A., PA	AHP-Provisional	Physician Assistant	Emergency Medicine	To new APP Emergency Medicine Privilege Form
Ledbetter, Rodney A., PA	AHP	Physician Assistant	Emergency Medicine	To new APP Emergency Medicine Privilege Form
Matthew, Troy A., PA	AHP	Physician Assistant	Emergency Medicine	To new APP Emergency Medicine Privilege Form
Medina, Kelly D., PA	AHP	Physician Assistant	Emergency Medicine	To new APP Emergency Medicine Privilege Form
Ramirez, Camille A., PA	AHP	Physician Assistant	Emergency Medicine	To new APP Emergency Medicine Privilege Form

NAME CHANGE

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	CHANGE TO:
None				

AUTOMATIC TERMINATION, PER BYLAWS 3.8-3 (FAILURE TO COMPLETE PROCTORING)

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
None				

AUTOMATIC TERMINATION, PER BYLAWS 3.5-b (FAILURE TO MEET MEMBERSHIP/PRVILEGE CRITERIA)

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
None				

AUTOMATIC TERMINATION, PER BYLAWS 6.4-9 (FAILURE TO FILE COMPLETE REAPPOINTMENT)

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
None				

AUTOMATIC TERMINATION, PER BYLAWS 9.5-4 (SUSPENSION OF PRIVILEGES 90 DAYS)

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Egan, Katherine, CRNA	AHP	Nurse Anesthetist	Anesthesia	90 Day Suspension exp. ACLS. Provider relocated out of state

VOLUNTARY RESIGNATIONS/WITHDRAWALS*

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	REASON/EFFECTIVE
Chen, Ronnie C., MD	Active	Interventional Radiology	Radiology (LLU Int.)	Voluntary Resignation Effective 01/18/2025
Gentry, Tanya N., DO	Active	Pediatrics	Pediatrics	Voluntary Resignation Effective 01/31/2025

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 2/28/2025
MEC DATE: 3/13/2025
BOARD DATE: 3/13/2025

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

Javier, Rommel, CRNA	AHP	Nurse Anesthetist	Anesthesia	Voluntary Resignation Effective 01/16/2025
Kumar, Vikram MD	Active	Pediatrics	Pediatrics	Voluntary Resignation Effective 05/31/2025
McCarty, Zachery D., MD	Active	Emergency Medicine	Emergency Medicine	Voluntary Resignation Effective 2/20/2025
Shrestha, Manish P., MD	Active	Gastroenterology	Medicine/ Gastroenterology	Voluntary Resignation, Effective 2/16/2025
Tomihama, Roger T., MD	Active	Interventional Radiology	Radiology (LLU Int.)	Voluntary Resignation Effective 2/13/2025
Vance, Kristofer J., MD	Active	Pediatrics	Pediatrics	Voluntary Resignation Effective 01/31/22025

End of Report

I hereby:
1) Attest that the medical center's Medical Executive Committee meeting on October 10, 2024, recommended approval of the appointment, reappointments, proctoring, change of status, withdraw of privileges, automatic terminations, resignation/withdrawals and privilege forms.
2) Approve the listed changes as recommended by the Medical Executive Committee; and
3) Recommend that the Board of Supervisors ratify the listed changes as recommended by the Medical Executive Committee.

_____
Jennifer Cruikshank
Chief Executive Officer – RUHS Medical Center

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 3/28/2025
MEC DATE: 4/10/2025
BOARD DATE: 4/10/2025

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

Date: April 10, 2025

To: File

From: Medical Staff Executive Committee

Subject: Medical Staff Attestation Appointment, Reappointments and Clinical Privileges

INITIAL APPOINTMENT – April 10, 2025 – March 31, 2027

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	BOARD STATUS
Ali, Musaab, MD **Temporary Privilege Request Effective 3/31/2025**	Provisional	Psychiatry	Psychiatry	Psychiatry
Bakhtiani, Priyanka, MD	Provisional	Peds Endocrinology	Pediatrics / Endocrinology	Pediatrics Pediatric Endocrinology
Brown, Bryan, PA	AHP-Provisional	Physician Assistant	Emergency Medicine	NCCPA
Cendejas, Brandon L., PA	AHP-Provisional	Physician Assistant	Emergency Medicine	NCCPA
Fan, Juston, DO	Provisional	Orthopedic Surgery	Orthopedic Surgery	Eligible
Frank, Stephanie J., MD	Provisional	Anesthesia	Anesthesia	Addiction Medicine Anesthesiology
Kumar, Arun, MD	Provisional	Radiology	Radiology (Tele-Health)	Diagnostic Radiology Neuroradiology
LaVoise Jessica, PA	AHP-Provisional	Physician Assistant	Surgery/Vascular	NCCPA
Martin, Travis P., MD	Provisional	Emergency Medicine	Emergency Medicine	Emergency Medicine Pain Medicine
Ponciano, Meagan J., PA	AHP-Provisional	Physician Assistant	Emergency Medicine	NCCPA
Pawar, Rahul, MD	Provisional	Radiology	Radiology	Diagnostic Radiology Neuroradiology
Sales, Kimberly S., FNP	AHP-Provisional	Family Nurse Practitioner	Emergency Medicine	AANP
Williams, Shammah O., MD **Temporary Privilege Request Effective 4/2/2025**	Provisional	Cardiology	Medicine/Cardiology	Internal Medicine Cardiovascular Disease Interventional Cardiology
Yoo, Bo Ram, MD	Provisional	Psychiatry	Psychiatry	Eligible

REAPPOINTMENTS – May 1, 2025 – April 30, 2027

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	BOARD STATUS

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 3/28/2025
MEC DATE: 4/10/2025
BOARD DATE: 4/10/2025

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

Alastra, Anthony J., MD Status changed from Active to Courtesy due to no patient volume	Courtesy	Neurosurgery	Clinical Neurological Sciences	Neurological Surgery
Azad, Armaghan, MD	Active	Family Medicine	Emergency Medicine	Family Medicine
Chaterjee, Anish, MD	Active	Radiology	Radiology (Teleradiology)	Diagnostic Radiology
Collins, Chelsea L., MD	Active	Hematology/Oncology	Pediatrics	Pediatrics Pediatric Hematology/Oncology
Hampson, Christopher O., MD	Active	Radiology	Radiology (Teleradiology)	Diagnostic Radiology
Hata, Justin T., MD	Active	Anesthesia	Anesthesia	Pain Medicine Physical Medicine & Rehabilitation
Hoogervorst, Jacqueline, NP	AHP	Nurse Practitioner	Surgery/Critical Care	AACN
Pak, Eugene, MD	Active	Anesthesia	Anesthesia	Neurology Pain Medicine
Patel, Rita NP	AHP	Nurse Practitioner	Pediatrics	NCC
Sweetnam, Chad W., PA	AHP	Physician Assistant	Orthopedic Surgery	NCCPA
Ursu, Stefan, MD	Active	Psychiatry	Psychiatry	Psychiatry

FPPE/RECIPROCAL* COMPLETE REMAIN ON PROVISIONAL

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Ahmed, Ayesha, MD	Provisional	Pediatric Infectious Diseases	Pediatrics/ Infectious Diseases	Complete remain on Provisional until eligible for advancement.
Kamassah, Mawusi E., MD	Provisional	Anesthesiology	Anesthesia	Complete remain on Provisional until eligible for advancement.
Kasturi, Vellore, MD	Provisional	Pediatrics Genetics	Pediatrics/Genetics	Complete remain on Provisional until eligible for advancement.
Rana, Prachi, MD	Provisional	Transplant Hepatology	Medicine/ Gastroenterology	Complete remain on Provisional until eligible for advancement.

FINAL FPPE/RECIPROCAL* ADVANCEMENT OF STAFF CATEGORY

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 3/28/2025
MEC DATE: 4/10/2025
BOARD DATE: 4/10/2025

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

Ishimitsu, David N., MD	Provisional	Teleradiology	Radiology/Teleradiology	Advanced to Active Status
Keyes, Brian O, DO	Provisional	Anesthesiology	Anesthesia	Advanced to Active Status
Pham, Ngoc-Minh, DO	Provisional	Psychiatry	Psychiatry	Advanced to Active Status
Salib, Michael F., MD	Provisional	Psychiatry	Psychiatry	Advanced to Active Status
Winter, Aaron W., MD	Provisional	Ophthalmology	Ophthalmology	Advanced to Active Status
Wu, Biran W., MD	Provisional	Psychiatry	Psychiatry	Advanced to Active Status

FPPE FINAL PROCTORING FOR ALLIED HEALTH PROFESSIONALS

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Nelch, Heather R., NP	AHP-Provisional	Nurse Practitioner	Medicine/Neurology	Complete
Ojo, Temitayo O., FNP	AHP-Provisional	Family Nurse Practitioner	Emergency Medicine	Complete
Yamamoto, Alaina, CRNA	AHP-Provisional	Certified Registered Nurse Anesthetist	Anesthesia	Complete

FPPE FINAL PROCTORING FOR ADDITIONAL PRIVILEGES

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
None				

FPPE PARTIAL PROCTORING COMPLETE

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Imam, Danyal O., MD	Provisional	Internal Medicine	Medicine	Pending Proctoring: • ACCU • PCU
Kwon, Sue Min, MD	Provisional	Internal Medicine	Medicine	Pending Proctoring: • ACCU • PCU

ADDITIONAL PRIVILEGES

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Benjamin J. Caudill, FNP	AHP	Nurse Practitioner	Dept 2 – Radiology (IR)	Additional Privileges: • APP NP Neuro-Interventional Radiology General Clinical Core Privileges
Nelch, Heather R., NP	AHP-Provisional	Nurse Practitioner	Medicine/Neurology	Additional Privileges: • Perform intramuscular injections of

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 3/28/2025
MEC DATE: 4/10/2025
BOARD DATE: 4/10/2025

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

				botulinum toxic for the treatment of migraine headaches • Perform local infiltration of anesthetic solutions for the treatment of musculoskeletal headaches

WITHDRAWN PRIVILEGES

NAME	STATUS	SPECIALTY	DEPARTMENT/ DVISION	COMMENTS
Kwon, Sue Min, MD	Provisional	Internal Medicine	Medicine	Withdraw of Privilege: • Ambulatory
Nelch, Heather R., NP	AHP-Provisional	Nurse Practitioner	Medicine/Neurology	Withdraw of Privilege: • Informed Consent
Rana, Prachi, MD	Provisional	Transplant Hepatology	Medicine/ Gastroenterology	Withdraw of Privilege: • Ambulatory

CHANGE IN STAFF CATEGORY

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Ghosh, Pradipta, MD	Provisional	Rheumatology	Medicine/Rheumatology	Advance to Active Status

CHANGE IN STAFF REAPPOINTMENT DATES TO ALIGN WITH CHC

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Thomas, Sneha E., MD	Provisional	Internal Medicine	Medicine	MC 7/31/2026 to CHC 5/31/2026

MODIFICATION OF PRIVILEGES

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Cantu, Daae, PA	AHP	Physician Assistant	Emergency Medicine	To new APP Emergency Medicine Privilege form
Juarez, Benjamin, PA	AHP	Physician Assistant	Emergency Medicine	To new APP Emergency Medicine Privilege Form
Koenig, Rodney J., PA	AHP	Physician Assistant	Emergency Medicine	To new APP Emergency Medicine Privilege Form
Ojo, Temitayo O., FNP	AHP-Provisional	Family Nurse Practitioner	Emergency Medicine	To new APP Emergency Medicine Privilege Form
Peterson, Nancy, NP	AHP	Nurse Practitioner	Emergency Medicine	To new APP Emergency Medicine Privilege Form
Wang, Sharon D., NP	AHP	Nurse Practitioner	Emergency Medicine	To new APP Emergency Medicine Privilege Form

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 3/28/2025
MEC DATE: 4/10/2025
BOARD DATE: 4/10/2025

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

NAME CHANGE

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	CHANGE TO:
None				

AUTOMATIC TERMINATION, PER BYLAWS 3.8-3 (FAILURE TO COMPLETE PROCTORING)

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
None				

AUTOMATIC TERMINATION, PER BYLAWS 3.5-b (FAILURE TO MEET MEMBERSHIP/PRVILEGE CRITERIA)

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
None				

AUTOMATIC TERMINATION, PER BYLAWS 6.4-9 (FAILURE TO FILE COMPLETE REAPPOINTMENT)

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Booth, Gene H., CRNA	AHP	Nurse Anesthetist	Anesthesia	Resignation effective 04/30/2025
Reyes, Gina, CRNA	AHP	Nurse Anesthetist	Anesthesia	Resignation effective 04/30/2025
Zanial, Ammar, CRNA	AHP	Nurse Anesthetist	Anesthesia	Resignation effective 04/30/2025

VOLUNTARY RESIGNATIONS/WITHDRAWALS*

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	REASON/EFFECTIVE
Del Prado, Daniel, MD	Telehealth	Diagnostic Radiology	Radiology (Telemedicine)	Voluntary Resignation Effective 09/25/2024
Glivar, Phillip J., MD	Active	Orthopedic Surgery	Orthopedic Surgery	Voluntary Resignation Effective 03/04/2025
Hadley, Henry R., MD	Active	Surgery	Surgery/Urology	Voluntary Resignation 03/11/2025
Parmar, Monish A. MD	Active	Psychiatry	Psychiatry	Voluntary Resignation Effective 02/28/2025
Quinonez, Bridgett X., FNP	AHP	Family Nurse Practitioner	Medicine/Neurology	Voluntary Resignation Effective 3/17/2025
Ree, Michael H., DO	Active	Internal Medicine	Medicine	Voluntary Resignation Effective 04/03/2025
Rossie, Daniel J., MD	Active	Emergency Medicine	Emergency Medicine	Voluntary Resignation Effective 03/21/2025
Thompson, Kevin S., MD	Active	Pathology	Pathology	Voluntary Resignation Effective 09/30/2025
St. Clair, Vanessa J., NP	AHP	Radiology	Radiology (Neuro)	Voluntary Resignation Effective 04/30/2025
Uyesugi, Walter Y., DO	Provisional	Radiology	Radiology (Tele-Health)	Voluntary Resignation Effective 01/14/2025

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 3/28/2025
MEC DATE: 4/10/2025
BOARD DATE: 4/10/2025

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

Van Hal, Michele A., MD	Active	Anesthesia	Anesthesia	Voluntary Resignation Effective 05/31/2023

End of Report

I hereby:
1) Attest that the medical center's Medical Executive Committee meeting on October 10, 2024, recommended approval of the appointment, reappointments, proctoring, change of status, withdraw of privileges, automatic terminations, resignation/withdrawals and privilege forms.
2) Approve the listed changes as recommended by the Medical Executive Committee; and
3) Recommend that the Board of Supervisors ratify the listed changes as recommended by the Medical Executive Committee.

_____
Jennifer Cruikshank
Chief Executive Officer – RUHS Medical Center

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 4/25/2025
MEC DATE: 5/08/2025
BOARD DATE: 5/08/2025

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

Date: May 8, 2025

To: File

From: Medical Staff Executive Committee

Subject: Medical Staff Attestation Appointment, Reappointment and Clinical Privileges

INITIAL APPOINTMENT – May 08, 2025 – April 30, 2027

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	BOARD STATUS
Bowerman, Christopher, PA	AHP-Provisional	Physician Assistant	Emergency Medicine	NCCPA
Hernandez, Janet, NP	AHP-Provisional	Nurse Practitioner	Medicine/Cardiology	AANP
Johnson, Joshua R., PA	AHP-Provisional	Physician Assistant	Emergency Medicine	NCCPA
Narurkar, Roshni, MD	Provisional	Hematology/ Oncology	Medicine/Hematology Oncology	Internal Medicine Hematology Medical Oncology
Patterson, Stephen C., MD	Provisional	Emergency Medicine	Emergency Medicine	Emergency Medicine Emergency Medicine Services
Wright, Andrew P., MD	Provisional	Gastroenterology	Medicine/ Gastroenterology	Internal Medicine Gastroenterology

REAPPOINTMENTS – June 1, 2025 – May 31, 2027

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	BOARD STATUS
Bravo, Thomas P., MD	Courtesy	Neurology	Medicine/Neurology	Neurology
Caputo, Roy J., MD	Active	Orthopedic Surgery	Orthopedic Surgery	Orthopedic Surgery Surgery of the Hand
Chang, Andrew C., MD	Active	Gastroenterology	Medicine/ Gastroenterology	Gastroenterology
Daguio, Amy Lynn MD	Active	Internal Medicine	Family Medicine	Internal Medicine
Haycock, Korbin H., MD	Active	Emergency Medicine	Emergency Medicine	Emergency Medicine
Ilano, Lynette E., MD	Active	Internal Medicine	Medicine	Internal Medicine
Morris, Susie L., MD	Active	Psychiatry	Psychiatry	Forensic Psychiatry Psychiatry

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 4/25/2025
MEC DATE: 5/08/2025
BOARD DATE: 5/08/2025

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

Jain, Akshat MD Pending: Occ Health	Active	Hematology/Oncology	Pediatrics	Pediatrics Pediatric Hematology Oncology
Mattheis, Jay K., MD	Active	Ophthalmology	Ophthalmology	Ophthalmology
Pandey, Neha, MD	Active	Internal Medicine	Medicine	Internal Medicine
Patel, Ami N., MD	Active	Hematology/Oncology	Medicine/Hematology Oncology	Internal Medicine Hematology Medical Oncology
Selim, Khaled M., MD	Active	Gastroenterology/ Transplant Hepatology	Medicine/ Gastroenterology	Gastroenterology Transplant Hepatology
Sierpina, David I., MD	Active	Ophthalmology	Ophthalmology	Ophthalmology
Spencer, Rosemarie D., NP	AHP	Neonatology	Pediatrics	NCC: Neonatal NP
Thapamagar, Suman B., MD	Active	Pulmonary Critical Care Medicine	Medicine/PCCM	Internal Medicine Pulmonary Disease Critical Care Medicine
Vercio, Chad J., MD	Active	Pediatrics	Pediatrics	Pediatrics Pediatric Hospital Medicine Internal Medicine

FPPE/RECIPROCAL* COMPLETE REMAIN ON PROVISIONAL

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Benanti, Michael J., DO	Provisional	Diagnostic Radiology	Radiology/ Teleradiology	Complete. Remain on Provisional until eligible for advancement
Dehoff, George W., MD	Provisional	Diagnostic Radiology	Radiology/ Teleradiology	Complete. Remain on Provisional until eligible for advancement
Johnson, Evan J., MD	Provisional	Diagnostic Radiology	Radiology/ Teleradiology	Complete. Remain on Provisional until eligible for advancement
Nemirov, Alexander M, DO	Provisional	Anesthesiology	Anesthesia	Complete. Remain on Provisional until eligible for advancement
Nguyen, Vinh T., MD	Provisional	Pediatric Allergy & Immunology	Pediatrics/Allergy & Immunology	Complete. Remain on Provisional until eligible for advancement
Sag, Randy A., MD	Provisional	Diagnostic Radiology	Radiology/ Teleradiology	Complete. Remain on Provisional until eligible for advancement

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 4/25/2025
MEC DATE: 5/08/2025
BOARD DATE: 5/08/2025

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

Song, Joseph W., MD	Provisional	Diagnostic Radiology	Radiology/TeleRadiology	Complete. Remain on Provisional until eligible for advancement
Wilson, Thaddeus E., MD	Provisional	Physical Medicine & Rehab.	Medicine/Physical Medicine & Rehab.	Complete Remain on Provisional until eligible for advancement

FINAL FPPE/RECIPROCAL* ADVANCEMENT OF STAFF CATEGORY

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Carrillo, Alfonso J., MD	Provisional	Diagnostic Radiology	Radiology/TeleRadiology	Advance to Tele-Health
Magsamen, Karl E., MD	Provisional	Diagnostic Radiology	Radiology/TeleRadiology	Advance to Tele-Health
Naeini, Kourosh M., MD	Provisional	Teleradiology	Radiology/TeleRadiology	Advance to Tele-Health
Rubin, JP, MD	Provisional	Diagnostic Radiology	Radiology/TeleRadiology	Advance to Tele-Health
Tran, Duc A., MD	Provisional	Physical Medicine & Rehab.	Medicine/Physical Medicine & Rehab.	Advance to Active Status
Tran, Victoria M., MD	Provisional	Physical Medicine & Rehab.	Medicine/Physical Medicine & Rehab.	Advance to Active Status

FPPE FINAL PROCTORING FOR ALLIED HEALTH PROFESSIONALS

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Jones, Junelle, CRNA	AHP-Provisional	Certified Registered Nurse Anesthetist	Anesthesia	Complete
Patel, Dhara, NP	AHP-Provisional	Pediatric Urology	Surgery/Urology	Complete

FPPE FINAL PROCTORING FOR ADDITIONAL PRIVILEGES

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
None				

FPPE PARTIAL PROCTORING COMPLETE REQUEST FOR EXTENSION

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Loi, Michael T., DO	Provisional	Internal Medicine	Medicine	Pending: • ACCu • PCU
Raynor, Brittany C., DO	Provisional	Internal Medicine	Medicine	Pending: • ACCU • PCU

ADDITIONAL PRIVILEGES

NAME	STATUS	SPECIALTY	DEPARTMENT/ DVISION	COMMENTS
None				•

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 4/25/2025
MEC DATE: 5/08/2025
BOARD DATE: 5/08/2025

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

WITHDRAWN PRIVILEGES

NAME	STATUS	SPECIALTY	DEPARTMENT/ DVISION	COMMENTS
Loi, Michael T., DO	Provisional	Internal Medicine	Medicine	• Ambulatory
Tran, Duc A., MD	Provisional	Physical Medicine & Rehab.	Medicine/Physical Medicine & Rehab.	• Ambulatory

CHANGE IN STAFF CATEGORY

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Patil, Abhijit, MD	Provisional	Diagnostic Radiology	Radiology/TeleRadiology	Advance to Tele-Health Status

CHANGE IN STAFF REAPPOINTMENT DATES TO ALIGN WITH CHC

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
None				

MODIFICATION OF PRIVILEGES

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Bailey, Kevin J., PA	AHP	Physician Assistant	Emergency Medicine	To new APP Emergency Medicine Privilege Form
Nguyen, Tammy T., PA	AHP	Physician Assistant	Emergency Medicine	To new APP Emergency Medicine Privilege Form
Weiner, Alyssa R., PA	AHP	Physician Assistant	Emergency Medicine	To new APP Emergency Medicine Privilege Form

NAME CHANGE

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	CHANGE TO:
Malcolm, Sarah C., MD	Active	Emergency Medicine	Emergency Medicine	Sarah C. Leaf

AUTOMATIC TERMINATION, PER BYLAWS 3.8-3 (FAILURE TO COMPLETE PROCTORING)

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
None				

AUTOMATIC TERMINATION, PER BYLAWS 3.5-b (FAILURE TO MEET MEMBERSHIP/PRVILEGE CRITERIA)

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
None				

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 4/25/2025
MEC DATE: 5/08/2025
BOARD DATE: 5/08/2025

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

AUTOMATIC TERMINATION, PER BYLAWS 6.4-9 (FAILURE TO FILE COMPLETE REAPPOINTMENT)

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Yeager, Violet, MD	Active	Psychiatry	Psychiatry	4/30/2025

VOLUNTARY RESIGNATIONS/WITHDRAWALS*

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	REASON/EFFECTIVE
Amador, Cory, PA	AHP	Physician Assistant	Medicine/ Gastroenterology	Resignation Effective 2/25/2025
Carroll, Maya, NP	AHP-Provisional	Psychiatry	Psychiatry	Resignation Effective 3/07/2025
Chin, Samuel, MD	Active	Psychiatry	Psychiatry	Voluntary Resignation 4/17/2025
Chon, Telianne H., DO	Active	Anesthesiology	Anesthesia	5/31/2025
Dennis, Tshekedi G., MD	Active	Psychiatry	Psychiatry	Voluntary Resignation 4/18/2025
Downing, Stephanie, MD	Active	Surgery	Surgery/critical Care	Voluntary Resignation 4/7/2025
Gupta, Subhas, MD	LOA	Plastic Surgery	Surgery/Plastics	Voluntary Resignation 5/1/2025
Kim, Hahns, MD	LOA	Plastic Surgery	Surgery/Plastics	Voluntary Resignation 5/1/2025
Martin, Mark, MD	LOA	Plastic Surgery	Surgery/Plastics	Voluntary Resignation 5/1/2025
Murga, Allen, MD	Active	Surgery	Surgery/Vascular	Voluntary Resignation 4/22/2025
Navarro, Jesus, NP	AHP	Nurse Practitioner	Medicine/Cardiology	Voluntary Resignation 4/9/2025
Rao, Veena A., MD	Provisional	Rheumatology	Medicine/ Rheumatology	Voluntary Resignation 4/15/2025
Ray, Andrea, MD	LOA	Plastic Surgery	Surgery	Voluntary Resignation 5/1/2025
Rendon, Juan, MD	Provisional	Plastic Surgery	Surgery/Plastics	Voluntary Resignation 4/22/2025
Shen, Bailey Y., MD	Active	Ophthalmology	Ophthalmology	Voluntary Resignation 5/30/2025

End of Report

hereby:
1) Attest that the medical center's Medical Executive Committee meeting on October 10, 2024, recommended approval of the appointment, reappointments, proctoring, change of status, withdraw of privileges, automatic terminations, resignation/withdrawals and privilege forms.
2) Approve the listed changes as recommended by the Medical Executive Committee; and
3) Recommend that the Board of Supervisors ratify the listed changes as recommended by the Medical Executive Committee

_____
Jennifer Cruikshank
Chief Executive Officer – RUHS Medical Center

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 5/23/2025
MEC DATE: 6/12/2025
BOARD DATE: 6/12/2025

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

Date: **June 12, 2025**

To: **File**

Subject: **Medical Staff Attestation Appointment, Reappointment and Clinical Privileges**

INITIAL APPOINTMENT – June 12, 2025 – May 31, 2027

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	BOARD STATUS
Davis, Michael M., MD	Provisional	Radiology	Radiology/Telerad	Diagnostic Radiology
Leaf, Patrick D., MD	Provisional	Emergency Medicine	Emergency Medicine	Emergency Medicine
Smith, Jordan, MD	Provisional	Pediatrics	Pediatrics	Pediatrics

REAPPOINTMENTS – July 1, 2025 – June 30, 2027

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	BOARD STATUS
Akanda, Marib I., MD	Active	Ophthalmology	Ophthalmology	Ophthalmology
Au, Huy D., MD	Active	Internal Medicine	Medicine	Internal Medicine
Borden, Kimberly G., MD	Active	Internal Medicine	Medicine	Internal Medicine
Brothers, Joel M., MD	Courtesy	Hematology/Oncology	Medicine/ Hematology Oncology	Internal Medicine Hematology Medical Oncology
Carbajal, Shannon M., MD	Active	Internal Medicine	Medicine	Internal Medicine
Chevinsky, Jennifer R., MD	Adjunct	Public Health	Family Medicine	Life Science Medicine Preventative Medicine
Cooper, Kyle J., MD	Active	Radiology	Interventional Vascular Radiology/LLU	Diagnostic Radiology Interventional Radiology
Dao, Jr., Harry, MD	Active	Dermatology	Medicine/Dermatology	Dermatology
Davalos, Michael A., PA	AHP	Physician Assistant	Emergency Medicine	NCCPA
Dave, Amar M., MD	Active	Family Medicine	Family Medicine	Family Medicine
Del Rosario, Christia J., MD	Active	Ob-Gyn	Ob-Gyn	Ob-Gyn
Eichenberg, Brian J., MD	Active	Plastic Surgery	Surgery/Plastics	Plastic Surgery
Friedman, Alexander, DO	Active	Internal Medicine	Medicine	Internal Medicine
Giang, Michael, MD	Active	Pediatrics	Pediatrics	Pediatrics
Gilmore, Mariam M., DO	Active	Internal Medicine	Medicine	Internal Medicine
Gould, Tracy A., DO	Active	Pediatrics	Pediatrics	Pediatrics
Hawkey, Rebecca, CRNA	AHP	Anesthesia	Anesthesia	Certified Registered Nurse Anesthetist
Hill, Bryan J., MD	Active	Ob-Gyn	Ob-Gyn	Ob-Gyn
Isaeff, Wayne B., MD	Active	Ophthalmology	Ophthalmology	Ophthalmology
Jack, Sharon A., NP	AHP	Family Medicine	Family Medicine	ANCC
Jellison, Forrest C., MD	Active	Urology	Surgery/Urology	Urology
LaBarte, Theresa L., DO	Active	Neurology	Medicine/Neurology	Neurology Clinical Neurophysiology
Lan, Howard W., DO	Active	Cardiology	Medicine/Cardiology	Internal Medicine Cardiovascular Disease Interventional Cardiology
Leaf, Sarah C., MD	Active	Emergency Medicine	Emergency Medicine	Emergency Medicine
Lim, Simon Christopher L., MD	Active	Internal Medicine	Medicine	Internal Medicine

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 5/23/2025
MEC DATE: 6/12/2025
BOARD DATE: 6/12/2025

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

Loyola, Kevin, MD	Active	Neurology	Medicine	Neurology
Ludi, Giselle Y., PA	AHP	Physician Assistant	Emergency Medicine	NCCPA
McCowan, Ronald J., MD	Active	Internal Medicine	Medicine	Internal Medicine Cardiovascular Disease Hospice & Palliative Clinical Cardiac Elect.
Mupanduki, Media R., FNP	AHP	Psychiatry	Psychiatry	AANP
Puri, Latika, MD	Courtesy	Hematology/Oncology	Pediatrics	Pediatrics Pediatric Hematology/Oncology
Russell, Amy E., MD	Active	Emergency Medicine	Emergency Medicine	Emergency Medicine
Rybkin, Ivan, MD	Active	Ob-Gyn	Ob-Gyn	Ob-Gyn
Schmitz, Joseph W., MD	Active	Ophthalmology	Ophthalmology	Ophthalmology
Shafizadeh, Stephen F., MD	Active	Neurosurgery	Clinical Neurological Sciences	Neurological Surgery
Skubic, John W., MD	Active	Orthopedic Surgery	Orthopedic Surgery	Orthopedic Surgery
Smith, Jason C., MD	Active	Radiology	Radiology	Diagnostic Radiology Interventional Radiology
Solis, Daniel C., MD	Active	Internal Medicine	Medicine	Internal Medicine
Starkey, Marc C., MD	Active	Neurology	Medicine/Neurology	Neurology
Stevens, Paige, MD	Active	Critical Care Medicine	Pediatrics	Pediatrics Pediatric Critical Care
Stier, Gary, MD	Active	Anesthesiology	Anesthesia	Anesthesiology Critical Care Medicine Internal Medicine
Sweiss, Raed B., DO	Active	Neurosurgery	Clinical Neurological Sciences	Neurological Surgery
Tran, Nancy A., DO	Active	Internal Medicine	Medicine	Internal Medicine
Trinh, Viet, DO	Active	Anesthesiology	Anesthesia	
Williams, Adedapo B., MD	Active	Psychiatry	Psychiatry	Addiction Medicine Psychiatry Consultation-Liaison Psychiatry
Yoro-Bacay,,Vincent-Arthur A., MD	Active	Pediatrics	Pediatrics	Eligible

FPPE/RECIPROCAL* COMPLETE REMAIN ON PROVISIONAL

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Galley, Christopher J., MD	Provisional	Pediatrics	Pediatrics	Complete. Remain Provisional until eligible for advancement

FINAL FPPE/RECIPROCAL* ADVANCEMENT OF STAFF CATEGORY

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Cervantes, Richard J., MD	Provisional	Anesthesiology	Anesthesia	Advance to Active
Karidas, Steven J., MD	Provisional	Teleradiology	Radiology/Teleradiology	Advance to Tele-Health

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 5/23/2025
MEC DATE: 6/12/2025
BOARD DATE: 6/12/2025

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

FPPE FINAL PROCTORING FOR ALLIED HEALTH PROFESSIONALS

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
None				

FPPE FINAL PROCTORING FOR ADDITIONAL PRIVILEGES

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
None				

FPPE PARTIAL PROCTORING COMPLETE REQUEST FOR EXTENSION

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
None				

ADDITIONAL PRIVILEGES

NAME	STATUS	SPECIALTY	DEPARTMENT/ DVISION	COMMENTS
Albini, Paul, MD	Active	Surgery Critical Care	Surgery/Critical Care	Request Additional Privileges • Robotic Surgery

WITHDRAWN PRIVILEGES

NAME	STATUS	SPECIALTY	DEPARTMENT/ DVISION	COMMENTS
Galley, Christopher J., MD	Provisional	Pediatrics	Pediatrics	Remove Moderate Sedation

CHANGE IN STAFF CATEGORY

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Benitez, Christopher T., MD	Provisional	Psychiatry	Psychiatry	Change to Administrative
Wilson, Thaddeus E., MD	Provisional	Physical Med. & Rehab.	Medicine/PM&R	Advance to Active status

CHANGE IN STAFF REAPPOINTMENT DATES TO ALIGN WITH CHC

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
None				

MODIFICATION OF PRIVILEGES

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Davalos, Michael A., PA	AHP	Physician Assistant	Emergency Medicine	To new APP EM Privilege form

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 5/23/2025
MEC DATE: 6/12/2025
BOARD DATE: 6/12/2025

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

Le, Jocelyn H., PA	AHP-Provisional	Physician Assistant	Emergency Medicine	To new APP EM Privilege form
Ludi, Giselle Y., PA	AHP	Physician Assistant	Emergency Medicine	To new APP EM Privilege form

NAME CHANGE

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	CHANGE TO:
None				

AUTOMATIC TERMINATION, PER BYLAWS 3.8-3 (FAILURE TO COMPLETE PROCTORING)

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
None				

AUTOMATIC TERMINATION, PER BYLAWS 3.5-b (FAILURE TO MEET MEMBERSHIP/PRVILEGE CRITERIA)

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
None				

AUTOMATIC TERMINATION, PER BYLAWS 6.4-9 (FAILURE TO FILE COMPLETE REAPPOINTMENT)

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Clarey, Karen S., MD	Active	Psychiatry	Psychiatry	Effective 7/1/2025
Enghelberg, Moises, DO	Active	Ophthalmology	Ophthalmology	Effective 7/1/2025
Saavedra, Madeline M., MD	Active	Psychiatry	Psychiatry	Effective 06/30/2025

VOLUNTARY RESIGNATIONS/WITHDRAWALS*

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	REASON/EFFECTIVE
Ellis, John G., MD	Active	Orthopedic Surgery	Orthopedic Surgery	Voluntary Effective 5/14/2025
Jeu, Kelly A., MD	Active	Pediatrics	Pediatrics	Voluntary Effective 1/14/2025
Momohara, Michael M., MD	Active	Physical Med. & Rehab.	Medicine/PM&R	Voluntary Effective 6/25/2025
Patil, Shakuntala S., MD	Active	Nephrology	Medicine/Nephrology	Voluntary Effective 5/31/2025
Rai, Manjit K., NP	AHP-Provisional	Nurse Practitioner	Clinical Neurological Sciences	Voluntary Effective 4/29/2025
Roldan, Ashley N., MD	Active	Ophthalmology	Ophthalmology	Voluntary Effective 6/30/2025
Tshekedi, Dennis G., MD	Active	Psychiatry	Psychiatry	Voluntary Effective 4/18/2025
Williams, Chanell S., NP	Applicant	Nurse Practitioner	Emergency Medicine	Application Withdrawn

End of Report

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 5/23/2025
MEC DATE: 6/12/2025
BOARD DATE: 6/12/2025

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

hereby:

1) Attest that the medical center's Medical Executive Committee meeting on October 10, 2024, recommended approval of the appointment, reappointments, proctoring, change of status, withdraw of privileges, automatic terminations, resignation/withdrawals and privilege forms. 2) Approve the listed changes as recommended by the Medical Executive Committee; and 3) Recommend that the Board of Supervisors ratify the listed changes as recommended by the Medical Executive Committee

_____
Jennifer Cruikshank Chief Executive Officer – RUHS Medical Center

Riverside University HEALTH SYSTEM Medical Center

ANESTHESIOLOGY CLINICAL PRIVILEGES

Name: _____
(Last, First, Initial)

Effective: _____
(From—To) To be completed by MSO

- ❒ Initial Appointment
- ❒ Reappointment

Applicant: **CHECK (✓)** the "Requested" box for each privilege you are qualified to request and **SIGN** and **DATE** this form as indicated. Applicants may be requested to provide documentation of the number and types of hospital cases during the past 24 months. Applicants have the burden of producing information deemed adequate by RUHS for a proper evaluation of current competence and other qualifications, and for resolving any doubts. Privileges may only be exercised at the site(s) and/or setting(s) that have the appropriate equipment, license, beds, staff, and other support required to provide the services defined in this document.

ANESTHESIOLOGY CORE PRIVILEGES

Criteria: To be eligible to apply for core privileges in **Anesthesiology**, the applicant must meet the membership requirements of Riverside University Health System and the following privileging criteria:

- Successful completion of an Accreditation Council for Graduate Medical Education- (ACGME) or American Osteopathic Association- (AOA) accredited postgraduate training program in Anesthesiology.

AND

- Current certification or active participation in the examination process leading to certification in Anesthesiology by the relative American Board of Anesthesiology or the American Osteopathic Board of Anesthesiology.

Required Previous Experience: An applicant for initial appointment must be able to demonstrate:

- An active anesthesia practice in the privileges requested within the past 12 months.

OR

- Successful completion of a hospital-affiliated accredited residency or special clinical fellowship or research within the past 12 months.

AND

- Approval of the anesthesiology department chair.

Reappointment Requirements: To be eligible to renew core privileges in anesthesiology, the applicant must meet the following maintenance of privilege criteria:

- Current demonstrated competence and an active anesthesia practice with acceptable results in the privileges requested for the past 24 months based on ongoing professional practice evaluation and outcomes.

AND

- Meet the Continuing Medical Education (CME) requirement necessary for licensure by the applicable California medical board (the Medical Board of California or the Osteopathic Medical Board of California).

AND

- Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges.

Riverside University HEALTH SYSTEM Medical Center

ANESTHESIOLOGY CLINICAL PRIVILEGES

Name: _____
(Last, First, Initial)

Effective: _____
(From—To) To be completed by MSO

Description of Anesthesia Core Privilege

❒ **Requested** **Anesthesiology Core**

- Administration of anesthesia, including general, regional, and local, and administration of all levels of sedation to patients of all ages except as specifically excluded from practice.
- Care is directed toward patients rendered unconscious or insensible to pain and the management of emotional stress during surgical, obstetrical, and certain other medical procedures, including preoperative, intraoperative and postoperative evaluation and treatment (includes performance of history and physical exam).
- The support of life functions and vital organs under the stress of anesthetic, surgical, and other medical procedures.
- Medical management and consultation in pain medicine (acute and chronic) and critical care medicine.
- Direct resuscitation in the care of patients with cardiac or respiratory emergencies, including the need for artificial ventilation, pulmonary care, supervision of patients in post-anesthesia care units, and critically ill patients in special care units.
- Assess, stabilize, and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services.
- Admitting and discharge for patients requiring anesthesia services
- Peripheral nerve blocks (including catheter placement)
- Spinal/epidural injections

PEDIATRIC ANESTHESIOLOGY CORE PRIVILEGE

Criteria: To be eligible to apply for core privileges in pediatric anesthesiology the applicant must meet the following criteria:

- Meet the Anesthesiology Core Privilege Criteria

AND

- Successful completion of a Pediatric Anesthesiology Fellowship

OR

- Demonstrated **significant experience** performing anesthesia on pediatric patients as determined by the Chair

OR

- Successful completion of a Pediatric AND Anesthesiology Residency

Reappointment Requirements: To be eligible to renew core privileges in pediatric anesthesiology, the applicant must meet the following criteria:

- Current demonstrated competence and active Pediatric Anesthesia practice with acceptable results in the privileges requested for the past 24 months based on ongoing professional practice evaluation and outcomes.

Description of Pediatric Anesthesiology Core Privileges

☐ **Requested Pediatric Anesthesiology**

- Management of pediatric patients rendered unconscious or insensible to pain and emotional stress utilizing various pediatric sedation, general, local or regional anesthesia,
- Place and use of invasive monitors (including arterial, central venous, and pulmonary artery catheters,) during surgical and certain other medical procedures.
- preoperative, intraoperative and postoperative evaluation and treatment, support of life functions and vital organs under the stress of anesthetic, surgical and other medical procedures,
- medical management and consultation in pain medicine and critical care medicine,
- direct resuscitation in the care of patients with cardiac or respiratory emergencies, including the need for artificial ventilation, pulmonary care,
- supervision of pediatric patients and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services.
- Admitting and discharge for patients requiring anesthesia services

ANESTHESIOLOGY CLINICAL PRIVILEGES

Name: _____
(Last, First, Initial)

Effective: _____ Page 4
(From—To) To be completed by MSO

SUPERVISE ALLIED HEALTH PROFESSIONALS

Supervision: The supervising employing/alternate supervising physician provides general supervision of the activities and services of the allied health professional. The supervising physician provides supervision and direction on any specific patient. The AHP is not allowed to perform any clinical activity/procedure that is not within the clinical privileges of the supervising physician. The supervising physician must be immediately available by electronic communication or on hospital premises for consultation/direction of the AHP.

Criteria: To be eligible to supervise allied health professionals, the applicant must:

- Be credentialed and privileged at RUHS in accordance with applicable requirements.
- Provide care and supervision only for those clinical activities for which they are privileged.
- Be responsible for and must be personally involved in the care provided to individual patients in the inpatient and outpatient settings and must continue to maintain this personal involvement when AHPs are involved in the care of these patients.

Maintenance of Privilege:

- Ensure the quality of care delivered to each patient by any allied health professional. This is exercised by observation, consultation, and direction to the AHP.
- Assure that medical care for each patient is delivered in an appropriate, timely, and effective manner.
- Participate in the AHP's competency assessment process according to accrediting and certifying body requirements.
- Direct the care of the patient and provide the appropriate level of supervision based on the nature of the patient's condition, the likelihood of major changes in the management plan, the complexity of care, and the experience and judgment of the AHP being supervised.
- Assume responsibility for supervision or monitoring of the practice as stated in the appropriate hospital or medical staff policy governing AHPs.
- Be continuously available or provide an alternate to provide consultation when requested and to intervene when necessary.
- Assume total responsibility for the care of any patient when requested by the AHP or in the interest of patient care.
- Co-sign all orders entered by the AHP on the medical record of all patients seen or treated by the AHP in accordance with applicable requirements.

Description of Non-Core Privilege

❒ **Requested** **Supervision of Allied Health Professionals**

PARTICIPATE IN TEACHING PROGRAM

Supervision: Supervision is an intervention provided by a supervising practitioner to a resident physician. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functions of the resident while monitoring the quality of professional services delivered. Supervision is exercised through observation, consultation, directing the learning of the residents, and role modeling.

Criteria: To be eligible to participate in the teaching program, the applicant must:

- Be credentialed and privileged at RUHS in accordance with applicable requirements.
- Provide care and supervision only for those clinical activities for which they are privileged.
- Be responsible for and must be personally involved in the care provided to individual patients in the inpatient and outpatient settings and must continue to maintain this personal involvement when residents are involved in the care of these patients.

Maintenance of Privilege:

- Enhance the knowledge of the residents and ensure the quality of care delivered to each patient by any resident. This is exercised by observation, consultation, and direction to the resident.
- Assure that medical care for each patient is delivered in an appropriate, timely, and effective manner.
- Participate in the resident's evaluation process according to accrediting and certifying body requirements.
- Direct the care of the patient and provide the appropriate level of supervision based on the nature of the patient's condition, the likelihood of major changes in the management plan, the complexity of care, and the experience and judgment of the resident being supervised.
- Ensure that discharge or transfer of the patient from an inpatient team or clinic is appropriate, based on the specific circumstances of the patient's diagnoses and therapeutic regimen.
- Meet with each patient who received consultation by a resident and perform a personal evaluation in a timely manner based on the patient's condition, unless otherwise stated in the graduated levels of responsibility.
- Shall be immediately available to the resident in person or by telephone and able to be present within a reasonable period of time, 30 minutes, if needed.
- Provide an appropriate level of supervision during the performance of procedures. (Determination of this level of supervision is generally left to the discretion of the attending physician within the content of the previously described levels of responsibility assigned to the individual resident involved. This determination is a function of the experience and competence of the resident and the complexity of the specific case.)
- Documentation of resident supervision will be monitored during the course of peer review. Any case reviewed in which it appears that there is inadequate supervision will be forwarded to the Professional Practice Evaluation Committee.

Description of Teaching Non-Core Privilege

❒ **Requested** **Participate in Teaching Program**

ANESTHESIOLOGY CLINICAL PRIVILEGES

Name: _____
(Last, First, Initial)

Effective: _____
(From—To) To be completed by MSO

ACKNOWLEDGMENT OF PRACTITIONER

I have requested only those privileges which by education, training, current experience, and demonstrated performance that I am qualified to perform and wish to exercise at Riverside University Health System.

I understand that:

a. In exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.

b. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

_____ _____

Practitioner Signature **Date**

DEPARTMENT CHAIR / DESIGNEE RECOMMENDATION

I have reviewed the requested clinical privileges and supporting documentation and make the following recommendation:

- ☐ Recommend all requested privileges.
- ☐ Recommend privileges with conditions/modifications as noted below.
- ☐ Do not recommend the requested privileges as noted below.

Privilege	Condition / Modification / Explanation

_____ _____

Department Chair/Designee Signature **Date**

FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

Mechanism that may be used to confirm competency of new applicants and/or privileges or to address potential competency issues referred from Ongoing Professional Practice Evaluation (OPPE).

Department Chair/Designee:

Please indicate below the privileges/procedures and the number of FPPE cases to be done on the above-named practitioner, including the method of FPPE.

Please print legibly.

	Privileges/Procedures to be Proctored	Number of FPPE Cases	Method of FPPE A. Direct B. Chart C. Reciprocal
1	Anesthesia Core	5 Cases	A, B, C
2	Pediatric Anesthesia Core	3 Cases	A, B, C

Riverside University HEALTH SYSTEM Medical Center

ADVANCED PRACTICE PROVICER (APP)

PLASTIC SURGERY CLINICAL PRIVILEGES

Name:_____ Staff Category: **APP**
(Last, First, Initial)

Effective: _____
(From—To) (To be completed by MSO)

☐ Initial Appointment

☐ Reappointment

Applicant: **CHECK (✓)** the "Requested" box for each privilege requested and **SIGN** and **DATE** this form as indicated. New applicants may be requested to provide documentation of the number and types of hospital cases during the past 24 months. Applicants have the burden of producing information deemed adequate by the hospital for a proper evaluation of current competence, and other qualifications and for resolving any doubts. Privileges may only be exercised at the site(s) and/or setting(s) that have the appropriate equipment, license, beds, staff, and other support required to provide the services defined in this document.

QUALIFICATIONS FOR NURSE PRACTITIONER

CRITERIA: To be eligible to apply for clinical privileges as a Nurse Practitioner, the applicant must meet the following criteria:

Current demonstrated competence and an adequate level of current experience, documenting the ability to provide services at an acceptable level of quality and efficiency in the care of the trauma and critical care patient.

AND

Hold a valid and active registered nurse license in the State of California and a current active certificate by the California Board of Registered Nursing (CA BRN) as a nurse practitioner.

AND (for initial certification after January 1, 2008)

Completion of a master's degree in nursing or satisfactorily completed a nurse practitioner program approved by the CA BRN.

OR (for initial certification prior to January 1. 2008)

Completion of master's degree in nursing, a master's degree in clinical field related to nursing, or a graduate degree in nursing and to have satisfactorily completed a nurse practitioner program approved by the CA BRN.

AND

Current BLS and ACLS card approved by American Heart Association (AHA)

AND

Current certification by the American Academy of Nurse Practitioners (AANP) or the American Nurses Credentialing Center (ANCC), or any other accredited recognized board.

AND

Professional liability insurance coverage issued by a recognized company and of a type and in an amount equal to or greater than the limits established by the governing body.

AND

County employment, contracted employment or employment by or a formal agreement with a physician(s) currently appointed to the active or consulting medical staff of this hospital with scope of practice in the same area of specialty practice. According to the written agreement, the physician must:

- Assume responsibility for supervision or monitoring of the APP's practice as stated in the appropriate hospital or medical staff policy governing nurse practitioners.
- Be continuously available or provide an alternate to provide consultation when requested and to intervene when necessary;
- Assume total responsibility for the care of any patient when requested by the APP or required by this policy or in the interest of patient care;
- Review all orders entered by the APP on the medical record of all patients seen or treated by the APP.

ADVANCED PRACTICE PROVICER (APP)

PLASTIC SURGERY CLINICAL PRIVILEGES

Name:_____ Staff Category: **APP**
(Last, First, Initial)

Effective: _____
(From—To) (To be completed by MSO)

QUALIFICATIONS FOR PHYSICIAN ASSISTANT

CRITERIA*:* To be eligible to apply for clinical privileges as a Physician Assistant, the applicant must meet the following criteria:

Current demonstrated competence and an adequate level of current experience documenting the ability to provide services at an acceptable level of quality and efficiency,

AND

Graduate from an ARC-PA (Accreditation Review Commission for the Physician Assistant) approved program. (Additional education may be required for some specialty areas),

AND

Current certification by the National Commission on Certification of Physician Assistants (NCCPA),

AND

Current licensure to practice as a physician assistant issued by the California Board of Medicine,

AND

Current BLS and ACLS card approved by American Heart Association (AHA)

AND

Professional liability insurance coverage issued by a recognized company and of a type and in an amount equal to or greater than the limits established by the governing body.

AND

County employment by or an agreement with a physician(s) currently appointed to the medical staff of this hospital to supervise the PA's practice in the hospital.

According to the Practice agreement, the physician must:

- Assume responsibility for supervision or monitoring of the PA's practice as stated in the appropriate hospital or medical staff policy governing PA's.
- Be continuously available or provide an alternate to provide consultation when requested and to intervene when necessary.
- Assume total responsibility for the care of any patient when requested by the PA or required by this policy or in the interest of patient care.

CATEGORIES OF PATIENTS PRACTITIONER MAY TREAT

May provide services consistent with the policies stated herein to patients of medical staff member(s) with whom the APP has a documented formal affiliation or to patients assigned by the chair of the department to which the APP is assigned.

SUPERVISION

The exercise of these clinical privileges requires a designated collaborating/supervising physician with clinical privileges at this hospital. All practice is performed under the supervision of the physician/designee and in accordance with written policies and protocols developed and approved by the relevant clinical department or service, the Medical Executive Committee, Nursing Administration, and the Governing Body. Collaborating/supervising physician must be physically present, on hospital/clinic premises or readily available by electronic communication.

ADVANCED PRACTICE PROVICER (APP)

PLASTIC SURGERY CLINICAL PRIVILEGES

Name:_____ Staff Category: **APP**
(Last, First, Initial)

Effective: _____
(From—To) (To be completed by MSO)

MEDICAL RECORD CHARTING RESPONSIBILITIES

Clearly, legibly, completely, and in timely fashion, describe each service the APP provides to a patient in the hospital or clinic setting and relevant observations. Standard rules regarding authentication of, necessary content of, and required time frames for preparing and completing the medical record and portions thereof are applicable to all entries made.

GENERAL RELATIONSHIP TO OTHERS

Advanced Practice Provider have authority to direct any hospital personnel in the provision of clinical services to patients to the extent that such direction is necessary in order to carry out the services required by the patient and which the APP is authorized to provide.

PERIODIC COMPETENCE ASSESSMENT

Applicants must also be able to demonstrate they have maintained competence based on unbiased, objective results of care according to the hospital's existing quality assurance mechanisms and by showing evidence that they have met the continued competence requirements established by the state licensing authority, applicable to the functions for which they are seeking to provide at this hospital. In addition, continuing education related to the specialty area of practice is required as mandated by licensure.

To the applicant: If you wish to **exclude** any procedures, please strike through those procedures which you do not wish to request, initial, and date.

APP- CLINICAL PRIVILEGES — GENERAL / CORE

☐ **Request** Patients within age group of collaborating physician except as specifically excluded from practice. Assess, stabilize, and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. Privileges include but are not limited to:

- Obtain and document medical, surgical, social and medication history and perform physical examination as indicated according to established standardized procedures and protocol as agreed upon by the APP and supervising physician (to be countersigned by collaborating physician within 24hours).
- Preliminary interpretation of simple plain radiological films and EKG's with final interpretation by supervising physician.
- Order and interpret laboratory tests and diagnostic procedures results.
- Develop treatment plan and implements plan, educating patient and family members as applicable.
- Order treatment modalities such as medications, IV fluids, electrolytes etc. in accordance with standardized procedures, protocols and formulary as agreed upon by APP ad supervising physician.
- Counsel and instruct patients and significant others on disease processes, medications, preventative health and treatment plan including pre and post procedure teaching.
- Monitor and manage acute and chronic illnesses of the population consulting with supervising physician regarding acute, unstable patients as per SP.
- Monitor and refer to consulting services as deemed necessary such as dietician, physical therapy, social worker/case management, palliative care, etc.
- Write discharge summaries (to be countersigned by the collaborating physician).

- Round on inpatients daily observing and evaluating the patient's vital signs, intake and output, laboratory and imaging results, nutritional plan, medication review, pain level, activity, psychiatric or behavioral issues.

APP- Clinical Privileges — General / Core Continued

- Write new orders and/or change orders that are within scope of practice and notify responsible physician of changes in patient's condition or any concerns.
- Act as a liaison between the nursing department and other clinical departments, promoting teamwork and communication.
- Advanced Cardiac Life Support
- Defibrillation
- Bladder decompression and catheterization techniques
- GI decontamination (emesis, lavage, charcoal)
- Simple wound debridement and repair
- Perform medical screening exams
- Perform histories and physicals
- Develop treatment plan
- Perform electrocardiogram tracing, preliminary electrocardiogram interpretation with final interpretation by supervising physician
- Arterial puncture
- Bladder decompression and catheterization techniques
- Insertion and removal of nasogastric tube
- Order diagnostic testing and therapeutic modalities such as medications treatments, IV fluids, and electrolytes, etc.
- Patient education and counseling covering such things as health status, test, results, disease processes, and discharge planning
- Provide pre- and post-operative surgical care
- Record progress notes
- Suture lacerations
- Perform venipuncture
- Write discharge summaries
- Telemedicine: Provide services remotely through telemedicine capabilities
- Arrange appropriate outpatient follow up within department outpatient clinics as needed

Special Non-Core Privileges (See Specific Criteria)

If desired, non-core privileges are requested individually in addition to requesting the core. Each individual requesting non-core privileges must meet the specific threshold criteria governing the exercise of the privilege requested including training, required previous experience, and for maintenance of clinical competence.

FIRST ASSISTANT

CRITERIA: Physician Assistant - Direct supervision and those technical and management skills, which qualify the Physician Assistant to perform First Assistant by virtue of training and experience.

Nurse Practitioner - Certificate from an accredited Registered Nurse First Assistant program. Direct supervision and those technical and management skills, which qualify the Nurse Practitioner to perform First Assistant by virtue of training and experience.

REQUIRED PREVIOUS EXP*ERIENCE*: Demonstrate current competence and evidence of the performance of at least three (3) procedures in the past 12 months.

MAINTENANCE OF PRIVILEGE: Demonstrate current competence and the performance of at least one (1) procedure in the past 24 months.

☐ **Requested** Assist Attending Physician with Surgical Procedures as a First Assistant

❒ **Approved** ❒ **Not Approved**

OBTAINING INFORMED CONSENT

CRITERIA: Completion of module on informed consent with completion of post-test with 100% score
AND

- Direct observation/proctoring of informed consent when proctoring of each privilege is granted that required informed consent.

REQUIRED PRIOR EXPERIENCE: None
MAINTENANCE OF PRIVILEGE: Successful completion of informed consent module with renewal of privileges.

❒ **Requested** Obtaining Informed Consent ❒ **Approved** ❒ **Not Approved**

INJECTION OF TISSUE EXPANDERS

CRITERIA: Direct supervision and those technical and management skills, which qualify the APP to perform Injection of Tissue Expanders by virtue of training and experience.

REQUIRED PREVIOUS EXP*ERIENCE*: Demonstrate current competence and evidence of the performance of at least five (5) procedures in the past 12 months.

MAINTENANCE OF PRIVILEGE: Demonstrate current competence and the performance of at least one (2) procedure in the past 24 months.

☐ **Requested** Injection of Tissue Expanders ❒ **Approved** ❒ **Not Approved**

PRESCRIPTIVE AUTHORITY AS DELEGATED BY A PHYSICIAN IN A COLLABORATIVE PRACTICE AGREEMENT IN ACCORDANCE WITH STATE AND FEDERAL LAW

CRITERIA: Prescriptive authority as delegated by a physician in a collaborative practice agreement in accordance with State and Federal Law. Prescribing medications must be under RUHS protocol(s), and formulary, which have been established as required by the Department of Consumer Affairs in the "Business and Professions Code."

Drug and Devices:

- NP: Maintain a current Furnishing Number for prescription for Controlled Substances Schedule II-V:
- APP: Drug Enforcement Administration (DEA) number is required for controlled substances. http://www.m.ca.gov/pdfs/regulations/npr-b-51.pdf
- https://www.deadiversion.usdoj.gov/drugreg/practioners/index.html

Requested	Prescriptive Authority	
	The delegation to the APP to administer or dispense drugs shall include the prescribing of controlled substances.	❒ **Approved** ❒ **Not Approved**

Riverside University HEALTH SYSTEM Medical Center

ADVANCED PRACTICE PROVICER (APP)

PLASTIC SURGERY CLINICAL PRIVILEGES

Name:_____ Staff Category: **APP**
(Last, First, Initial)

Effective: _____
(From—To) (To be completed by MSO)

ACKNOWLEDGMENT OF PRACTITIONER

I have requested only those privileges which by education, training, current experience, and demonstrated performance that I am qualified to perform and which I wish to exercise at RUHS.

I understand that:

a. In exercising any clinical privileges granted and in carrying out the responsibilities assigned to me, I am constrained by Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.

b. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the policies governing allied health professionals or related documents.

_____ _____
Practitioner Signature **Date**

ENDORSEMENT OF PHYSICIAN EMPLOYER / SUPERVISOR

Signature: _____ Date: _____

Signature: _____ Date: _____

DEPARTMENT CHAIR / DESIGNEE RECOMMENDATION

I have reviewed the requested clinical privileges and supporting documentation and make the following recommendation:

- ❒ Recommend all requested privileges.
- ❒ Recommend privileges with conditions/modifications as noted below.
- ❒ *Do not recommend the requested privileges as noted below.

Privilege	Condition / Modification / Explanation

_____ _____
Department Chair/Designee Signature **Date**

_____ _____
IDPC Chair/Designee Signature **Date**

FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

Mechanism that may be used to confirm competency (including providing appropriate informed consent) of new applicants and/or privileges or to address potential competency issues referred from Ongoing Professional Practice Evaluation (OPPE).

DEPARTMENT CHAIR/DESIGNEE: For the above-named applicant, please indicate below the privileges/ procedures and the number of cases to be proctored, including the method of proctoring.
Please print legibly.

Privileges / Procedures to be Proctored	Number of Cases to be Proctored	Method of Proctoring A. Direct Observation B. Retrospective Chart Review C. Simulation
GENERAL CORE	5	A ,B,C
FIRST ASSISTANT	3	A, B, C
INFORMED CONSENT	1	A
INJECTION OF TISSUE EXPANDERS	3	A, B, C

***Indicate** N/A if privilege not requested

RIVERSIDE UNIVERSITY HEALTH SYSTEM

GENERAL SURGERY CLINICAL PRIVILEGES

Name:_____ ❒ Initial Appointment
(Last, First, Initial) ❒ Reappointment

Effective: _____
(From—To) (To be completed by MSO)

Applicant: **CHECK (✓)** the "Requested" box for each privilege you are qualified to request and **SIGN** and **DATE** this form as indicated. Applicants may be requested to provide documentation of the number and types of hospital cases during the past 24 months. Applicants have the burden of producing information deemed adequate by RUHS for a proper evaluation of current competence and other qualifications, and for resolving any doubts.

Privileges may only be exercised at the following site(s) and/or setting(s) that have the appropriate equipment, license, beds, staff, and other support required to provide the services defined in this document.

- RUHS- Medical Center
- RUHS-MSC clinics and OR

QUALIFICATIONS FOR CORE GENERAL SURGERY PRIVILEGES

GENERAL SURGERY CORE PRIVILEGES

CRITERIA: To be eligible to apply for core privileges in general surgery, the initial applicant must meet the membership requirements of Riverside University Health System and the following privileging criteria:

- Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited post-graduate training program in general surgery

AND

- Current board certification or board eligible candidate in the examination process in surgery by the American Board of Surgery and/or Royal College of Surgeons or the American Osteopathic Board of Surgery and/or American College of Osteopathic Surgeons or the Royal College of Physicians and Surgeons of Canada.

REQUIRED PREVIOUS EXPERIENCE: An applicant for initial appointment must be able to demonstrate:

- Performance of at least 100 general surgery procedures, reflective of the privileges requested, during the past 12 months.

OR

- Successful completion of a hospital-affiliated ACGME or AOA accredited residency or special clinical fellowship or research within the past 12 months.

OR

- Proficiency in general surgery to the satisfaction of the department chair and majority of the members of the General Surgery Division.

REAPPOINTMENT REQUIREMENTS: To be eligible to renew core privileges in general surgery, the applicant must meet the following maintenance of privilege criteria:

- Current demonstrated competence and performance of 50 general surgery procedures with acceptable results in the privileges requested for the past 24 months or at the discretion of the Chair/Chief based on results of ongoing professional practice evaluation and outcomes.)
- based on results of ongoing professional practice evaluation and outcomes.

AND

- Documentation that confirms 50 Category I CME hours during the past two years related to clinical privileges being requested. (CME Attestation)

AND

- Maintenance of board certification and/or board eligibility

AND

- Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges.

GENERAL SURGERY CLINICAL PRIVILEGES

Name:_____
(Last, First, Initial)

Effective: _____ Page 2

(From — To)___ (To be completed by MSO)__

General Surgery Core Privileges

❒ **Requested** **General Surgery Core Privileges** ❒ Approved ❒ Not Approved

Admit, evaluate, diagnose, consult, and provide pre-, intra- and post-operative care, and perform surgical procedures, to patients of all ages, except as specifically excluded from practice; to correct or treat various conditions, diseases, disorders, and injuries of the alimentary tract, abdomen and its contents, extremities, breast, skin and soft tissue, head and neck, vascular and endocrine systems, and with upper and lower endoscopy excluding colonoscopy. Management of critically ill patients with underlying surgical conditions in the emergency department, intensive care unit and trauma units to include ventilator management and emergency thoracic and vascular surgery. Includes performance of medical history and physical exam. Assess, stabilize, and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. Telemedicine: Provide services remotely through telemedicine capabilities.

❒ **Requested** **Outpatients – Ambulatory Care Setting** ❒ Approved ❒ Not Approved

Privileges to manage and treat outpatients in the ambulatory-care setting at RUHS and provide services remotely through telemedicine capabilities.

CORE PROCEDURES LIST: This list is a sampling of procedures included in the core. This is not intended to be an all-encompassing list but rather reflective of the categories/types of procedures included in the core.

Please cross out any Core privileges you are not requesting at RUHS facilities.

❒ Requested **General Surgery Core Procedures** ❒ Approved ❒ Not Approved

CORE PROCEDURES

- Amputations, above the knee & below knee, toe, transmetatarsal, digits
- Anoscopy
- AppendectomyBiliary tract resection/reconstruction
- Breast: complete mastectomy with or without axillary lymph node dissection, excision of breast lesion, breast biopsy, incision and drainage of abscess, modified radical mastectomy, operation for gynecomastia, partial mastectomy with or without lymph node dissection, radical mastectomy, subcutaneous mastectomy
- Bronchoscopy
- Colectomy (abdominal)
- Colon surgery for benign or malignant disease (minimal of 6 annually or at the discretion of the Chair/Chief based on results of ongoing professional practice evaluation and outcomes).
- Colotomy, colostomy
- Correction of intestinal obstruction
- Drainage of intra-abdominal, deep ischiorectal abscess
- Endoscopy (intraoperative)
- Enteric fistulae, management
- Enterostomy (feeding or decompression)
- Esophagogastrectomy
- Excision of fistula in ano/fistulotomy, rectal lesion
- Excision of pilonidal cyst/marsupialization
- Gastroduodenal surgery

General Surgery Core Privileges Continued

Please cross out any Core privileges you are not requesting at RUHS facilities.

❒ **Requested** **General Surgery Core Procedures Continued:** ❒ Approved ❒ Not Approved

CORE PROCEDURES CONTINUED:

- Gastrostomy (feeding or decompression)
- Genitourinary procedures incidental to malignancy or trauma
- Gynecological procedure incidental to abdominal exploration
- Hepatic resection
- Temporary Hemodialysis access procedures
- Hemorrhoidectomy
- Incision and drainage of abscesses and cysts
- Incision and drainage of pelvic abscess
- Incision, excision, resection and enterostomy of small intestine
- Incision/drainage and debridement, perirectal abscess
- Insertion and management of pulmonary artery catheters
- IV access procedures, central venous catheter, and ports
- Laparoscopy, diagnostic, appendectomy, cholecystectomy, lysis of adhesions, mobilization and catheter positioning, colectomies
- Laparotomy for diagnostic or exploratory purposes or for management of intra-abdominal sepsis or trauma
- Liver biopsy (intra operative), liver resection
- Management of burns
- Management of hemorrhoids (internal and external) including hemorrhoidectomy
- Management of soft-tissue tumors, inflammations and infection
- Operations on gallbladder, biliary tract, bile ducts, hepatic ducts, excluding biliary tract reconstruction
- Pancreatectomy, total or partial (minimum of 7 annually or at the discretion of the Chair/Chief based on results of ongoing professional practice evaluation and outcomes.)
- Proctosigmoidoscopy, rigid with biopsy, with polypectomy/tumor excision
- Radical regional lymph node dissections
- Removal of ganglion (palm or wrist; flexor sheath)
- Repair of perforated viscus (gastric, small intestine, large intestine)
- Scalene node biopsy
- Selective vagotomy
- Sigmoidoscopy, fiberoptic with or without biopsy, with polypectomy
- Skin grafts (partial thickness, simple)
- Small bowel surgery for benign or malignant disease
- Splenectomy (trauma, staging, therapeutic)
- Surgery of the abdominal wall open or laparoscopic including management of all forms of hernias, including diaphragmatic hernias, inguinal hernias, and orchiectomy in association with hernia repair
- Thoracentesis
- Thoracoabdominal exploration
- Tracheostomy
- Tube thoracotomy
- Telemedicine: Provide services remotely through telemedicine capabilities

TRAUMA / ACUTE CARE SURGERY CORE PRIVILEGES

CRITERIA: To be eligible for trauma care core privileges, the applicant must have:

- Successful completion of an ACGME-accredited residency in general surgery that included training in trauma and critical care. The approval of these privileges requires a recommendation for appointment by the Medical Director of Trauma Services.

AND

- Successful completion of an ACGME-accredited surgical critical Care fellowship

AND

- Current board certification in surgery granted by the American Board of Surgery and/or Royal College of Surgeons or active candidate in the examination process.

AND

- Current ATLS

REQUIRED PREVIOUS EXPERIENCE: Demonstrated current competency and evidence of trauma care within the past 24 months. If the requirement is not met, the surgeon will be required to attend a trauma review course and pass proctoring in trauma before privileges for independent trauma care are granted.

MAINTENANCE OF PRIVILEGE: Demonstrated current competence and evidence of the performance as determined by the Medical Director of Trauma Services.

AND

- Documentation that confirms 16 Category I trauma-related CME hours per year averaged over a 3-year period. Documentation must include the CME topic, date, location, and number of CME hours awarded.

Please cross out any Core privileges you are not requesting at RUHS facilities.

❒ **Requested** **Adult Trauma Care Core Privileges** ❒ **Approved** ❒ **Not Approved**

Admit, evaluate, diagnose, and manage patients older than 15 years of age, except as specifically excluded from practice, presenting with trauma-related injuries and disorders, including resuscitation, surgical intervention, diagnostic studies, and coordination of operative procedures to be performed by other healthcare professionals, supervise and perform all necessary operative care, manage the trauma patient throughout the stay in the acute-care facility, and coordinate the early institution of rehabilitation and discharge planning

The provider must have General Surgery Core Privileges

❒ **Requested** **Pediatric Trauma Care Core Privileges** ❒ **Approved** ❒ **Not Approved**

Admit, evaluate, diagnose, and manage pediatric patients 15 years of age and younger, except as specifically excluded from practice, presenting with trauma-related injuries and disorders, including resuscitation, surgical intervention, diagnostic studies, and coordination of operative procedures to be performed by other healthcare professionals, supervise and perform all necessary operative care, manage the trauma patient throughout the stay in the acute-care facility, and coordinate the early institution of rehabilitation and discharge planning.

The provider must complete and maintain pediatric advance life support (PALS) training

❒ **Requested** **Trauma/Special Care** ❒ **Approved** ❒ **Not Approved**

Rib plating and Video assisted thoracic surgery for trauma (VATs) for Trauma (minimum of 2 annually or at the discretion of the Chair/Chief based on results of ongoing professional practice evaluation and outcomes.)

❒ **Requested** **Trauma Endovascular Procedures** ❒ **Approved** ❒ **Not Approved**

Reboa/Aortic Balloon Endovascular Privilege

- Successful completion of the American College of Surgeons BEST course or instructor status.

SURGICAL CRITICAL CARE CORE PRIVILEGES

CRITERIA: To be eligible for **surgical critical care** core privileges, the applicant must have:

- Successful completion of an ACGME-accredited or AOA accredited surgical critical care fellowship or equivalent.

AND

- Current board certification in surgical critical care granted by the American Board of Surgery and/or Royal College of Surgeons or active candidate in the examination process.

AND

- At least 25 critical care cases reflective of the scope of privileges requested within the past 12 months.

MAINTENANCE OF PRIVILEGE:

DEMONSTRATED CURRENT COMPETENCE IN THE CARE OF 20 CRITICALLY ILL PATIENTS IN THE PAST 24 MONTHS.

❒ **Requested** **Surgical Critical Care Core Privileges** ❒ Approved ❒ Not Approved

VASCULAR SURGERY CORE PRIVILEGES

CRITERIA: To be eligible for **vascular surgery** core privileges, the applicant must have:

- Successful completion of an ACGME-accredited or AOA accredited vascular surgery fellowship.

AND

- Current board certification in vascular surgery granted by the American Board of Surgery and/or Royal College of Surgeons or active candidate in the examination process.

AND

- At least 50 vascular surgery procedures reflective of the scope of privileges requested within the past 12 months.

MAINTENANCE OF PRIVILEGE:

- Demonstrated current competence in the performance of 5 open and 5 endo- vascular surgeries in the past 24 months or at the discretion of the Chair/Chief based on results of ongoing professional practice evaluation and outcomes.

❒ **Requested** **Vascular Surgery Core Privileges** ❒ Approved ❒ Not Approved
The core privileges in this specialty include the procedures on the attached procedure list and such other procedures that are extensions of the same techniques and skills.
These core privileges do NOT include privileges for endovascular surgical procedures.

CORE PROCEDURES LIST: This list is a sampling of procedures included in the core. This is not intended to be an all-encompassing list but rather reflective of the categories/types of procedures included in the core.

Please cross out any Core privileges you are not requesting at RUHS facilities.

❒ **Requested** **Vascular Surgery Core Procedures** ❒ **Approved** ❒ **Not Approved**

CORE PROCEDURES

- Performance of history and physical exam
- Amputations of an upper or lower extremity
- Aneurysm repair, abdominal aorta and peripheral vessels emergent and elective

Vascular Surgery Core Privileges Continued

- Angioplasty
- Bypass grafting all vessels excluding coronary and intracranial vessels
- Central venous access catheters and ports
- Cervical, thoracic or lumbar sympathectomy
- Diagnostic biopsy or other diagnostic procedures on blood vessels
- Embolectomy or thrombectomy for all vessels excluding coronary and intra cranial vessels
- Endarterectomy for all vessels excluding coronary and intra cranial vessels
- Extra cranial carotid and vertebral artery surgery including carotid endarterectomy (10 cases annually at the discretion of the Chair/Chief based on results of ongoing professional practice evaluation and outcomes.
- Hemodialysis access procedures
- Intraoperative angiography
- Nephrectomy for renovascular hypertension
- Other major open peripheral vascular arterial and venous reconstructions
- Reconstruction, resection, repair of major vessels with anastomosis or replacement (excluding cardiopulmonary, intracranial)
- Sclerotherapy
- Temporal artery biopsy
- Thoracic outlet decompression procedures including rib resection
- Vein ligation and stripping
- Venous reconstruction

ENDOVASCULAR SURGERY CORE PRIVILEGES

CRITERIA: To be eligible for **endovascular surgery** core privileges, the applicant must have:

- Successful completion of an ACGME-accredited or AOA accredited vascular surgery fellowship.

AND

- Current board certification in vascular surgery granted by the American Board of Surgery and/or Royal College of Surgeons or active candidate in the examination process.

REQUIRED PREVIOUS EXPERIENCE:

- Provide documentation of education and experience in the conditions and procedures listed in the attached procedure list: 50 cases for diagnostic endovascular procedures, 25 cases for endovascular intervention, and 5 cases for endovascular graft.

MAINTENANCE OF PRIVILEGE*:*

- Demonstrated competence with evidence of a total of ten (10) endovascular diagnostic cases with at least 5 interventions during the past 24 months.

❒ **Requested** **Endovascular Surgery Core Privileges** ❒ **Approved** ❒ **Not Approved**
The core privileges in this specialty include the procedures on the attached procedure list and such other procedures that are extensions of the same techniques and skills.

CORE PROCEDURES LIST: This list is a sampling of procedures included in the core. This is not intended to be an all-encompassing list but rather reflective of the categories/types of procedures included in the core.

Please cross out any Core privileges you are not requesting at RUHS facilities.

Endovascular Surgery Core Privileges Continued

ENDOVASCULAR CORE PROCEDURES

- Balloon angioplasty
- Diagnostic angiography: excluding intra-cerebral and coronary procedures
- Embolization
- Endovascular graft
- Peripheral arterial and venous access
- Remote endarterectomy
- Stenting
- Thrombolysis
- Venous radio frequency ablation
- Vena cava filter insertion

CARDIAC SURGERY CORE PRIVILEGES

CRITERIA: To be eligible for **Cardiac Surgery** core privileges, the applicant must have:

- Successful completion of an ACGME-accredited or AOA accredited cardio-thoracic surgery fellowship

AND

- Current board certification in thoracic and cardiac surgery granted by the American Board of Thoracic Surgery and/or Royal College of Surgeons or active candidate in the examination process.

REQUIRED PREVIOUS EXPERIENCE: Demonstrate current competency and evidence of performance of at least 20 cardio thoracic cases in the past 12 months.

MAINTENANCE OF PRIVILEGE: Applicant must be able to show maintenance of competence with evidence of at least five (5) cardio thoracic cases during the past 12 months.

❒ **Requested** **Cardiac Surgery Core Privileges** ❒ **Approved** ❒ **Not Approved**

The core privileges in this specialty include the procedures on the attached procedure list and such other procedures that are extensions of the same techniques and skills.

CORE PROCEDURES LIST: THIS LIST IS A SAMPLING OF PROCEDURES INCLUDED IN THE CORE. THIS IS NOT INTENDED TO BE AN ALL-ENCOMPASSING LIST BUT RATHER REFLECTIVE OF THE CATEGORIES/TYPES OF PROCEDURES INCLUDED IN THE CORE.

Please cross out any Core privileges you are not requesting at RUHS facilities.

❒ **Requested** **Cardiac Surgery Core Procedures** ❒ **Approved** ❒ **Not Approved**

CORE PRIVILEGES

- Pericardiocentesis
- Repair of heart trauma
- Provide consultation in person or through telemedicine, on the management of patients undergoing PCI.
- Provide consultation in person or through telemedicine, on the management of patients who have left main, three-vessel CAD or two-vessel CAD with involvement of the LAD or comorbidities such as diabetes, depressed LV function or complex anatomy.
- Provide consultation in person or through telemedicine, about cardiac revascularization options.
- Provide consultation in person or through telemedicine, about cardiac surgical options for patients with structural and valvular heart disease.

THORACIC SURGERY CORE PRIVILEGES

CRITERIA: To be eligible for **thoracic surgery** core privileges, the applicant must have:

- Successful completion of an ACGME-accredited or AOA accredited thoracic surgery fellowship during the last three years.

OR

- Additional thoracic surgery training that demonstrates proficiency in thoracic surgery to the satisfaction of the department chair and the majority of the members of the General Surgery Division.

AND

- Current board certification in surgery granted by the American Board of Surgery and/or Royal College of Surgeons or active candidate in the examination process.

REQUIRED PREVIOUS EXPERIENCE: Demonstrate current competency and evidence of performance of at least 20 thoracic cases in the past 12 months.

- **MAINTENANCE OF PRIVILEGE:** Applicant must be able to show maintenance of competence with evidence of at least five (5) thoracic cases during the past 12 months or at the discretion of the Chair/Chief based on results of ongoing professional practice evaluation and outcomes.

❒ **Requested** **Thoracic Surgery Core Privileges** ❒ **Approved** ❒ **Not Approved**

The core privileges in this specialty include the procedures on the attached procedure list and such other procedures that are extensions of the same techniques and skills.

CORE PROCEDURES LIST: This list is a sampling of procedures included in the core. This is not intended to be an all-encompassing list but rather reflective of the categories/types of procedures included in the core.

Please cross out any Core privileges you are not requesting at RUHS facilities.

CORE PRIVILEGES

- Performance of history and physical exam
- Bronchoscopy: diagnostic, G.B. management, therapeutic procedures
- Cardiac Surgery: including pericardiocentesis, repair of major thoracic vessel or heart trauma
- Chest wall and pleural space surgery: including rib resection, management of chest wall trauma
- Esophagoscopy: diagnostic, F.B. removal, therapeutic procedures
- Esophageal surgery: including resection, repair or reconstruction. Hiatal hernia and associated esophageal procedures (minimum of 7 esophagectomies annually or at the discretion of the Chair/Chief based on results of ongoing professional practice evaluation and outcomes.
- Neck and tracheal surgery: including tracheal repair with reconstruction, cervical node and scalene pad biopsy, mediastinoscopy, mediastinotomy and drainage, resection of mediastinal tumor or cyst
- Tracheobronchial tree and lung surgery: including pulmonary resection of any type
- Application of fixation devices to stabilize rib fractures and chest wall.

QUALIFICATIONS FOR SPECIAL NON-CORE PRIVILEGES

- See Specific Criteria below:
- If desired, non-core privileges are requested individually in addition to requesting the core. Each individual requesting non-core privileges must meet the specific threshold criteria governing the exercise of the privilege requested including training, required previous experience, and maintenance of clinical competence.

PARTICIPATE IN TEACHING PROGRAM

SUPERVISION: Supervision is an intervention provided by a supervising practitioner to a resident physician. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functions of the resident while monitoring the quality of professional services delivered. Supervision is exercised through observation, consultation, directing the learning of the residents, and role modeling.

CRITERIA: To be eligible to participate in the teaching program, the applicant must:

- Be credentialed and privileged at RUHS in accordance with applicable requirements.
- Provide care and supervision only for those clinical activities for which they are privileged.
- Be responsible for and must be personally involved in the care provided to individual patients in the inpatient and outpatient settings and must continue to maintain this personal involvement when residents are involved in the care of these patients.

MAINTENANCE OF PRIVILEGE:

- Enhance the knowledge of the residents and ensure the quality of care delivered to each patient by any resident. This is exercised by observation, consultation, and direction to the resident.
- Assure that medical care for each patient is delivered in an appropriate, timely, and effective manner.
- Participate in the resident's evaluation process according to accrediting and certifying body requirements.
- Direct the care of the patient and provide the appropriate level of supervision based on the nature of the patient's condition, the likelihood of major changes in the management plan, the complexity of care, and the experience and judgment of the resident being supervised.
- Within 24 hours of a patient's admission or transfer (including weekends and holidays), shall personally examine the patient, establish a personal and identifiable relationship with the patient, and record an appropriate history, physical examination, working diagnostic impression(s) and plan for treatment. The attending shall countersign and add an addendum to the resident's note detailing his/her involvement and supervision.
- Ensure that discharge or transfer of the patient from an inpatient team or clinic is appropriate, based on the specific circumstances of the patient's diagnoses and therapeutic regimen.
- Meet with each patient who received consultation by a resident and perform a personal evaluation in a timely manner based on the patient's condition, unless otherwise stated in the graduated levels of responsibility.
- Shall be immediately available to the resident in person or by telephone and able to be present within a reasonable period of time, 30 minutes, if needed.
- Available for supervision during clinic hours and ensure the coordination of care that is provided to the patients.
- Provide an appropriate level of supervision during the performance of procedures. (Determination of this level of supervision is generally left to the discretion of the attending physician within the content of the previously described levels of responsibility assigned to the individual resident involved. This determination is a function of the experience and competence of the resident and the complexity of the specific case.)
- Documentation of resident supervision will be monitored during the course of peer review. Any case reviewed in which it appears that there is inadequate supervision will be forwarded to the Professional Practice Evaluation Committee.

Non-Core Privilege

❒ **Requested** **Participate in Teaching Program** ❒ **Approved** ❒ **Not Approved**

SUPERVISE ALLIED HEALTH PROFESSIONALS

SUPERVISION: The supervising employing/alternate supervising physician provides general supervision of the activities and services of the allied health professional. The supervising physician provides supervision and direction on any specific patient. The AHP is not allowed to perform any clinical activity/procedure that is not within the clinical privileges of the supervising physician. The supervising physician must be immediately available by electronic communication or on hospital premises for consultation/direction of the AHP.

CRITERIA: To be eligible to supervise allied health professionals, the applicant must:

- Be credentialed and privileged at RUHS in accordance with applicable requirements.
- Provide care and supervision only for those clinical activities for which they are privileged.
- Be responsible for and must be personally involved in the care provided to individual patients in the inpatient and outpatient settings and must continue to maintain this personal involvement when AHPs are involved in the care of these patients.
- Have a current Practice Agreement on file with Physician Assistants being supervised.

MAINTENANCE OF PRIVILEGE:

- Ensure the quality of care delivered to each patient by any allied health professional. This is exercised by observation, consultation, and direction to the AHP.
- Assure that medical care for each patient is delivered in an appropriate, timely, and effective manner.
- Participate in the AHP's competency assessment process according to accrediting and certifying body requirements.
- Direct the care of the patient and provide the appropriate level of supervision based on the nature of the patient's condition, the likelihood of major changes in the management plan, the complexity of care, and the experience and judgment of the AHP being supervised.
- Assume responsibility for supervision or monitoring of the practice as stated in the appropriate hospital or medical staff policy governing AHPs.
- Be continuously available or provide an alternate to provide consultation when requested and to intervene when necessary.
- Assume total responsibility for the care of any patient when requested by the AHP or in the interest of patient care.
- Co-sign all orders entered by the AHP on the medical record of all patients seen or treated by the AHP in accordance with applicable requirements.

❒ **Requested** **Supervision of Allied Health Professionals** ❒ **Approved** ❒ **Not Approved**

ADVANCED LAPAROSCOPIC SURGERY

CRITERIA: To be eligible for advanced **laparoscopic surgery** non-core privileges, the applicant must meet the following privileging criteria:

- Successful completion of an ACGME or AOA accredited laparoscopic surgery fellowship

OR

- Successful completion of an accredited residency in general surgery that included advanced laparoscopic training in the procedures to perform. AND additional training in advanced laparoscopic surgery to the satisfaction of the Chair of the Surgery Department.

  For new advanced laparoscopic procedures, a formal course in the advanced laparoscopic procedure and preceptorship by a surgeon experienced in the procedure.

  REQUIRED PREVIOUS EXPERIENCE: Demonstrate current competency and evidence of performance of at least 10 cases in the past 24 months.

  MAINTENANCE OF PRIVILEGE: Applicant must be able to show maintenance of competence with evidence of at least 5 cases in the past 12 months.

❒ **Requested**	Laparoscopic Adrenalectomy	❒ **Approved**	❒ **Not Approved**
❒ **Requested**	Laparoscopic Splenectomy	❒ **Approved**	❒ **Not Approved**
❒ **Requested**	Laparoscopic Low Anterior Resection	❒ **Approved**	❒ **Not Approved**
❒ **Requested**	Laparoscopic Paraesophageal Hernia Repair	❒ **Approved**	❒ **Not Approved**
❒ **Requested**	Laparoscopic Fundoplication (Nissen/Dor/Toupet)	❒ **Approved**	❒ **Not Approved**

ADVANCED COLO-RECTAL SURGERY

CRITERIA: To be eligible for advanced **colorectal surgery** non-core privileges, the applicant must meet the following privileging criteria:

- Successful completion of an accredited ACGME or AOA colorectal surgery fellowship

OR

- Successful completion of an accredited residency in general surgery that included advanced colorectal training in the procedures to perform. AND additional training in advanced colorectal surgery to the satisfaction of the Chair of the Surgery Department.

  REQUIRED PREVIOUS EXPERIENCE: Demonstrate current competency and evidence of performance of at least 6 cases in the past 24 months.

  MAINTENANCE OF PRIVILEGE: Applicant must be able to show maintenance of competence with evidence of at least 6 cases in the past 24 months.

❒ **Requested**	Abdominoperineal Resection (laparoscopic/open)	❒ **Approved**	❒ **Not Approved**
❒ **Requested**	Low Anterior Resection (laparoscopic/open)	❒ **Approved**	❒ **Not Approved**
❒ **Requested**	Laparoscopic/Open Rectopexy for rectal prolapsed	❒ **Approved**	❒ **Not Approved**

ADVANCED HERNIA SURGERY

CRITERIA: To be eligible for **advanced hernia surgery** non-core privileges, the applicant must meet the following privileging criteria:

- Successful completion of an accredited ACGME or AOA minimally invasive surgery fellowship

OR

- Successful completion of an accredited residency in general surgery

AND

- additional training in complex ventral hernia management to the satisfaction of the Chair of the Surgery Department.

REQUIRED PREVIOUS EXPERIENCE: Demonstrate current competency and evidence of performance of at least 10 cases in the past 24 months.

MAINTENANCE OF PRIVILEGE: Applicant must be able to show maintenance of competence with evidence of at least 10 cases in the past 24 months.

❒ **Requested**	Recurrent Hiatal Hernia	❒ **Approved**	❒ **Not Approved**
❒ **Requested**	Ventral Hernia repair with posterior component separation/TAR	❒ **Approved**	❒ **Not Approved**

BARIATRIC SURGERY

CRITERIA: To be eligible for **bariatric surgery** non-core privileges, the applicant must meet the following privileging criteria:

- Successful completion of an accredited ACGME or AOA bariatric surgery fellowship

OR

- Successful completion of an accredited residency in general surgery that included bariatric surgery training in the procedures to perform.

AND

- Additional training in minimally invasive surgery to the satisfaction of the Chair of the Surgery Department.

REQUIRED PREVIOUS EXPERIENCE: Demonstrate current competency and evidence of performance of at least 10 cases in the past 24 months.

MAINTENANCE OF PRIVILEGE: Applicant must be able to show maintenance of competence with evidence of at least 10 cases in the past 24 months.

❒ **Requested**	Sleeve Gastrectomy	❒ **Approved**	❒ **Not Approved**
❒ **Requested**	Gastric Bypass	❒ **Approved**	❒ **Not Approved**
❒ **Requested**	Other Bariatric Procedures	❒ **Approved**	❒ **Not Approved**

MODERATE SEDATION

PROCEDURES UNDER FLUOROSCOPY

Criteria: To be eligible for Fluoroscopy non-core privilege, the applicant must successfully complete an ACGME- or AOA-accredited residency training program in general surgery and possess a valid State of California fluoroscopy certificate.

Initial Privilege requirement: Current valid State of California fluoroscopy certificate.

Maintenance of Privilege: Must maintain current valid State of California fluoroscopy certificate.

❒ **Requested**	**Fluoroscopy Use and Supervision**	❒ **Approved**	❒ **Not Approved**

SURGICAL ASSIST ONLY

CRITERIA: To be eligible to apply for surgical assist privileges, the applicant must:

- Applicant must be a Physician licensed in the State of California and in good standing
- Applicant must meet the requirements of Medical Staff
- Applicant must provide evidence of 5 surgical cases within the past 12 months.

MAINTENANCE OF PRIVILEGE:

- Demonstrated current competence and evidence of 5 cases in the past 24 months based on ongoing professional practice evaluation and outcomes

Surgical Assist Only

❒ **Requested**	**Surgical Assist Only**	❒ **Approved**	❒ **Not Approved**

SURGICAL ROBOTIC PLATFORM

CRITERIA: To be eligible for Surgical Robotic Platform privileges, the initial applicant must meet the following privilege criteria:

- Completed an ACGME approved residency program in General Surgery.
- Certification by the American Board of Surgery OR must be eligible to sit for that board OR demonstrated equivalent competency in General Surgery.
- Current active privileges to perform the underlying surgical procedure to be performed on the Robotic Surgical Platform or be eligible for privileges.
- Privileges obtained during tenure must be approved by Department Chari or designee

ROBOTIC PLATFORM TRAINING
In order to apply for robotic privileges, the physician must have completed at least one of the following three training experiences:

1. Teaching Proctor Experience:

   a. Evidence of training by attendance at a hands-on training practicum in the use of the Robotic Surgical Platform of at least eight (8) hours duration with experience in a laboratory setting, which includes a minimum of three (3) hours of personal time on the system during animate or cadaver models on console performing routine maneuvers such as knot tying.

   b. Successful completion of a minimum of five (5) cases is required under the supervision of and with the help of a teaching proctor. A proctor of the same specialty is required for the first two (2) cases but is not required for the remaining three cases.

   c. This teaching proctor may be a physician who is privileged to proctor robotic cases OR an outside physician with temporary privileges to proctor. This teaching proctor will be compensated for his/her services.

2. Fellowship or Residency Training Experience:

Previous practical experience via an accredited fellowship or residency program with documented clinical experience in a minimum of thirty (30) robotic-assisted procedures in that program. If less than thirty (30) robotic-assisted procedures done, follow the process in 1 b. above

OR

3. Robotic Privileges at another Hospital:

Previous full robotic surgery privileges at another hospital as documented by providing operative reports and discharge summaries for the last ten (10) consecutive robotic cases performed as the operating surgeon (cases performed as assistant surgeon do not count) for review.

MEDICAL STAFF PROCTORING REQUIREMENTS

Once provisional robotic privileges are granted, the applicant will need to be proctored on at least two (2) additional cases performed without the assistance of the proctor. The proctor will be present during the entire case and will observe the procedure.

This proctoring must be performed by a member of the Medical Staff who has full robotic privileges. In the event there is no such member appointed to the General Surgery specialty, an outside provider from an established vendor or affiliated institution may serve as the proctor at the discretion of the Medical Staff, with approval of the Department Chair. This provider will have met all proctoring standards including the required credentials and clinical knowledge and practice to provide performance oversight. Up to five (5) cases may be required in some circumstances, but after two to five (2–5) cases, full robotic privileges will be either approved, referred for additional training, or denied based on the proctoring reports and the determination of the appropriate service chief.

This proctor is provided without charge to the applicant in the usual manner for medical staff proctoring requirements. Refer to Department Rules and Regulations for the Requirements for a Teaching proctor at RUHS.

MAINTAINING ROBOTIC PRIVILEGES

The surgeon must have performed 20 cases, including eight (8) within the last two (2) years, or they will either not be eligible to reapply for the privilege or they will be referred for additional proctoring.

The surgeon should participate actively in the ongoing performance improvement programs of the medical staff, hospital, and department.

Surgical Robotic Platform Non-Core Privileges Continued

REQUIREMENTS FOR A TEACHING PROCTOR AT RIVERSIDE UNIVERSTIY HEALTH SYSTEMS

At least one of the following three levels of experience:

1. Full robotic privileges at another hospital as documented by providing operative reports and discharge summaries for the last twenty (20) consecutive robotic cases performed as the operative surgeon (cases performed as assistant surgeon do not count) for review. Service Chief to review cases.
2. Current Intuitive Surgical approved proctor.
3. Full robotic privileges granted by Medical Staff.

Description of Non-Core Privilege

❒ **Requested** **Surgical Robotic Platform** ❒ **Approved** ❒ **Not Approved**

THYROID/PARATHYROID CORE

CRITERIA: To be eligible to apply for core privileges in Thyroid/Parathyroid Core, the initial applicant must meet the membership requirements of Riverside University Health System and the following privileging criteria:

- Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited post-graduate training program in general surgery.

AND

- Current board certification or active candidate in the examination process in surgery by the American Board of Surgery and/or Royal College of Surgeons or the American Osteopathic Board of Surgery and/or American College of Osteopathic Surgeons or the Royal College of Physicians and Surgeons of Canada.

REQUIRED PREVIOUS EXPERIENCE: An applicant for initial appointment must be able to demonstrate:

- Performance of at least 5 thyroid/parathyroid procedures during the past 12 months.

REAPPOINTMENT REQUIREMENTS: To be eligible to renew core privileges in general surgery, the applicant must meet the following maintenance of privilege criteria:

- Current demonstrated competence and an adequate volume of experience in thyroid/parathyroid procedures with acceptable results in the privileges requested for the past 24 months based on results of ongoing professional practice evaluation and outcomes.

❒ **Requested** **Thyroid/Parathyroid Core** ❒ **Approved** ❒ **Not Approved**

CORE PROCEDURES LIST: This list is a sampling of procedures included in the core. This is not intended to be an all-encompassing list but rather reflective of the categories/types of procedures included in the core.

Please cross out any Core privileges you are not requesting at RUHS facilities.

❒ **Requested** **Thyroid/Parathyroid Core Procedures** ❒ **Approved** ❒ **Not Approved**

CORE PRIVILEGES

- Parathyroidectomy
- Thyroidectomy
- Thyroglossal duct excision
- Neck Dissection
- Fine needle aspiration thyroid

ACKNOWLEDGMENT OF PRACTITIONER

I have requested only those privileges which by education, training, current experience, and demonstrated performance that I am qualified to perform and wish to exercise at Riverside University Health System.

I understand that:

a. In exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.

b. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

_____ _____
Practitioner Signature **Date**

DEPARTMENT CHAIR / DESIGNEE RECOMMENDATION

I have reviewed the requested clinical privileges and supporting documentation and make the following recommendation:

❒ Recommend all requested privileges.
❒ Recommend privileges with conditions/modifications as noted below.
❒ Do not recommend the requested privileges as noted below.

Privilege	Condition / Modification / Explanation

_____ _____
Medical Director of Trauma Services/Designee **Date**
(If applicable)

_____ _____
Department Chair/Designee Signature **Date**

MEC Approval: 6/12/08
Revised: 4/9/09; 6/10/10; 3/10/11, 1/31/12, 3/26/13, 6/12/14, 8/14/14, 9/11/14, 2/10/15, 8/11/16, 11/10/16, 8/10/17, 2/8/18, 7/12/18, 2/14/19, 8/8/19, 10/10/19, 10/2021, 2/9/2023, 7/13/2023; 11/9/23 ; 3/13/25

Mechanism that may be used to confirm competency of new applicants and/or privileges or to address potential competency issues referred from Ongoing Professional Practice Evaluation (OPPE).

Department Chair/Designee:

Please indicate below the privileges/procedures and the number of FPPE cases to be done on the above-named practitioner, including the method of FPPE.

Privileges/Procedures to be Proctored	Number of Cases to be Proctored*	Method of FPPE A. Concurrent B. Retrospective C. Reciprocal
General Surgery, Core	5 varied cases	A,B,C, as applicable
Trauma, Core	5 varied cases	A,B,C, as applicable
Vascular Surgery, Core	5 varied cases	A,B,C, as applicable
Endovascular Surgery Core	10 total cases with at least 5 Interventional	A,B,C, as applicable
Thoracic Surgery, Core	1 case	A,B,C, as applicable
Advanced Laparoscopic Surgery, Non-Core	5 total cases with at least 1 case in each category	A,B,C, as applicable
Advanced Colo-Rectal Surgery	2 cases	A,B,C, as applicable
Procedures under Fluoroscopy	1 case	A,B,C, as applicable
Surgical Robotic Platform	2 cases	A
Thyroid/Parathyroid Core	3 cases	A,B,C, as applicable
Moderate Sedation	1 case	A,B,C, as applicable

***Indicate N/A** if privilege not requested

Riverside University HEALTH SYSTEM Medical Center

MEDICAL STAFF BYLAWS

AND

Rules and Regulations

2025 - 2026

RIVERSIDE UNIVERSITY HEALTH SYSTEM - MEDICAL CENTER
MEDICAL STAFF BYLAWS, RULES AND REGULATIONS
2025-2026

TABLE OF CONTENTS

Contents

RULES AND REGULATIONS 1

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER 1

CONSTRUCTION OF TERMS AND HEADINGS 1

DEFINITIONS 2

ARTICLE I - NAME 4

ARTICLE II - PURPOSES 4

ARTICLE III - MEMBERSHIP 4

3.1 NATURE OF MEMBERSHIP 4

3.2 QUALIFICATIONS FOR MEMBERSHIP 5

3.2-1 GENERAL QUALIFICATIONS 5

3.2-2 PARTICULAR QUALIFICATIONS 5

3.2-3 PROFESSIONAL LIABILITY INSURANCE 6

3.3 EFFECT OF OTHER AFFILIATIONS 6

3.4 NONDISCRIMINATION 6

3.5 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP 7

3.6 HARASSMENT PROHIBITED 8

3.7 STANDARDS OF CONDUCT 9

3.7-1 GENERAL 9

3.7-2 CONDUCT GUIDELINES 10

3.8 ORGANIZED HEALTH CARE ARRANGEMENT 10

ARTICLE IV - CATEGORIES OF MEMBERSHIP 11

4.1 CATEGORIES 11

4.2 ACTIVE STAFF 11

4.2 1 QUALIFICATIONS 11

4.2-2 PREROGATIVES 11

4.2-3 RESPONSIBILITIES 11

4.3 PROVISIONAL STAFF 12

4.3-1 QUALIFICATIONS 12

4.3-2 PREROGATIVES 12

4.3-3 RESPONSIBILITIES 12

4.3-4 OBSERVATION OF PROVISIONAL STAFF MEMBER 13

4.3-5 ACTION AT CONCLUSION OF PROVISIONAL STAFF STATUS 13

4.4 COURTESY STAFF 13

4.4-1 QUALIFICATIONS 13

4.4-2 PREROGATIVES 14

4.4-3 RESPONSIBILITIES 14

4.5 HONORARY STAFF 14

4.5-1 QUALIFICATIONS 14

4.5-2 PREROGATIVES 14

4.5-3 RESPONSIBILITIES 14

4.6 ADJUNCT STAFF 15

4.6-1 QUALIFICATIONS 15

4.6-2 PREROGATIVES 15
4.6-3 RESPONSIBILITIES 15
4.7 PER DIEM RESIDENT/MOONLIGHTING STAFF 15
4.7-1 QUALIFICATIONS 15
4.7-2 PREROGATIVES 15
4.8 ADMINISTRATIVE STAFF 16
4.9 TELEHEALTH STAFF 17
4.9-1 QUALIFICATIONS OF TELEHEALTH PROVIDERS: 17
4.9-2 PREROGATIVES 17
4.9-3 RESPONSIBILITIES 17
ARTICLE V - ALLIED HEALTH PROFESSIONALS 18
5.1 QUALIFICATIONS 18
5.2 DELINEATION OF CATEGORIES OF AHPs ELIGIBLE TO APPLY FOR PRACTICE PRIVILEGES 19
5.3 PROCEDURE FOR GRANTING PRACTICE PRIVILEGES 19
5.4 PREROGATIVES 19
5.5 RESPONSIBILITIES 20
5.6 REAPPLICATION 20
ARTICLE VI - PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT 21
6.1 GENERAL PROCEDURE 21
6.2 APPLICATION FOR APPOINTMENT 21
6.2-1 CONTENT 21
6.2-2 EFFECTS OF APPLICATION 23
6.2-3 PHYSICAL AND MENTAL CAPABILITIES 23

6.3 PROCESSING THE APPLICATION 25

6.3-1 APPLICANT'S BURDEN 25

6.3-2 VERIFICATION OF INFORMATION 25

6.3-3 DEPARTMENT AND CREDENTIALS COMMITTEE ACTION 25

6.3-4 MEDICAL EXECUTIVE COMMITTEE (MEC) ACTION 26

6.3-5 APPOINTMENT REPORTS 26

6.3-6 BASIS FOR APPOINTMENT 26

6.3-7 EFFECT OF MEDICAL EXECUTIVE COMMITTEE ACTION 26

6.3-8 ACTION BY THE GOVERNING BOARD 27

6.3-9 NOTICE OF FINAL DECISION 28

6.3.10 DURATION OF APPOINTMENT 28

6.3-11 REAPPLICATION AFTER ADVERSE DECISION DENYING APPLICATION, ADVERSE CORRECTIVE ACTION DECISION, OR RESIGNATION IN LIEU OF MEDICAL DISCIPLINARY ACTION 28

6.3-12 TIME PERIOD FOR PROCESSING 28

6.3-13 EXPEDITED REVIEW 29

6.4 REAPPOINTMENTS 29

6.4-1 APPLICATION FOR REAPPOINTMENT; SCHEDULE FOR REVIEW 29

6.4-2 VERIFICATION OF INFORMATION 30

6.4-3 DEPARTMENT ACTION 30

6.4-4 CREDENTIALS COMMITTEE ACTION 30

6.4-5 MEDICAL EXECUTIVE COMMITTEE ACTION 30

6.4-6 REAPPOINTMENT REPORTS 31

6.4-7 BASIS FOR REAPPOINTMENT 31

6.4-8 FAILURE TO FILE REAPPOINTMENT FORM 32
6.4-9 CHANGES BETWEEN ROUTINE REAPPOINTMENT DATES 32
6.5 PROCTORING REQUIREMENTS 32
6.5-1 FOR INITIAL APPOINTMENT 32
6.5- 2 FOR MODIFICATION OF MEMBERSHIP STATUS OR PRIVILEGES 33
6.5- 3 TERM OF PROCTORING PERIOD 33
6.5-4 RECIPROCAL PROCTORING 33
6.6 LEAVE OF ABSENCE 35
6.6-1 LEAVE STATUS 35
6.6-2 REASONS FOR GRANTING LEAVE 35
6.6-3 TERMINATION OF LEAVE 35
ARTICLE VII - CLINICAL PRIVILEGES 36
7.1 EXERCISE OF PRIVILEGES 36
7.2 DELINEATION OF PRIVILEGES IN GENERAL 36
7.2-1 REQUESTS 36
7.2-2 BASIS FOR PRIVILEGES DETERMINATION 36
7.2-3 PROCEDURE 36
7.3 SPECIAL CONDITIONS APPLICABLE TO DENTAL AND PODIATRIC PRIVILEGES 36
7.4 TEMPORARY PRIVILEGES 37
7.4-1 PENDING APPLICATION 37
7.4-2 SPECIFIC PATIENT CARE 37
7.4-3 CONDITIONS 37
7.5 EMERGENCY AND DISASTER PRIVILEGES 38

ARTICLE VIII - CORRECTIVE ACTION 38

8.1 ROUTINE CORRECTIVE ACTION 38

8.1-1 FOCUSED PROFESSIONAL PRACTICE REVIEW 38

8.1-2 CRITERIA FOR INITIATION 39

8.1-3 EXTERNAL PEER REVIEW 39

8.1-4 INVESTIGATION 39

8.1-5 MEDICAL EXECUTIVE COMMITTEE ACTION 40

8.1-6 DEFERRAL 40

8.1-7 PROCEDURAL RIGHTS 41

8.1-8 OTHER ACTION 41

8.2 SUMMARY RESTRICTION OR SUSPENSION 42

8.2-1 CRITERIA FOR INITIATION 42

8.2-2 WRITTEN NOTICE OF SUMMARY SUSPENSION 42

8.2-3 MEDICAL EXECUTIVE COMMITTEE ACTION 43

8.2-4 PROCEDURAL RIGHTS 43

8.2-5 INITIATION BY THE GOVERNING BOARD 44

8.3 AUTOMATIC AND IMMEDIATE SUSPENSION OR LIMITATION 44

8.3-1 LICENSURE 44

8.3-3 CONTROLLED SUBSTANCES 45

8.3-4 FAILURE TO SATISFY SPECIAL APPEARANCE REQUIREMENT 45

8.3-5 MEDICAL RECORDS 45

8.3-6 FAILURE TO PAY DUES/ASSESSMENTS 46

8.3-7 EXECUTIVE COMMITTEE DELIBERATION 47

8.3-8 PROFESSIONAL LIABILITY INSURANCE 47

ARTICLE IX – FAIR HEARINGS 48

9.1 GENERAL PROVISIONS 48

9.1-1 EXHAUSTION OF REMEDIES 48

9.1-2 APPLICATION OF ARTICLE 48

9.1-3 TIMELY COMPLETION OF PROCESS 48

9.1-4 FINAL ACTION 48

9.2 GROUNDS FOR HEARING 48

9.3 REQUESTS FOR FAIR HEARING 49

9.3-1 NOTICE OF ACTION OR PROPOSED ACTION 49

9.3-2 REQUEST FOR FAIR HEARING 49

9.3-3 TIME AND PLACE FOR FAIR HEARING 49

9.3-4 NOTICE OF HEARING CONTENTS 50

9.3-5 FAIR HEARING ARBITRATOR 50

9.3-6 FAILURE TO APPEAR OR PROCEED 50

9.3-7 POSTPONEMENTS AND EXTENSIONS 50

9.4 HEARING PROCEDURE 51

9.4-1 PREHEARING PROCEDURE 51

9.4-2 REPRESENTATION 52

9.4-3 RECORD OF THE HEARING 52

9.4-4 RIGHTS OF THE PARTIES 52

9.4-5 MISCELLANEOUS RULES 53

9.4-6 BURDENS OF PRESENTING EVIDENCE AND PROOF 53

9.4-7 ADJOURNMENT AND CONCLUSION..... 53

9.4-8 BASIS FOR DECISION..... 54

9.4-9 DECISION OF THE MEDICAL EXECUTIVE COMMITTEE 54

9.5 EXCEPTIONS TO HEARING RIGHTS..... 54

9.5-2 FAIR HEARING AND APPEALS FOR ALLIED HEALTH PRACTITIONERS (AHPs) 54

9.5-3 AHP AUTOMATIC SUSPENSION, LIMITATION OF PRACTICE PRIVILEGES, OR TERMINATION... 55

9.5 4 AUTOMATIC SUSPENSION OR LIMITATION OF PRACTICE PRIVILEGES..... 55

ARTICLE X - CLINICAL DEPARTMENTS AND DIVISIONS 56

10.1 ORGANIZATION OF DEPARTMENTS AND DIVISIONS 56

10.2 DESIGNATION..... 56

10.3 DEPARTMENT/DIVISION FORMATION OR ELIMINATION..... 56

10.4 ASSIGNMENT TO DEPARTMENTS AND DIVISIONS..... 57

10.4 FUNCTIONS OF DEPARTMENTS 57

10.5 FUNCTIONS OF DIVISIONS/SUBDIVISIONS 58

10.6 MODIFICATIONS IN CLINICAL ORGANIZATION UNIT 58

ARTICLE XI - OFFICERS..... 59

11.1 GENERAL OFFICERS OF THE MEDICAL STAFF..... 59

11.1-1 IDENTIFICATION 59

11.1-2 QUALIFICATIONS 59

11.1-3 NOMINATIONS..... 59

11.1-4 ELECTION 59

11.1-5 CHIEF OF MEDICAL STAFF AND IMMEDIATE PAST CHIEF OF..... 60

MEDICAL STAFF PROVISIONS 60

11.1-6 TERM OF ELECTED OFFICERS 60

11.1-7 REMOVAL OF ELECTED OFFICERS 60

11.1-8 VACANCIES IN ELECTED OFFICE 60

11.2 DUTIES OF GENERAL OFFICERS 61

11.2-1 MEDICAL DIRECTOR 61

11.2-2 CHIEF OF MEDICAL STAFF 61

11.2-3 CHIEF OF MEDICAL STAFF ELECT 62

11.22 IMMEDIATE PAST CHIEF OF MEDICAL STAFF 62

11.23 SECRETARY TREASURER 63

11.3 DEPARTMENT CHAIR 63

11.3-1 QUALIFICATIONS 63

11.3-2 SELECTION 63

11.3-3 TERM OF OFFICE 64

11.3-4 DUTIES 64

11.4 DEPARTMENT VICE CHAIR 65

11.4-1 QUALIFICATIONS 65

11.4-2 SELECTION 65

11.4-3 TERM OF OFFICE 65

11.4-4 REMOVAL 65

11.4-5 DUTIES 66

11.5 DIVISION/SUBDIVISION CHAIR 66

11.5-1 QUALIFICATIONS 66

11.5-2 SELECTION 67
11.5-3 TERM OF OFFICE 67
11.5-4 DUTIES 67
12.1 GENERAL 67
12.1-1 AD HOC COMMITTEES 68
12.1-2 TERMS AND REMOVAL OF COMMITTEE CHAIRS 68
12.1-3 TERMS AND REMOVAL OF COMMITTEE MEMBERS 68
12.1-4 VACANCIES 68
12.1-5 CONDUCT AND RECORDS OF MEETINGS 68
12.2 MEDICAL EXECUTIVE COMMITTEE (MEC) 69
12.2-1 COMPOSITION 69
12.2-2 OFFICERS 69
12.2-3 DUTIES 69
12.2-4 MEETINGS 70
ARTICLE XIII – MEETINGS 71
13.1 MEETINGS 71
13.1-2 AGENDA 71
13.1-3 SPECIAL MEETINGS 71
13.2 COMMITTEE AND DEPARTMENT MEETINGS 72
13.21 REGULAR MEETINGS 72
13.22 SPECIAL MEETINGS 72
13.3 NOTICE OF MEETINGS 72
13.4 QUORUM 72

13.4-1 DEPARTMENT AND COMMITTEE MEETINGS 72
13.4-2 ANNUAL STAFF MEETING 72
13.5 MANNER OF ACTION 73
13.6 MINUTES 73
13.7 ATTENDANCE REQUIREMENT 73
13.7-1 REGULAR ATTENDANCE 73
13.7-2 ABSENCE FROM MEETINGS 73
13.7-3 SPECIAL APPEARANCE 74
13.8 CONDUCT OF MEETINGS 74
ARTICLE XIV - CONFIDENTIALITY, IMMUNITY, AND RELEASES 74
14.1 AUTHORIZATION AND CONDITIONS 74
14.2 CONFIDENTIALITY OF INFORMATION 75
14.2-1 GENERAL 75
14.2-2 BREACH OF CONFIDENTIALITY 75
14.2-3 CONFIDENTIALITY AGREEMENT 75
14.3 IMMUNITY FROM LIABILITY 76
14.3-1 FOR ACTION TAKEN 76
14.3-2 FOR PROVIDING INFORMATION 76
14.4 ACTIVITIES AND INFORMATION COVERED 76
14.5 RELEASES 77
ARTICLE XV - GENERAL PROVISIONS 77
15.1-1 MEDICAL STAFF RULES AND REGULATIONS 77
15. 1-2 DEPARTMENTAL RULES AND REGULATIONS 77

15.2 MEDICAL STAFF COMMITTEES AND FUNCTIONS DOCUMENT 77

15.3 FEES/DUES 78

15.4 AUTHORITY TO ACT 78

15.5 ACCEPTANCE OF PRINCIPLES 78

15.6 DIVISION OF FEES 78

15.7 MEDICAL STAFF REPRESENTATION BY LEGAL COUNSEL 78

15.8 NOTICES 78

15.8 Official MS email address 79

15.9 SECRET WRITTEN BALLOT 79

ARTICLE XVI - ADOPTION AND AMENDMENT OF BYLAWS 79

16.1 ADOPTION AND AMENDMENT 79

16.2 TECHNICAL AND EDITORIAL AMENDMENTS 80

RULES AND REGULATIONS 81

RULES AND REGULATIONS

Number

1. Assignment of Patients 81
2. Attending Staff Notes 81
3. Attending Staff Private Patient Charges 81
4. Autopsies 82
5. Clinic Patients 82
6. Consent Form 82
7. Consultation Criteria 82
8. Drugs 82
9. Graduate Education Programs 82
10. Medical History and Physical for Inpatient and Outpatient Services 83
11. Media Release 83
12. Medical Record 83
13. Medical Records Property of the Hospital 83
14. Medical Screening Examination 83
15. Medical Staff Requirement 83
16. Notification of Attending Staff 84
17. Operative Record 84
18. Orders, STANDING 84
19. Orders, VERBAL 84
20. Orders, WRITTEN 84
21. Patients' Bill of Rights 85
22. Pregnancy Test 85
23. Preoperative Procedures 85
24. Preoperative Record 85
25. Private Patients 85
26. Provisional Diagnosis 85
27. Publications 85
28. Records Authentication 86
29. Research Projects 86
30. Responsibility for Private Patients 86
31. Restraint and/or Seclusion 86
32. Retrospective Record Reviews 86
33. Sterilization 86
34. Suicide 86
35. Surgery Schedule 86
36. Surgical Assistants 87
37. Symbols and Abbreviations 87
38. Tissue 87
39. Physician Reference Manual 87

RIVERSIDE UNIVERSITY
HEALTH SYSTEM – MEDICAL CENTER

MEDICAL STAFF BYLAWS

PREAMBLE

WHEREAS, Riverside University Health System is a public general acute hospital organized under the laws of the State of California; and

WHEREAS, its purpose is to serve as a general acute hospital providing patient care, education, and research; and

WHEREAS, it is recognized that the governing board has the ultimate authority and responsibility for all aspects of the hospital operation, including the professional component and, therefore, the medical staff is accountable to the governing board for the proper discharge of its responsibilities, and all medical staff activities and actions are subject to review and approval by the governing board; and

WHEREAS, it is recognized that the medical staff is delegated responsibility by the governing board for the quality of medical care at the hospital and must accept and discharge this responsibility subject to the governing board's ultimate authority; and

WHEREAS, it is recognized that the cooperative efforts of the medical staff, the hospital administration, and the governing board are necessary to fulfill the foregoing responsibilities of the medical staff and the hospital's obligations to its patients; and

WHEREAS, only duly qualified physicians, dentists, podiatrists, and clinical psychologists are eligible for medical staff membership, privileges and prerogatives; and

WHEREAS, some duly qualified allied health professionals may be eligible to participate as independent practitioners in the provision of certain patient care services in the hospital setting;

THEREFORE, the physicians, dentists, podiatrists, and clinical psychologists practicing at this hospital hereby organize themselves into a medical staff in conformity with these bylaws.

CONSTRUCTION OF TERMS AND HEADINGS

Words used in these bylaws shall be read as the masculine or feminine gender and as the singular or plural as the context and circumstances require. The captions and headings in these bylaws are for convenience only and are not intended to limit or define the scope or effect of any provision of these bylaws

DEFINITIONS

1. ALLIED HEALTH PROFESSIONAL or AHP means a Physician Assistant, Nurse Practitioner, Nurse Certified Midwife, Certified Registered Nurse Anesthetist, or Audiologist who exercises judgment within the areas of professional competence and the limits established by the governing board, the medical staff and the applicable State Practice Acts; who is qualified to render direct or indirect medical, dental, podiatric or clinical psychological care under the supervision or direction of a medical staff member possessing privileges to provide such care in the hospital; and who may be

2. CHIEF OF MEDICAL STAFF or CHIEF OF STAFF means the chief administrative officer of the medical staff.

3. CLINICAL PRIVILEGES means the permission granted to a medical staff and allied health professionals to render specific diagnostic, therapeutic, medical, dental, podiatric, clinical psychological, or surgical services.

4. COMPLETE APPLICATION means the applicant has filled out the application form in full, answered all questions, signed and dated all forms that require signature and has paid the required fees; items on the application have been verified as specified in the Credentials Policies and Procedures Manual (not verified by documents provided by the applicant); the applicant has provided answers to all questions which have arisen during the application verification process; and the relevant department chair, the Credentials Committee and the Medical Executive Committee have all the information they need to make a decision.

5. EX-OFFICIO MEMBER means an officer or other individual as designated by these bylaws, who maybe a committee member by virtue of elected or appointed position. An ex-officio member may attend meetings with power to vote unless otherwise stated in these bylaws or in the Medical Staff Committee and Functions Manual.

6. GOVERNING BOARD or BOARD means the Riverside County Board of Supervisors.

7. HOSPITAL or RUHS MC means Riverside University Health System University Health System Medical Center.

8. HOSPITAL DIRECTOR or ADMINISTRATOR means the person appointed by the governing board to act on its behalf in the overall management of the hospital, or the Hospital Director's authorized representative.

9. IN GOOD STANDING means a practitioner is currently not under suspension or serving with any limitations of voting or other prerogatives imposed by operation of the bylaws, rules and regulations or policies of the medical staff.

10. INVESTIGATION means a process specifically instigated by the Medical Executive Committee to determine the validity, if any, to a concern or complaint raised against a member of the medical staff and does not include activities of the Physician Well-Being Committee.

11. MEDICAL DIRECTOR or CHIEF MEDICAL OFFICER means the medical administrative officer of the hospital.

12. MEDICAL EXECUTIVE COMMITTEE or MEC means the Medical Executive Committee of the medical staff.

13. MEDICAL STAFF or STAFF means the formal organization of all licensed physicians, dentists, podiatrists, and clinical psychologists who are privileged to attend patients at the hospital.

14. MEDICAL STAFF YEAR means the period from July l to June 30.

15. MEDICO ADMINISTRATIVE OFFICER means a practitioner, employed by or otherwise serving
the hospital on a full or part time basis, whose duties include certain responsibilities which are both administrative and clinical in nature. Clinical responsibilities, as used herein, are those responsibilities which require a practitioner to exercise clinical judgment with respect to patient care and it includes the supervision of professional activities of practitioners under the medico-administrative officer's direction.

16. PHYSICIAN means an individual with a M.D. or D.O. degree or the equivalent degree (i.e., foreign) as recognized by the Medical Board of California (MBC) or the Board of Osteopathic Examiners (BOE), who is licensed by either the MBC or the BOE.

17. PRACTITIONER means physician, dentist, podiatrist, or clinical psychologist or allied health professional who exercises clinical privileges at the hospital.

18. PREROGATIVE means a participatory right granted, by virtue of staff category or otherwise, to a medical staff member, which is exercisable subject to, and in accordance with, the conditions imposed by these bylaws and by other hospital and medical staff rules, regulations, or policies.

ARTICLE I - NAME

The name of this organization is the medical staff of Riverside University Health System Medical Center.

ARTICLE II - PURPOSES

The purposes of this organization are:

1. The purpose of this medical staff is to organize the activities of physicians and other clinical practitioners who practice at Riverside University Health System University Health System Medical Center in order to carry out, in conformity with these bylaws, the functions delegated to the medical staff by the hospital's Governing Board.

2. To initiate and maintain rules and regulations for the medical staff to carry out its responsibilities to be self-governing with respect to the professional work performed in the hospital.

3. To provide means whereby issues concerning the medical staff and the hospital may be discussed by the medical staff with the governing board and the Hospital Director.

4. To be responsible, in cooperation with affiliated institutions, to carry out the education and training of the house staff as prescribed by the Council on Medical Education and Hospitals of the American Medical Association.

5. To carry out the education and training of other allied hospital personnel.

ARTICLE III - MEMBERSHIP

3.1 NATURE OF MEMBERSHIP

Medical Staff Membership shall be extended only to professionally competent physicians, dentists, podiatrists or clinical psychologists who continuously meet the qualifications, standards and requirements set forth in these bylaws. Appointment to and membership in the medical staff shall confer on the member only such privileges and prerogatives as have been granted by the governing board in accordance with these bylaws. No practitioner shall admit or provide services to patients at the hospital unless medical staff privileges have been granted in accordance with the procedures set forth in these bylaws, any limitations by the Medical Board of California and the Credentials Policies and Procedures Manual.

3.2 QUALIFICATIONS FOR MEMBERSHIP

3.2-1 GENERAL QUALIFICATIONS

Practitioners shall be qualified for medical staff membership only if they:

a) Document their current licensure, experience, background, training, demonstrated ability, current professional competence and good judgment to demonstrate that any patient treated by them will receive care of the generally recognized professional level of quality and efficiency established by the hospital, and that they are qualified to exercise clinical privileges at the hospital.

b) Provider applicants that are board eligible based on the American Board of Medical Specialties (ABMS) eligibility period, must achieve board certification status before the ABMS eligibility period lapses. If the applicant's specialty board eligible period has expired based on the number of years following completion of residency, then they must achieve board certification prior to applying for medical staff privileges.

(c) Notwithstanding Section (b) above, these bylaws are not intended to preclude qualified applicants from pursuing board certification through Medical Board sanctioned alternative pathways for International Medical Graduates (IMG) trainees or who are academically eminent in their specialty and provided a Special Faculty Permit by the California Medical Board are determined, on the basis of documented references, to adhere strictly to the lawful ethics of their respective professions, including the principles of the California Medical Association and the Principles of Ethics of the American Medical Association or the American Dental Association, to work cooperatively with others in the hospital setting so as not to adversely affect patient care or hospital operations, to be willing to participate in and properly discharge medical staff responsibilities, and to be willing to commit to and regularly assist the hospital in fulfilling its obligations related to patient care, within the areas of their professional competence and credentials;

(d) Are located closely enough to the hospital to provide continuous care to their patients or provide alternate coverage; and document physical and mental status (subject to any necessary reasonable accommodation) to demonstrate to the satisfaction of the medical staff that s/he is professionally and ethically competent so that patients can reasonably expect to receive the generally recognized professional level of quality of care for this community.

3.2-2 PARTICULAR QUALIFICATIONS

(a) Physicians. An applicant for physician membership in the medical staff, except for honorary staff, must hold a M.D. or D.O. degree or their equivalent and a valid, unrevoked and unsuspended certificate to practice medicine issued by the Medical Board of California or the Osteopathic Medical Board of California. For the purpose of this section, "or the equivalent" shall mean any degree (i.e., foreign) recognized by the Medical Board of California or the Osteopathic Medical Board of California.

(b) Special Permits. An applicant for physician membership in the medical Staff, who has been granted a certificate of registration by the Medical Board of California under Section 2113 or 2168 of Business and Professions Code may be eligible to apply for Medical Staff membership.

(c) Practitioners in the Administrative and Honorary Status categories are not required to maintain professional licensure.

Applicants who are progressing toward board certification must have completed the educational requirements for board certification and must become board certified within the candidate's eligibility determined by the ABMS Member Board, unless extended for good cause by the Medical Staff Executive Committee.

(d) Dentists. An applicant for dental membership in the medical staff, except for honorary staff, must hold a D.D.S. or equivalent degree issued by a dental school and a valid, unrevoked and unsuspended certificate to practice dentistry issued by the Dental Board of California.

(e) Podiatrists. An applicant for podiatric membership in the medical staff, except for honorary staff, must hold a D.P.M. degree and a valid, unrevoked, and unsuspended certificate to practice podiatry issued by the Medical Board of California.

(f) Clinical Psychologists. An applicant for clinical psychologist membership, except for the honorary staff, must hold a clinical psychologist degree, have not less than two (2) years clinical experience in a multi-disciplinary facility licensed or operated by this or another state or by the United States to provide healthcare or be listed in the latest edition of the National Register of Health Service Psychologists, and hold a valid, unrevoked, and unsuspended license to practice clinical psychology issued by the California Board of Psychology.

3.2-3 PROFESSIONAL LIABILITY INSURANCE

A member granted clinical or practice privileges in the hospital shall maintain in force professional liability insurance in a form and amount satisfactory to the County of Riverside's Risk Management department.

3.3 EFFECT OF OTHER AFFILIATIONS

No practitioner shall be automatically entitled to medical staff membership, or to exercise any particular clinical privilege, merely because the practitioner holds a certain degree, is licensed to practice in California or any other state, is a member of any professional organization, is certified by any clinical board, or had or presently has, staff membership or privileges at this hospital or at another health care facility. Medical staff membership or clinical privileges shall not be conditioned or determined on the basis of an individual's participation or non- participation in a particular medical group, IPA, PPO, PHO, hospital-sponsored foundation, or other organization or in contracts with a third party which contracts with this hospital.

3.4 NONDISCRIMINATION

No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, national origin, sexual orientation, or on the basis of any other criterion, unrelated to the delivery of quality patient care in the hospital setting, to professional qualifications, the

hospital's purposes, needs and capabilities, or community needs.

3.5 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Except for honorary, retirees and Administrative members, all other members of the medical staff shall:

(a) Provide patients with care at the generally recognized professional level of quality and efficiency established by the hospital's medical staff.

(b) Retain responsibility within the area of professional competence for the continuous care and supervision of patients at the hospital for whom providing services, arrange for a suitable alternative physician, who is on the medical staff with equivalent clinical privileges, to assure such care and supervision.

(c) Abide by the medical staff bylaws and rules and regulations and by all other lawful standards, policies, and rules of the hospital and shall conform to current accreditation, federal and state mandated standards.

(d) Comply with all requirements set forth in the medical staff bylaws and rules and regulations, including, but not limited to, those requiring maintenance of professional liability insurance (Section 3.2-3), payment of medical staff dues (Section 15.5), acceptance of principles (Section 15.8), and refraining from division of fees (Section 15.9).

(e) Discharge such personal, medical staff, department, committee and hospital functions, including, but not limited to, peer review, patient care audit, utilization review, quality assessment, emergency service and back-up functions, for which the member is responsible by virtue of staff category assignment, appointment, election, utilization of allied health professionals or exercise of privileges, prerogatives or other rights in the hospital.

(f) Prepare and complete in a timely fashion the medical and other required records for all patients the staff member admits or in any way provides care to at the hospital.

(g) Complete and document a medical history and physical examination in accordance with the Medical Staff Rules and Regulations performed within (30) days prior to a patient's admission or within 24 hours after admission or registration but prior to surgery or a procedure requiring anesthesia services. For a medical history and physical examination that was performed thirty (30) days prior to inpatient admission, an updated examination of the patient, including any changes in the patient's condition, shall be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. When the medical history and physical examination are completed within 30 days before admission or registration then any appropriate screening tests, based on the needs of the patient, shall be accomplished and recorded in the patient's chart within 72 hours prior to the patient's surgery. As in the ASA (American Society of Anesthesiology) Class I and II patients, appropriate screening tests will be considered acceptable if done within seven (7) days prior to the patient's surgery. The examination of the patient, including any changes in the patient's condition, must be completed and documented by a Doctor of Medicine, osteopathy, surgeon, oral or maxillofacial surgeon, doctor of podiatry medicine or other qualified licensed practitioner, who has been granted privileges at RUHS MC.

(h) Aid in any educational programs for medical staff members, medical students, resident physicians, resident dentists, nurses, and other personnel when so assigned. A medical staff member who chooses not to participate in the teaching programs is not subject to denial or limitation of privileges for this reason alone.

(i) Provide continuous quality care for patients.

(j) Assist the hospital in fulfilling its uncompensated or partially compensated patient care obligations within the areas of the staff member's professional competence and credentials. Pledge not to receive or pay to another physician or dentist, either directly or indirectly, any part of a fee received for professional services.

(k) Pledge to maintain an ethical practice, including to refrain from illegal inducements for patient referral, and to refrain from failing to disclose to patients when another surgeon will be performing the surgery.

(l) Refrain from any unlawful harassment or discrimination against any person (including any patient, hospital employee, hospital independent contractor, medical staff member, volunteer, visitor, etc.) based upon the person's age, sex, religion, race, creed, color, national origin, or health status as further described in Section 3.10, or ability to pay or source of payment.

(m) Refrain from delegating patient care responsibility, including diagnosis or care of hospitalized or outpatient patients to a practitioner or allied health professional that is not qualified to undertake this responsibility or who is not adequately supervised.

(n) Coordinate individual patient care, treatment, and service with other practitioners and hospital personnel, including, but not limited to, seeking consultation whenever warranted by the patient's condition or when required by the rules or policies and procedures of the medical staff or applicable department.

(o) Recognize the importance of confidentially communicating concerns to appropriate department officers and/or medical staff officers when s/he obtains credible information including that a fellow medical staff member may have engaged in unprofessional or unethical conduct or may have a health condition which poses a significant risk to the well-being or care of patients, and then cooperate as reasonably necessary toward the appropriate resolution of any such manner.

(p) Participate in the medical staff focused professional practice evaluation and ongoing professional practice evaluation in accordance with the bylaws, rules and policies and procedures of the medical staff.

(q) Immediately notify the Medical Staff Services Office by telephone and furnish in writing within ten (10) calendar days upon notification of any action taken regarding the member's license, DEA registration, privileges at other facilities, changes in liability insurance coverage, any report filed with the National Practitioner Data Bank, or any other change or circumstance that could affect his/her medical staff standing and/or clinical privileges at the hospital.

(r) Adhere to the medical staff organization's Standards of Conduct (as further described in Section (3.11), so as not to adversely affect patient care or hospital operations.

3.6 HARASSMENT PROHIBITED

Harassment by a medical staff member against any individual (e.g., against another medical staff member, house staff, hospital employee or patient) on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability,

marital status, sex or sexual orientation shall not be tolerated.
Sexual harassment is unwelcome verbal or physical conduct of a sexual nature which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as the display of derogatory cartoons, drawings, or posters).

Sexual harassment includes unwelcome advances, requests for sexual favors, and any other verbal, visual, or physical conduct of a sexual nature when (1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, or other aspects of employment; or (2) this conduct substantially interferes with the individual's employment or creates an intimidating, hostile, or offensive work environment. Sexual harassment also includes conduct which indicates that employment and/or employment benefits are conditioned upon acquiescence in sexual activities.

All allegations of sexual harassment shall be immediately investigated by the medical staff and, if confirmed, will result in appropriate corrective action, from reprimands up to and including termination of clinical privileges or membership, if warranted by the facts.

3.7 STANDARDS OF CONDUCT

Members of the medical staff and allied health professionals are expected to adhere to the Medical Staff Standards of Conduct, including but not limited to the following:

3.7-1 GENERAL

(a) It is the policy of the medical staff to require that its members fulfill their medical staff obligations in a manner that is within generally accepted bounds of professional interaction and behavior. The medical staff is committed to supporting a culture and environment that values integrity, honesty, and fair dealing with each other, and to promoting a caring environment for patients, practitioners, employees, and visitors.

(b) Rude, combative, obstreperous behavior, as well as willful refusal to communicate or comply with reasonable rules of the medical staff and the hospital may be found to be disruptive behavior. It is specifically recognized that patient care and hospital operations can be adversely affected whenever any of the foregoing occurs with respect to interaction at any level of the hospital, in that all personnel play an important part in the ultimate mission of delivering quality patient care.

(c) In assessing whether particular circumstances in fact are affecting quality patient care or hospital operations, the assessment need not be limited to care of specific patients, or to direct impact on patient health. Rather, it is understood that quality patient care embraces – in addition to medical outcome – matters such as timeliness of services, appropriateness of services, timely and thorough

communications with patients, their families, and their insurers (or third-party payors) as necessary to effect payment for care, and general patient satisfaction with the services rendered and the individuals involved in rendering those services.

3.7-2 CONDUCT GUIDELINES

(a) Upon receiving medical staff membership and/or privileges at the hospital, the member enters common goal with all members of the organization to endeavor to maintain the quality of patient care and appropriate professional conduct.

(b) Members of the medical staff are expected to always behave in a professional manner and with all people—patients, professional peers, hospital staff, visitors, and others in and affiliated with the hospital.

(c) Interactions with all persons shall be conducted with courtesy, respect, civility, and dignity. Members of the medical staff shall be cooperative and respectful in their dealings with other persons in and affiliated with the hospital.

(d) Complaints and disagreements shall be aired constructively, in a non-demeaning manner, and through official channels.

(e) Cooperation and adherence to the rules of the hospital and the medical staff is required.

(f) Members of the medical staff shall not engage in conduct that is offensive or disruptive, whether it is written, oral, or behavioral.

3.8 ORGANIZED HEALTH CARE ARRANGEMENT

Under the privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA), the medical staff and the hospital are permitted to operate in an Organized Health Care Arrangement (OHCA). The OHCA is a clinically integrated care setting in which individuals receive health care from more than one provider and the providers hold themselves out to the public as participating in a joint arrangement. The medical staff is in an OHCA with the hospital for care provided at hospital locations. This joint arrangement is disclosed to the patients in the Notice of Privacy Practices given to patients when they access care at any hospital and county affiliated facility. Members of the medical staff shall use patient medical and demographic information only as described in the Notice of Privacy Practices.

ARTICLE IV - CATEGORIES OF MEMBERSHIP

4.1 CATEGORIES

The categories of the medical staff shall include the following: active, provisional, courtesy, honorary, adjunct, Per Diem Resident/Moonlighting and Administrative.

4.2 ACTIVE STAFF

4.2 1 QUALIFICATIONS

The active staff shall consist of practitioners who:

(a) Meet the qualifications set forth in Section 3.2.

(b) Regularly admit patients to or otherwise regularly provide professional services for patients at the hospital and regularly participate in medical staff functions.

(c) Have satisfactorily completed appointment in the provisional category.

4.2-2 PREROGATIVES

The prerogatives of active medical staff members shall be to:

(a) Exercise such clinical privileges as are granted to them pursuant to Article VII.

(b) Hold office in the medical staff and in the department and committees of which they are a member, and serve on committees, including as the Committee Chair, unless otherwise provided in the medical staff bylaws and/or the Medical Staff Committees and Functions Manual.

(c) Vote for medical staff officers, on bylaws' amendments, and on all matters presented at general and special meetings of the medical staff and of the department and committee of which they are members, unless otherwise provided in the medical staff bylaws and/or the Medical Staff Committees and Functions Manual.

(d) Treat and service patients, in both inpatient and outpatient services, as assigned by their department chair and in accordance with privileges granted.

(e) Serve as Chair of Medical Staff Committee(s)

4.2-3 RESPONSIBILITIES

Active staff members shall:

(a) Meet the basic responsibilities set forth in Section 3.6

(b) Actively participate in and regularly assist the hospital in fulfilling its obligations related to patient care within areas of professional competence, including but not limited to emergency service and back-up function, patient care audit, peer review, utilization review, quality evaluation and related monitoring activities required of

and by the medical staff in supervising and proctoring initial appointees and AHPs, and in discharging such other functions as may be required from time to time.

(c) Participate in educational programs and departmental functions at the hospital. Minimum standards of active participation in the teaching program shall be established by the chair, or designee, of each department in consultation with the medical director. Active staff members shall participate in teaching programs as requested by the medical director.

4.3 PROVISIONAL STAFF

4.3-1 QUALIFICATIONS

The provisional staff shall consist of practitioners who meet the qualifications for membership set forth in Section 3.2, except that they have not yet satisfactorily completed the proctoring requirements specified in Section 3.8; have been medical staff members for less than one year; and/or have not fulfilled such other requirements as may be set forth in these bylaws, the medical staff and department rules and regulations, or hospital policies.

4.3-2 PREROGATIVES

The prerogatives of provisional staff members shall be to:

(a) Exercise such clinical privileges as are granted to them pursuant to Article VII.

(b) Serve on committees, unless provided otherwise in these bylaws and/or in the Medical Staff Committees and Functions Manual. Provisional members may not hold office in the medical staff or in the department and committee of which they are members, unless otherwise provided in these bylaws.

(c) Vote on all matters presented at committee meetings of which they are members. Provisional members may not vote for medical staff officers, on bylaws' amendments, or on any matters presented at general and special meetings of the medical staff and of the department of which they are members, unless otherwise provided in these bylaws and/or in the Medical Staff Committees and Functions Manual.

4.3-3 RESPONSIBILITIES

Provisional staff members shall be required to discharge the responsibilities which are specified in Section 4.2 3 for active staff members. Failure to fulfill those responsibilities shall be grounds for denial of advancement to active, courtesy, or consulting staff status and termination of provisional staff status.

4.3-4 OBSERVATION OF PROVISIONAL STAFF MEMBER

The provisional staff member shall undergo a period of observation by designated monitors as described in Section 3.8. The purpose of observation shall be to evaluate the member's:

(a) Proficiency in the exercise of clinical privileges initially granted, and
(b) Overall eligibility for continued staff membership and advancement within staff categories.

Observation of a provisional staff member shall follow whatever frequency and format the department deems appropriate in order to adequately evaluate the provisional staff member including, but not limited to, concurrent or retrospective chart review, mandatory consultation, and/or direct observation. Appropriate records shall be maintained. The results of the observation shall be communicated by the department chair to the Credentials Committee.

4.3-5 ACTION AT CONCLUSION OF PROVISIONAL STAFF STATUS

(a) If the provisional staff member has satisfactorily demonstrated the ability to exercise the clinical privileges initially granted and otherwise appears qualified for continued medical staff membership, the member shall be eligible for placement in the active, courtesy or consulting staff as appropriate, upon the recommendation of the Credentials Committee and the Medical Executive Committee.
(b) In all other cases, the appropriate department chair shall advise the Credentials Committee, who shall make its recommendation to the Medical Executive Committee regarding a modification of clinical privileges, a modification of staff category, or termination of medical staff membership.

4.4 COURTESY STAFF

4.4-1 QUALIFICATIONS

The courtesy staff shall consist of practitioners who:

(a) Meet the qualifications set forth in Section 3.2.
(b) Are involved in sufficient patient care activities at the hospital or provide supplemental ongoing professional practice documentation so that the medical staff will be able to evaluate the staff member’s current clinical competency on an ongoing basis. Courtesy staff members who provide services for more than twelve (12) patients during each medical staff year will be given the opportunity to be appointed to the active staff category.
(c) Have satisfactorily completed appointment in the provisional category.

4.4-2 PREROGATIVES

The prerogatives of courtesy staff members shall be to:

(a) Admit or provide professional services at the hospital during each medical staff year. Courtesy members whose activity meets the minimum volume set forth in 4.4-1 (b) may apply and qualify for active staff status.
(b) Attend meetings of the medical staff and the department of which they are members. Courtesy staff members may serve on committees.
(c) Courtesy staff members may not hold office in the medical staff or in the department of which they are members.
(d) Courtesy staff members may not vote on any medical staff matter.

4.4-3 RESPONSIBILITIES

Courtesy staff members shall meet the basic responsibilities set forth in Section 3.6.

4.5 HONORARY STAFF

4.5-1 QUALIFICATIONS

The honorary staff shall consist of practitioners who do not actively practice at the hospital but are deemed deserving of membership by virtue of their outstanding reputation, noteworthy contributions to the health or medical sciences, or their previous long-standing service to the hospital, and who continue to exemplify high standards of professional and ethical conduct.

4.5-2 PREROGATIVES

The prerogatives of honorary staff members shall be to:

Honorary staff members are not eligible to admit patients to the hospital or to exercise clinical privileges in the hospital. They may, however, attend staff and department meetings and any staff or hospital educational meetings. Honorary staff members may not vote on any medical staff matter, hold office in the medical staff or in the department of which they are a member, or serve on committees.

4.5-3 RESPONSIBILITIES

Honorary staff members shall meet the basic responsibilities specified in Section 3.6, Paragraphs (c), (k), (m), (p), (r), and (s).

4.6 ADJUNCT STAFF

4.6-1 QUALIFICATIONS

The adjunct staff shall consist of practitioners who do not have clinical privileges.

4..6-2 PREROGATIVES

Adjunct staff members may observe the care and treatment of their patients that are cared for at this hospital. Adjunct staff members shall not be assigned to a specific department; therefore, they shall not be expected to attend departmental meetings. They shall not have the right to vote or to serve on committees. Adjunct staff members shall not require proctoring.

4.6-3 RESPONSIBILITIES

Adjunct staff members shall meet the basics responsibilities specified in Section 3.6, Paragraphs (c), (k), (m), (p), (r), (s), and including any others which would be relevant to their staff category.

4.7 PER DIEM RESIDENT/MOONLIGHTING STAFF

4.7-1 QUALIFICATIONS

Per diem/moonlighting resident medical staff membership shall be held by post-doctoral residents who:

(a) have successfully completed at least (2) two out of (3) three years of an accredited residency program approved by the Accreditation Council on Graduate Education (ACGME);

(b) who are not eligible for another staff category;

(c) who are either licensed or registered with the appropriate State of California licensing board. All per diem/moonlighting resident medical staff members must have a training license to practice medicine within the State of California; and

(d) Have approval and acknowledgement of their moonlighting by their Residency Program Director.

4.7-2 PREROGATIVES

(a) Members of the per diem resident/moonlighting medical staff are not eligible to hold office within the medical staff, but may participate in the activities of the medical staff through membership on medical staff committees

(b) All medical care provided by per diem resident medical staff is under the supervision of the department chair and/or his designee(s). Care should be in

accordance with the provision of a residency program approved by and in conformity with the Accreditation Council on Graduate Medical Education (ACGME) or the American Dental Association's Commission on Dental Accreditation.

(c) Appointment to the per diem resident medical staff shall be for (1) one year and may be renewed annually.

(d) Per diem resident medical staff membership may not be considered as the observational period required to be completed by provisional staff.

(e) Per diem resident medical staff membership terminates with termination from the training program. Upon completion of the training program, per diem resident medical staff may apply for regular medical staff membership.

4.8 ADMINISTRATIVE STAFF

The administrative staff shall consist of practitioners who are members of the Medical Staff who have no clinical privileges and who must:

a) Possess expertise in the area that they are working and come to RUHS when scheduled or when called to assist in the Medical Staff administration including, but not limited to, quality improvement, utilization review, and/or patient referral work, or for Medical Staff, Resident, or student educational activities.

b) Agree to refrain from participating in any activities within the Medical Center that require Clinical Privileges.

c) Be recommended for appointment or reappointment to the Administrative Staff by the Chief of the Clinical Service, the Credentials Committee, and by Medical Staff Executive Committee.

Failure to continue to meet any of these qualifications will be adequate grounds to deny reappointment.

4.8-1 PREROGATIVES:

The prerogatives of an Administrative Staff member shall be to:

a) Attend meetings of the Medical Staff and the Clinical Service to which s/he has been assigned.

b) Shall document their current licensure, adequate experience, education and training, current professional competency, good judgment, and current physical and mental health status, so as to demonstrate to the satisfaction of the Medical Staff that they are professionally and ethically competent to exercise their duties.

A member of the Administrative Staff may not serve as chair or vice chair of a clinical department or hold office in the Medical Staff but may be a voting member or chair on committees they are asked to serve on. By virtue of their position administrative staff cannot be a voting member of the Medical Executive Committee.

4.8-2 RESPONSIBILITIES:

Each member of the Administrative Staff shall meet the standards in Section 3.2 other than the standards which in the judgment of the Credentials Committee and Medical Staff Executive Committee do not apply because of the absence of clinical activity. If a patient of a member of the Administrative Staff requires care by the Medical Center, the Administrative Staff member relinquishes all responsibility for the patient to a Medical Staff member with the appropriate clinical privileges.

4.8-3 CARE OF PATIENTS

If the Administrative Staff member wishes to obtain clinical privileges in the Medical Center, that member must apply for Medical Staff membership Category as described in Section 4.2

4.9 TELEHEALTH STAFF

Telehealth means the delivery of the health care services via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's healthcare while the patient is at the originating site and the health care provider is at a distant site. Telehealth is not a telephone conversation, email/instant message conversation, or fax; it typically involves the application of videoconferencing or store and forward technology to provide or support healthcare delivery.

4.9-1 QUALIFICATIONS OF TELEHEALTH PROVIDERS:

Providers shall consist of practitioners who:

(a) Meet the qualifications set forth in Section 3.2.

(b) only provide diagnostic or treatment services to hospital patients via telehealth technology:

(c) Have satisfactorily completed credentialing by (1) a distant site provider that is either a Medicare certified hospital or a telemedicine provider accredited by the Joint Commission which has a current agreement with the County of Riverside to provide such credentialing and (2) credentialing by the Credentialing committee of this Medical Staff.

4.9-2 PREROGATIVES

The prerogatives for Telehealth provider members shall be to: (a) Exercise such clinical privileges as are delineated by the Department Chair and granted to them pursuant to Article Vll. (b) Participate in educational programs and departmental functions at the hospital, but without any rights to vote on departmental of medical staff matters. (c) Treat and service patients in accordance with privileges granted.

4.9-3 RESPONSIBILITIES

Telehealth provider members shall: (a) Meet the basic responsibilities set forth in section 3.6. (b) Actively participate in quality evaluation and related monitoring activities required

of and by the medical staff relating to their delivery of care to hospital patients. Compliance Plan and other regulatory responsibilities.

4.10 Modification of Medical Staff membership

4.10-1 Any Medical Staff member other than a member in the Provisional Category may request a change in a year in which the member is not already scheduled for reappointment. To request a change, the member must:

Apply in writing for transfer to another staff category.

Apply for clinical privileges. The Medical Staff will evaluate the requested clinical privileges using the same procedure that is followed in evaluating a request for clinical privileges that accompanies a reapplication.

Assist the Medical Staff in resolving any quality-of-care issues that may have existed during any appointment period during which the member had been granted clinical privileges.

4.10-2 Modification Of Medical Staff membership Category At The time of Reappointment

The Credentials Committee may recommend a change in staff category at the time of reappointment based on the information and materials available to the Credentials Committee at that time.

4.10-3 Modification Of Medical Staff membership Category By The Medical Staff Executive Committee

On its own, upon recommendation of the Credentials Committee, or pursuant to a request by a member, or upon direction of the Governing Body as set forth in Section 6.4-5, the Medical Staff Executive Committee may recommend a change in the Medical Staff category of a member consistent with the requirements of the Bylaws.

ARTICLE V - ALLIED HEALTH PROFESSIONALS

5.1 QUALIFICATIONS

Allied Health Professionals (AHPs) holding a license, certificate or such other credentials, if any, as required by California law, which authorize the AHPs to provide certain professional services, are not eligible for medical staff membership. Such AHPs are eligible for practice privileges at this hospital only if they:

(a) hold a license, certificate or other legal credential in a category of AHPs which the Medical Executive Committee has identified as eligible to apply for practice privileges;
(b) document their experience, background, training, demonstrated ability, judgment, and physical and mental health status with sufficient adequacy to demonstrate that any patient treated by them will receive care of the generally recognized

professional level of quality and efficiency established by the hospital, and that they are qualified to exercise practice privileges at the hospital; and

(c) are determined, on the basis of documented references, to adhere strictly to the lawful ethics of their respective professions; to work cooperatively with others in the hospital setting; and to be willing to commit to and regularly assist the hospital in fulfilling its obligations related to patient care, within the areas of their professional competence and credentials.

5.2 DELINEATION OF CATEGORIES OF AHPs ELIGIBLE TO APPLY FOR PRACTICE PRIVILEGES

For each eligible AHP category, the Medical Executive Committee shall identify the mode of practice in the hospital setting and the practice privileges and prerogatives that may be granted to qualified AHPs in that category. The Medical Executive Committee shall also identify the terms and conditions which may be granted and apply to AHPs in each category. The delineation of categories of AHPs eligible to apply for practice privileges and the corresponding practice privileges, prerogatives, terms, and conditions for each such AHP category, when approved by the Medical Executive Committee, shall be set forth by the department in which they serve.

5.3 PROCEDURE FOR GRANTING PRACTICE PRIVILEGES

AHPs must apply and qualify for practice privileges. Applications for initial granting of practice privileges, and biennial renewal thereof, shall be submitted by the Interdisciplinary Practice Committee to the Credentials Committee.

AHPs who do not have licensure or certification in an AHP category identified as eligible for practice privileges in the manner required by Section 5.2 above cannot apply for practice privileges but may submit a written request to the Interdisciplinary Practice Committee, asking that the Medical Executive Committee consider identifying the appropriate category of AHPs as eligible to apply for practice privileges. AHPs shall be assigned to the clinical department appropriate to their occupational or professional training and, unless otherwise specified in the rules and regulations, shall be subject to terms and conditions paralleling those specified in Article VIII (Corrective Action), as they may be applied to AHPs and appropriately tailored to the particular AHP's profession.

5.4 PREROGATIVES

The prerogatives which may be extended to AHPs shall be defined in the medical staff rules or regulations or hospital policies. Such prerogatives may include:

(a) Provision of specified patient care services under the supervision or direction of a physician member of the medical staff and consistent with the practice privileges granted to the AHP and within the scope of the AHP’s licensure or certification.

(b) Service on medical staff, department, and hospital committees.

(c) Attendance at meetings of the department to which assigned, as permitted by the department rules and regulations, and attendance at hospital education programs in their field of practice.

5.5 RESPONSIBILITIES

Allied Health Professionals shall:

(a) Meet those responsibilities required by the medical staff rules and regulations, and if not so specified, meet those responsibilities specified in Section 3.5 (Basic Responsibilities of Medical Staff Membership) and 6.5 (Proctoring Requirements) as are generally applicable to the more limited practice of AHPs.

(b) Retain appropriate responsibility within their area of professional competence for the care and supervision of patients at the hospital for whom they are providing services.

(c) Participate, as appropriate, in-patient care audit and other quality review, evaluation, and monitoring activities required of AHPs, in supervising initial appointees of their same occupation or profession or of a lessor included occupation or profession, and in discharging such other functions as may be required from time to time.

5.6 REAPPLICATION

An allied health professional must reapply every two years for practice privileges in accordance with Section 5.3 Procedure for Granting Practice Privileges.

ARTICLE VI - PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT
(Including Telehealth Services)

6.1 GENERAL PROCEDURE

The medical staff through its designated departments, committees, and officers shall consider each completed application for appointment or reappointment to the staff and for clinical privileges and each request for modification of staff membership status or clinical privileges, utilizing the resources of the Hospital Director and its staff to evaluate and validate the contents of the application, before adopting and transmitting its recommendation to the governing board.

The medical staff shall also perform the same function in connection with any individual who has applied only for temporary privileges or who otherwise seeks to exercise privileges or to provide specified medical services in any hospital department or service.

6.2 APPLICATION FOR APPOINTMENT

6.2-1 CONTENT

All applications for appointment to the medical staff shall be in writing, submitted on a form prescribed by the Medical Executive Committee, with all provisions completed (or an explanation why answers are unavailable), and signed by the applicant. The applicant shall be given a copy of these bylaws, the medical staff rules and regulations, and the hospital bylaws.

The application form shall require detailed information including, but not limited to:

(a) The applicant's professional qualifications and competency, including, but not limited to, professional training and experience, current California licensure, current DEA registration if applicable, and continuing medical education information related to the clinical privileges to be exercised by the applicant.

(b) The names of at least three (3) persons who hold the same professional license, whenever possible, as the applicant, including, whenever possible, at least two (2) staff members who can provide adequate references based on their current knowledge of the applicant's professional qualifications, professional competency, and ethical character. The medical staff may request directed references.

(c) Information as to whether any action, including any investigation, has ever been undertaken, whether it is still pending or completed, which involves denial, revocation, suspension, reduction, limitation, probation, nonrenewal, voluntary or involuntary relinquishment by resignation or expiration (including relinquishment

that was requested or bargained for) of the applicant's membership status and/or clinical privileges and/or prerogatives at any other hospital or institution; membership or fellowship in any local, state, regional, national, or international professional organization; license to practice any profession in any jurisdiction; Drug Enforcement Administration or other controlled substances registration; specialty board certification; and/or professional school faculty position or membership.

(d)Information pertaining to the applicant's professional liability insurance coverage, any professional liability claims, complaints, or causes of action that have been lodged against the applicant and the status or outcome of such matters.

(e)Information as to any pending administrative agency or court cases, or administrative agency decisions or court judgments in which the applicant is alleged to have violated, or was found guilty of violating, any criminal law (excluding minor traffic violations) or is alleged to be liable, or was found liable, for any injury caused by the applicant's negligent or willful act or omission in rendering services.

(f)Information as to details of any prior or pending or current exclusion from a federal health care program, government agency or third-party payor proceeding or litigation challenging or sanctioning applicant's patient admission, treatment, discharge, charging, collection, or utilization practices, including but not limited to Medicare and Medi Cal fraud and abuse proceedings and convictions.

(g) Information pertaining to the applicant's physical and mental condition, and the applicant agrees to submit any additional documentation if requested.

(h) Certification of the applicant's agreement to terms and conditions set forth in Section 6.2 2 regarding the effects of the application.

(i) An acknowledgment that the applicant has received (or has been given access to) and read the medical staff bylaws and rules and regulations, has received an explanation of the requirements set forth therein and of the appointment process, and that the applicant agrees to be bound by the terms thereof, as they may be amended from time to time, if granted membership or clinical privileges, and to be bound by the terms thereof, without regard to whether or not the applicant is granted membership and/or clinical privileges in all matters relating to consideration of the application.

(j)

An acknowledgment of the applicant's responsibility to inform the Medical Staff Services Office of any change in the information provided through the application form during the application period or at any subsequent tim.

The applicant shall also identify the staff category, clinical department, and clinical privileges for which the applicant wishes to be considered. The applicant shall pay a nonrefundable application fee, payable in advance, in the amount established by the Medical Executive Committee pursuant to Section 15.5. The option to waive an applicant's

initial processing fee may be considered by the Credentials Committee if requested in writing by the relevant department chair.

6.2-2 EFFECTS OF APPLICATION

By applying for appointment to the medical staff, reappointment, advancement or transfer, the applicant thereby signifies willingness to appear for interviews in regard to the application; authorizes the hospital's medical staff or its designee to consult with members of medical staffs of other hospitals with which the applicant has been associated and with others who may have information bearing on the applicant's competence, character and ethical qualifications, and authorizes such persons to provide all such information; consents to the hospital's inspection of all records and documents that may be material to an evaluation of professional qualifications, personality, ability to cooperate with others, moral and ethical qualifications for membership, and physical, mental, and professional competence to carry out the clinical privileges the applicant requests and directs individuals who have custody of such records and documents to permit inspection and/or copying; certifies to report in writing any changes in the information submitted on the application form, which may subsequently occur, to the Credentials Committee and the Hospital Director; and releases from any and all liability, all individuals and organizations providing information to the hospital concerning the applicant and all hospital representatives for their acts performed in connection with evaluating the applicant and his/her credentials; agrees that the hospital and medical staff may share information with a representative or agent from affiliated health care entities and providers, including information obtained from other sources, and 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 likewise agrees that the hospital and its affiliated health care entities may act upon such information.

6.2-3 PHYSICAL AND MENTAL CAPABILITIES

(a) Obtaining Information:

i. When the Medical Staff Services Office verifies information and obtains references, it shall ask for any information concerning physical or mental disabilities to be reported. This information will also be referred to the department chair.

ii. The medical director, on behalf of the Physician Well-Being Committee, and with the assistance of the Physician Well-Being Committee, shall be responsible for investigating any practitioner who has or may have a physical or mental disability that might affect the practitioner's ability to exercise the requested privileges in a manner that meets the hospital and medical staff's quality of care standards. 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 the practitioner's ability to provide care which meets the hospital and medical staff's quality of care standards.
(2) Interview: To ascertain the condition of the practitioner and to assess if and how reasonable accommodations can be made.

iii. Practitioners who feel limited or challenged in any way by a qualified mental or physical disability in exercising their clinical privileges and in meeting quality of care standards should make such limitation immediately known to the medical director. Any such disclosure will be treated with the high degree of confidentiality that attaches to the medical staff's peer review activities.

(b) Review and Reasonable Accommodations:

i. Practitioners who disclose or manifest a qualified physical or mental disability will have their application processed in the usual manner without reference to the condition.

ii. The medical director shall not disclose any information regarding any practitioner's qualified physical or mental disability until the Credentials Committee (or, in the case of temporary privileges, the medical staff representatives who review temporary privileges requests and the Hospital Director) has determined that the practitioner is otherwise qualified for membership and/or to exercise the privileges requested. Once the determination is made that the practitioner is otherwise qualified, the medical director and the Physician Well-Being Committee may disclose information they have regarding any physical or mental disabilities and the effect of those on practitioner's application for membership and privileges. The medical director and the Physician Well-Being Committee and any other appropriate committees may meet with the practitioner to discuss if and how reasonable accommodations can be made.

iii. As required by law, the medical staff and hospital will attempt to provide reasonable accommodations to a practitioner with known physical or mental disabilities, if the practitioner is otherwise qualified and can perform the essential functions of the staff appointment and privileges in a manner which meets the hospital and medical staff quality of care and patient safety standards. If reasonable accommodations are not possible under the standards set forth herein, it may be necessary to withdraw or modify a practitioner's privileges and the practitioner shall have the hearing and appellate review rights described below.

6.3 PROCESSING THE APPLICATION

6.3-1 APPLICANT'S BURDEN

In connection with all applications for appointment and reappointment, the applicant shall have the burden of producing accurate and adequate information for a proper evaluation of the applicant's experience, background, training, demonstrated ability, physical and mental health status, and all other qualifications specified in the medical staff bylaws and rules and regulations, and of the applicant's compliance with standards and criteria set forth in the medical staff bylaws and rules and regulations, and for resolving any doubts about these matters. The applicant's failure to sustain this burden shall be grounds for denial of the application. The provision of information containing significant misrepresentations or omissions and/or a failure to sustain the burden of producing adequate information shall also be grounds for denial of the application.

6.3-2 VERIFICATION OF INFORMATION

The applicant shall deliver an application form in full to the Medical Staff Services Office which shall, in a timely fashion, seek to collect or verify the references, licensure, and other qualification evidence submitted. The Medical Staff Services Office shall promptly notify the applicant of any problems in obtaining the information required, and it shall then be the applicant's obligation to obtain the required information. An applicant whose application is not completed within six (6) months after being received by the Medical Staff Services Office shall be automatically removed from consideration for staff membership and/or clinical privileges. Such an applicant's application may, thereafter, be reconsidered only if all information therein which may change over time, including, but not limited to, hospital reports and personal references, has been resubmitted.

6.3-3 DEPARTMENT AND CREDENTIALS COMMITTEE ACTION

Under the direction of the Credentials Committee, the department chair and/or appropriate subject matter experts, as deemed necessary by the Credentials Committee, shall review the application and supporting documentation according to established medical staff criteria regarding clinical privileges, professional conduct and competence, and may conduct a personal interview with the applicant. The department chair subject matter expert shall forward a written evaluation to the Credentials Committee. The department chair subject matter expert may also suggest that the Credentials Committee defer action. The Credentials Committee, or in cases eligible for expedited process the duly appointed designee, shall transmit to the Medical Executive Committee its report and recommendation, prepared in accordance with Section 6.3 6.

6.3-4 MEDICAL EXECUTIVE COMMITTEE (MEC) ACTION

At its next regular meeting, after receipt of the Credentials Committee report and recommendation, the Medical Executive Committee shall consider the Credentials Committee report. The Medical Executive Committee may ask the applicant to appear for an interview and/or request further documentation. The Medical Executive Committee shall then immediately forward to the Hospital Director for prompt transmittal to the governing board, its recommendation. The recommendation shall be prepared in accordance with Section 6.3-6. The MEC may also defer action on the application pursuant to Section 6.3-7. (a).

6.3-5 APPOINTMENT REPORTS

The department chair, Credentials Committee, and Medical Executive Committee reports and recommendations shall be transmitted in the form prescribed by the Medical Executive Committee. The report and recommendation shall specify whether medical staff appointment is recommended, and, if so, the membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The reason for the recommendation shall be stated and supported by reference to the completed application and all other documentation which was considered, all of which shall be transmitted with the report.

6.3-6 BASIS FOR APPOINTMENT

The recommendation concerning an applicant for medical staff membership and clinical privileges shall be based upon whether the applicant meets the qualifications specified in Section 3.2; can carry out the responsibilities specified in Section 3.6; and meets all of the standards and requirements set forth in all sections of these bylaws and in the medical staff rules and regulations. Specifically, a recommendation shall also be based upon the practitioner's compliance with legal requirements applicable to the practice of the applicant's profession and other hospitals' medical staff bylaws, rules and regulations, and policies, rendition of services to patients, absence or accommodation of any physical or mental impairment which might interfere with the ability to practice medicine with reasonable skill and safety, and provision of accurate and adequate information to allow the medical staff to evaluate the applicant's competency and qualifications.

6.3-7 EFFECT OF MEDICAL EXECUTIVE COMMITTEE ACTION

(a) Interviews, Further Documentation, Deferral: Action by the MEC to interview the applicant, seek further documentation, or defer the application for further consideration must be followed up within seventy (70) days with a subsequent recommendation for appointment with specified clinical privileges, or for denial of the request for medical staff membership.

(b) Favorable Recommendation: When the MEC's recommendation is favorable to the applicant, the Hospital Director or Chief Operating Officer (COO) shall forward the recommendation to the governing board within 12 months. The Hospital Director

or COO is authorized by the Governing Board to make an appointment subject to final action by the Governing Board ratifying the appointment. In the event that the Governing Board does not ratify the Hospital Director's or COO action, that appointment shall be terminated, and the Hospital shall notify the applicant and follow the procedure set forth in Section 6.3-8 (a) below.

(c) Adverse Recommendation: When the MEC's recommendation is adverse to the applicant, the chief of medical staff shall give the applicant written notice of the adverse recommendation and of the applicant's right to request a hearing in the manner specified in Section 9.3 2; and the applicant shall be entitled to the procedural rights as provided in Article IX. For the purposes of this Section 6.3 8 (c), an "adverse recommendation" by the MEC is as defined in Section 9.2.

6.3-8 ACTION BY THE GOVERNING BOARD

(a) On Favorable Medical Executive Committee Recommendation: The governing board shall, in whole or in part, adopt or reject a Medical Executive Committee recommendation which is favorable to the applicant or refer the recommendation back to the Medical Executive Committee for further interviews, documentation, or consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation shall be made. If the recommendation of the governing board is one of those set forth in Section 9.2, the Hospital Director shall give the applicant written notice of the tentative adverse recommendation and of the applicant's right to request a hearing in the manner specified in Section 9.3 2; and the applicant shall be entitled to the procedural rights as provided in Article IX before any final adverse action is taken.

(b) Without Benefit of Medical Executive Committee Recommendation: If the governing board does not receive a Medical Executive Committee recommendation within the time period specified in Section 6.3 12, it may, after notifying the Medical Executive Committee, take action on its own initiative. If such recommendation is favorable, it shall become effective as the final decision of the governing board. If the recommendation is one of those set forth in Section 9.2, the Hospital Director shall give the applicant written notice of the tentative adverse recommendation and of the applicant's right to request a hearing in the manner specified in Section 9.3 2; and the applicant shall be entitled to the procedural rights as provided in Article IX before any final adverse action is taken.

(c) After Procedural Rights: In the case of an adverse Medical Executive Committee recommendation pursuant to Section 6.3-7 (c) or an adverse governing board recommendation pursuant to Section 6.3-8 (a) or (b), the governing board shall take final action in the matter only after the applicant has exhausted or has waived procedural rights as required in Article IX. Action thus taken shall be the conclusive decision of the governing board, except that the governing board may defer final determination by referring the matter back for further reconsideration. Any such referral back shall state the reasons thereof, shall set a time limit within which a subsequent recommendation to the governing board shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. After receipt of such subsequent recommendation and of new evidence in the matter, if any, the governing board shall make a final decision.

6.3-9 NOTICE OF FINAL DECISION

Notice of the final decision shall be given, through the Hospital Director, to the Medical Executive Committee, the Credentials Committee, the chair of each department concerned, and the applicant. A decision and notice to appoint shall include:

(a) the staff category to which the applicant is appointed;
(b) the department to which the applicant is assigned;
(c) the clinical privileges the applicant may exercise; and
(d) any special conditions attached to the appointment.
(e) board approval date and expiration date

6.3.10 DURATION OF APPOINTMENT

Initial appointment to the medical staff shall not exceed a period of two (2) years. Reappointment shall be for a period of not more than two (2) years.

6.3-11 REAPPLICATION AFTER ADVERSE DECISION DENYING APPLICATION, ADVERSE CORRECTIVE ACTION DECISION, OR RESIGNATION IN LIEU OF MEDICAL DISCIPLINARY ACTION

An applicant who has received a final adverse decision regarding membership, adverse corrective action decision or resigned in lieu of medical disciplinary action shall not be eligible to reapply to the medical staff for a period of thirty-six (36) months. Any such reapplication shall be processed as an initial application and the applicant shall submit such additional information as may be required to demonstrate that the basis for the earlier adverse action or medical disciplinary action no longer exists.

6.3-12 TIME PERIOD FOR PROCESSING

Applications shall be considered in a timely and good faith manner by all individuals and groups required by these bylaws to act thereon and, except for good cause, shall be processed within the time periods specified in Section 6.3-11 and 6.3-12. The Medical Staff Services Office shall transmit an application to the department chair or designee and Credentials Committee within fifteen (15) days after all information collection and verification tasks are completed and all relevant materials have been received. The relevant department chair or designee shall act on an application within fifteen (15) days after receiving it from the Medical Staff Services Office. The Credentials Committee or designee shall then make its recommendation within thirty (30) days after the department chair has acted. The Medical Executive Committee shall review the application and make its recommendation to the governing board within thirty (30) days after receiving the

Credentials Committee report. The governing board shall then take final action on the application within thirty (30) days. The time periods specified herein are to assist those named in accomplishing their tasks and shall not be deemed to create any right for the applicant to have the application processed within those periods.

In the event that relevant materials are not received within sixty (60) days after the application is received, the applicant shall be notified, and the application shall remain pending until either the materials are received by the Medical Staff Services Office or the expiration of six (6) months from the date the application was received. Applications that are not completed within six (6) months after receipt shall automatically be removed from consideration as specified in Section 6.3-2.

6.3-13 EXPEDITED REVIEW

The Medical Staff Services Office will process the application according to written policies and procedures as defined in the Credentials Policies and Procedures Manual. If the Medical Staff Services Administrative Supervisor determines an applicant has no negative information in the file, as defined in the Expedited Credentialing Evaluation Process Policy and Procedure, the file will be referred to the relevant department chair or designee, who will determine whether the applicant qualifies for expedited action and s/he will, also, make a recommendation for membership and privileges. If they agree the applicant qualifies for expedited action, the file shall be referred to the Credentials Committee Chair or the duly appointed designee for review and recommendation to the Medical Executive Committee. The Medical Executive Committee will act upon the recommendation at its next scheduled meeting and will then forward its recommendation to the Governing Board for final action.

6.4 REAPPOINTMENTS

6.4-1 APPLICATION FOR REAPPOINTMENT; SCHEDULE FOR REVIEW

At least 180 days prior to the expiration of a member's current staff appointment, the Medical Staff Services Office shall mail a reappointment application to the staff member. The schedule for review shall be established in the Credentials Policies and Procedures.

As discussed in Section 4.9-1, a member's request for a change in membership category or in privileges may be processed in a year in which the member is not scheduled for reappointment review; however, such member's reappointment shall also be reviewed in accordance with the schedule set forth in the medical staff rules.

At least sixty (60) days prior to the expiration date of staff appointment, the medical staff member shall submit to the Medical Staff Services Office a completed reappointment application form. The reappointment application shall be in writing, on a form prescribed by the medical staff, and it shall require detailed information concerning changes in the applicant's qualifications since the last review. Specifically, the reappointment application

form shall request all of the information and certifications requested in the appointment application form, as described in Section 6.2, including department chair recommendations, except for 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 form shall also require information as to whether the applicant requests any change in staff status and/or clinical privileges, including any reduction, deletion, or additional privileges. Request for additional privileges must be supported by the type and nature of evidence which would be necessary for such privileges to be granted in an initial application for same.

6.4-2 VERIFICATION OF INFORMATION

The Medical Staff Services Office shall, in a timely fashion, seek to collect or verify the additional information made available on the reappointment application form and to collect any other material or information deemed pertinent. The Medical Staff Services Office shall transmit the reappointment application form and supporting material to the chair, or designee, of each department in which the staff member has or requests privileges and to the Credentials Committee.

6.4-3 DEPARTMENT ACTION

The department chair or designee shall review the application, the staff member's file, and shall transmit to the Credentials Committee a written report and recommendation, which are prepared in accordance with Section 6.4 6. The chair or designee's report shall include review of peer review performance and quality assessment activities.

6.4-4 CREDENTIALS COMMITTEE ACTION

Following receipt of the department chair or designee's report concerning the application for reappointment, the Credentials Committee or in cases eligible for expedited process, the duly appointed designee, shall review the application, the department chair or designee's report, and all other pertinent information available on the member who is being considered for reappointment and shall transmit to the Medical Executive Committee its report and recommendation, which are prepared in accordance with Section 6.4 6.

6.4-5 MEDICAL EXECUTIVE COMMITTEE ACTION

The Medical Executive Committee shall review the department chair or designee and Credentials Committee's reports as well as all other relevant information available to it and shall forward immediately to the governing board, through the Hospital Director, its favorable reports and recommendations, which are prepared in accordance with Section 6.4 6.

When the Medical Executive Committee recommends adverse action, as defined in Section 9.2, either in respect to reappointment or clinical privileges, the chief of medical staff shall give the applicant written notice of the adverse recommendation and of the applicant's right to request a hearing in the manner specified in Section 9.3 2; and the applicant shall be entitled to the procedural rights as provided in Article IX. The governing board shall be informed of, but not take action on, the pending recommendation until the applicant has exhausted or waived procedural rights.

Thereafter, the procedures specified in Sections 6.3 9 (Action by the Governing Board), 6.3 10 (Notice of Final Decision) and 6.3 11 (Reapplication After Adverse Decision Denying Application, Adverse Corrective Action Decision, or Resignation in Lieu of Medical Disciplinary Action) shall be followed. The committee may also defer action; however, any such deferral must be followed up within seventy (70) days with a subsequent recommendation.

6.4-6 REAPPOINTMENT REPORTS

The department chair, Credentials Committee, and Medical Executive Committee reports and recommendations shall be written and submitted in the form prescribed by the Medical Executive Committee. The report and recommendation shall specify whether the applicant's appointment should be renewed, renewed with modified membership category, department affiliation, and/or clinical privileges, or terminated. Where nonrenewal, denial of requested privileges, a reduction in status, or a change in clinical privileges is recommended, the reason for such recommendation shall be stated and documented.

6.4-7 BASIS FOR REAPPOINTMENT

The recommendation concerning the reappointment of a medical staff member and the clinical privileges to be granted upon reappointment shall be based upon whether such member has met the qualifications specified in Section 3.2, carried out the responsibilities specified in Section 3.6, and met all of the standards and requirements set forth in all sections of these bylaws and in the medical staff rules and regulations. Current members of the Medical Staff who were not certified, as of 2012, board certified or progressing toward board certification, and who cannot reasonably be expected to pursue board certification, may be considered for renewal of Medical Staff membership if they can document sufficient training, experience, and competence, and otherwise meet the requirements of Medical Staff membership.

Specifically, recommendations shall also be based upon the practitioner's compliance with legal requirements applicable to the practice of the practitioner's profession, with the medical staff bylaws and rules and regulations and hospital policies, rendition of services to patients, any physical or mental impairment which might interfere with the ability to practice medicine with reasonable skill and safety, and the provision of accurate and adequate information to allow the medical staff to evaluate the practitioner's competency and qualifications.

6.4-8 FAILURE TO FILE REAPPOINTMENT FORM

A member shall be deemed to have voluntarily resigned his/her medical staff membership and clinical privileges if the member fails to file a complete application for reappointment at least sixty (60) days prior to the expiration date of medical staff membership privileges. If a practitioner subsequently wishes to apply for membership and clinical privileges at Riverside University Health System Medical Center, she/he shall be required to apply for membership and clinical privileges as a new applicant.

6.4-9 CHANGES BETWEEN ROUTINE REAPPOINTMENT DATES

Whenever a member of the medical staff is first made aware of any interim changes from the information provided during a previous appointment or reappointment (as listed below), s/he must immediately notify the Medical Staff Services Office by telephone and shall furnish the information in writing within ten (10) calendar days to the Medical Staff Services Office. If the Medical Staff Services Office is closed when the member first calls to report the change(s), the immediate notification by telephone will be made to the medical director or the administrator on call prior to doing any clinical work. "Immediately" is defined as "occurring or accomplished without loss or interval of time."

- notification of any action taken regarding the member's license,
- DEA registration,
- privileges at other facilities,
- changes in liability insurance coverage,
- any report filed with the National Practitioner Data Bank,
- or any other change or circumstance that could affect his/her medical staff standing and/or clinical privileges at the hospital.

6.5 PROCTORING REQUIREMENTS

6.5-1 FOR INITIAL APPOINTMENT

Except as otherwise determined by the Medical Executive Committee, all initial appointees to the medical staff that have been granted clinical privileges and all members granted additional clinical privileges, shall be subject to a period of proctoring. Proctoring can be prospective, concurrent and retrospective review. An initial appointee shall be assigned to a department where the appointee's performance shall be proctored by the chair of the department or the department designee, during the term of proctoring required by that department, as established pursuant to Section 3.8-3, to determine the initial appointee's eligibility for continued medical staff membership in the category to which appointed and to exercise the clinical privileges initially granted in that department. Proctoring arrangement shall be the responsibility of the appointee. The exercise of clinical privileges in any other department shall also be subject to prospective, concurrent and retrospective proctoring. The appointee shall remain subject to proctoring until the Credentials Committee has been furnished with:

A report signed by the chair, or designee, of the department to which the appointee is assigned describing the types and number of cases observed, an evaluation of the appointee's performance, and a statement that the appointee appears to meet all of the qualifications for unsupervised practice in that department, has discharged all of the responsibilities of staff membership, and has not exceeded or abused the prerogatives of the category to which appointed. The proctoring will include prospective, concurrent and retrospective chart review.

(a) A report signed by the chair, or designee, of the other department in which the appointee will exercise clinical privileges, describing the types and number of cases observed, an evaluation of the appointee's performance, and a statement that the appointee has satisfactorily demonstrated the ability to exercise the clinical privileges initially granted.

6.5- 2 FOR MODIFICATION OF MEMBERSHIP STATUS OR PRIVILEGES

When recommended by the Credentials and the Medical Executive Committees, and approved by the governing board, medical staff members who are granted additional privileges shall complete a period of proctoring with the procedures outlined in Section for initial appointees.

6.5- 3 TERM OF PROCTORING PERIOD

Each department may establish, in its rules and regulations, a term of proctoring and the number of cases, and/or specific number of cases applicable to particular clinical privileges whenever such requirements are appropriate in view of the clinical privileges which are involved. Proctoring will begin when privileges are initially granted, whether at the time of initial appointment or the granting of temporary privileges. The term of proctoring may be extended not more than twelve (12) months, for a total proctoring period of not more than twenty-four (24)) months. If an initial appointee fails within that period to complete the minimum number of cases the appointee's medical staff membership or particular clinical privilege, as applicable, shall be automatically terminated. If a medical staff member requesting modification fails within that period to complete the minimum number of cases the change in medical staff category or department assignment or the additional privileges, as applicable, shall be automatically terminated. The Medical Executive Committee Chair shall give the initial appointee, or medical staff member so affected, written notice that medical staff membership and/or clinical privileges have been automatically terminated because of failure to satisfactorily complete the proctoring requirements.

6.5-4 RECIPROCAL PROCTORING

Reciprocal Proctoring is defined as cases proctored at an outside hospital by proctoring physicians who may not have privileges at RUHS. These cases must have occurred within the last 2 years. Submitted cases must align with RUHS department specific proctoring requirements and forms. Minimally 50% of the cases must be proctored by a provider with RUHS active privileges.

Acceptance of reciprocal proctoring is at the discretion of the department chair. All proctoring forms/summary of cases should be signed by the RUHS department chair.

6.6 LEAVE OF ABSENCE

6.6-1 LEAVE STATUS

A leave of absence may be considered upon the written request of a medical staff member. A leave of absence may be granted for not more than two (2) years. On no condition will a leave of absence be granted beyond two years. The Credentials Committee will review the request for a leave of absence and the action by Credentials, upon ratification by the Medical Executive Committee, will be transmitted to the Hospital Director for notation in the practitioner's file. The practitioner must give a date of expected return in order that the leave of absence is kept current. During the period of the leave, the practitioner's clinical privileges, prerogatives, responsibilities shall be suspended.

6.6-2 REASONS FOR GRANTING LEAVE

The following reasons for granting a leave of absence shall be considered by the Credentials Committee:

(a) Illness
(b) Military service
(c) Temporary medical training or education
(d) Sabbatical leave
(e) Outside high achievement of exceptional merit
(f) Other special conditions as approved by the Credentials Committee

6.6-3 TERMINATION OF LEAVE

At least thirty (30) days prior to the termination of the leave, or at any earlier time, the medical staff member may request reinstatement of privileges and prerogatives by submitting a written notice to that effect to the Hospital Director and to the Credentials Committee. If so requested by the Medical Executive Committee or the Hospital Director, the staff member shall submit a written summary of relevant activities during the leave. The Medical Executive Committee shall recommend whether to approve the member's request for reinstatement of privileges and prerogatives; thereafter, the procedure set forth in Sections 6.3 7 through 6.3 11 shall be followed.

Failure, without good cause, to request reinstatement or to provide a requested summary of activities shall be deemed to be a voluntary resignation from the medical staff and shall result in automatic termination of membership, privileges, and prerogatives.

ARTICLE VII - CLINICAL PRIVILEGES

7.1 EXERCISE OF PRIVILEGES

A practitioner providing direct clinical services at this hospital, in connection with such practice and except as otherwise provided in Section 7.5 (Emergency Privileges) shall treat and service patients as assigned by the department chair and shall be entitled to exercise only those clinical privileges specifically approved by the medical staff and granted to the member by the governing board. Said privileges must be within the scope of any license, certificate, or other legal credential authorizing the member to practice in this state and consistent with any restrictions thereon.

7.2 DELINEATION OF PRIVILEGES IN GENERAL

7.2-1 REQUESTS

The application for appointment and reappointment must contain a request for the specific clinical privileges desired by the applicant. Request from an applicant for privileges, or from a member for modification of privileges, must be supported by documentation of the requisite training, experience, qualifications and competency to exercise such privileges.

7.2-2 BASIS FOR PRIVILEGES DETERMINATION

Requests for clinical privileges shall be evaluated on the basis of the member's education, training, experience, and demonstrated ability and judgment. The elements to be considered in making determination regarding privileges, whether in connection with periodic reappointment or otherwise, shall include education, training, observed clinical performance and judgment, performance of a sufficient number of procedures each year to develop and maintain the practitioner's skills and knowledge, and the documented results of the patient care audit and other quality review, evaluation, and monitoring activities required by these, and the hospital bylaws to be conducted at the hospital. Privileges determination shall also take into account pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a member exercises clinical privileges.

7.2-3 PROCEDURE

All requests for clinical privileges shall be processed pursuant to the procedures outlined in Article VI.

7.3 SPECIAL CONDITIONS APPLICABLE TO DENTAL AND PODIATRIC PRIVILEGES

Surgical procedures performed by a dentist shall be under the overall supervision of the chair of the department of surgery or designee. Surgical procedures performed by a podiatrist shall be under the overall supervision of the chair of the department of

orthopedic surgery or designee. All dental and podiatric patients shall be co admitted by a physician medical staff member and shall receive the same basic medical appraisal as patients admitted to other surgical services.

The co admitting physician medical staff member shall be responsible for the care of any medical problems that may be present at the time of admission or that may arise during hospitalization and shall determine the risk and effect of the proposed surgical procedure on the total health status of the patient. A request for clinical privileges from a dentist or podiatrist shall be processed in the manner specified in Section 7.2

7.4 TEMPORARY PRIVILEGES

7.4-1 PENDING APPLICATION

Temporary clinical privileges may be granted to a physician, dentist, podiatrist, clinical psychologist, or an allied health professional under strictly defined and enforced circumstances. Temporary privileges may be granted up to 120 calendar days when a complete application for membership or clinical privileges is pending review and recommendation by the Medical Executive Committee and Governing Body.

7.4-2 SPECIFIC PATIENT CARE

Temporary clinical privileges may be granted on a case-by-case basis when an important patient care issue exists that mandates an immediate authorization to practice, for a limited period of time, to a physician, dentist, podiatrist, clinical psychologist, or an allied health professional to fulfill an important patient care, treatment, and service need provided that the procedure described in the medical staff organization's Temporary Privileges Policy and Procedure and in the Credentials Policies and Procedures Manual, are followed.

7.4-3 CONDITIONS

(a) If granted temporary privileges, the applicant shall act under the supervision of the department chair to which the applicant has been assigned, and shall ensure the chair, or the chair's designee, is kept closely informed of his/her activities within the hospital.

(b) Temporary privileges shall automatically terminate at the end of the designated period, unless terminated earlier by the Medical Executive Committee upon recommendation of the department, the Credentials Committee, or the medical director. As necessary, the appropriate department chair or in the chair's absence, the chief of medical staff, shall assign a member of the medical staff to assume responsibility for the care of such member's patient(s). The wishes of the patient shall be considered in the choice of a replacement medical staff member.

(c) Temporary privileges may at any time be terminated with or without cause by the chief of medical staff, the chair of the department, or the Hospital Director after

conferring with either of the foregoing. The practitioner shall be entitled to the procedural rights afforded in Article IX of these bylaws only if temporary privileges are terminated or suspended for a medical disciplinary cause or reason. In all other cases, the individual shall not be entitled to any procedural rights based upon an adverse action involving temporary privileges. All persons requesting or receiving temporary privileges shall be bound by the bylaws and rules and regulations of the medical staff.

(d) There is no right to temporary privileges. Temporary privileges shall not be granted if the available information is incomplete, inconsistent or casts any reasonable doubt on the applicant's qualifications. Action on a request for temporary privileges shall be deferred until doubts have been satisfactorily resolved. A decision to defer shall not be deemed a denial of a request for temporary privileges. Such deferral shall not give rise to the rights set forth in Section IX.

7.5 EMERGENCY AND DISASTER PRIVILEGES

In the case of an emergency, any member of the medical staff, to the degree permitted by his/ her California license and regardless of department, staff status, or clinical privileges, shall be permitted to do everything reasonably possible to save the life of a patient or to save a patient from serious harm. The member shall make every reasonable effort to communicate promptly with the department chair concerning the need for emergency care and assistance by members of the medical staff with appropriate clinical privileges, and once the emergency has passed or assistance has been made available, shall defer to the chair with respect to further care of the patient at the hospital.

In the event of emergency disaster privileging, refer to the Emergency Privileging during Disaster Policy in the Credentials Policy/Procedure Manual. The procedures as described in the policy will be implemented.

ARTICLE VIII - CORRECTIVE ACTION

8.1 ROUTINE CORRECTIVE ACTION

8.1-1 FOCUSED PROFESSIONAL PRACTICE REVIEW

The Medical Executive Committee shall define, on a continuous basis, the circumstances warranting further intensive review of a member or other practitioner's services provided under privileges held and establish the parameters for participation of the subject under review in the focused review process. When circumstances warrant, the Medical Executive Committee shall refer the matter to the Professional Practice Evaluation Committee (PPEC) who shall conduct the review in accordance with the "PROFESSIONAL PRACTICE EVALUATION PROGRAM" policy. A focused professional review triggered by an adverse event will result in recommendations for changes to improve the member's performance; recommendations for system, protocol or policy changes; a request for investigation or corrective action or other action.

8.1-2 CRITERIA FOR INITIATION

Whenever a practitioner with clinical privileges shall engage in, make, or exhibit acts, statements, demeanor, or professional conduct, either within or outside of the hospital, and the same is, or is reasonably likely to be detrimental to patient safety or to the delivery of quality patient care at the hospital, to be disruptive to hospital operations, or improper use of hospital resources, or act contrary to the bylaws, or to constitute fraud or abuse; or the same results in the imposition of sanctions by any governmental authority; an investigation or corrective action against such person may be requested by any medical staff officer, by the medical director, or by the chair or vice chair of any department in which the practitioner is a member to exercise clinical privileges. The Professional Practice Evaluation Committee (PPEC) or Department Chairs may initiate Focused Professional Practice Evaluation (FPPE). The FPPE Policy describes the process and procedures to be followed.

8.1-3 EXTERNAL PEER REVIEW

External peer review may be used to inform medical staff peer review as delineated under these bylaws. The Credentials Committee or the Medical Executive Committee, upon request from a Department or upon its own motion, in evaluating or investigating an applicant, privileges holder, or member, shall obtain external peer review in the following circumstances:

(a) Committee or department review(s) that could affect an individual's membership or privileges do not provide a sufficiently clear basis for action;
(b) No current Medical Staff member can provide the necessary expertise in the clinical procedure or area under review;
(c) to promote impartial peer review;
(d) Upon the request of the practitioner.

8.1-4 INVESTIGATION

Upon receipt, the Medical Executive Committee may act on the proposal or direct that an investigation be undertaken. The Medical Executive Committee may conduct that investigation itself or may assign this task to an appropriately charged officer or to a standing or ad hoc medical staff committee. No such investigation process shall be deemed to be a “hearing” as that term is used in Article IX.

If the investigation is delegated to an officer or committee other than the Medical Executive Committee, such officer or committee shall forward a written report of the investigation to the Medical Executive Committee as soon as is practicable after the assignment to investigate has been made. The Medical Executive Committee may at any time within its discretion, and shall at the request of the governing board, terminate the investigative process and proceed with action as provided in Section 8.1- 5 below.

8.1-5 MEDICAL EXECUTIVE COMMITTEE ACTION

As soon as is practicable after the conclusion of the investigative process, if any, but in any event within sixty (60) days after the initiation of proposed corrective action, unless deferred pursuant to Section 8.16, the Medical Executive Committee shall act thereon. Such action may include, without limitation, the following actions or recommendations:

(a) Determine no corrective action to be taken, and if the Medical Executive Committee determines there was no credible evidence for the complaint in the first instance, removing any adverse information from the member's file.

(b) Refer the member to the Physician Well-Being Committee for evaluation and follow-up as appropriate.

(c) Issue letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude clinical department chairs from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected member may make a written response which shall be placed in the member's file.

(d) Recommend the imposition of terms of probation or special limitation upon continued medical staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admission, mandatory consultation, or monitoring.

(e) Recommend reductions of membership status or limitation of any prerogatives directly related to the member's delivery of patient care.

(f) Recommend suspension, revocation or probation of medical staff membership.

(g) Take other actions deemed appropriate under the circumstances.

Nothing set forth herein shall inhibit the Medical Executive Committee from implementing summary suspension at any time, in the exercise of its discretion pursuant to Section 8.2. (Summary Restriction or Suspension)

8.1-6 DEFERRAL

If additional time is needed to complete the investigative process, the Medical Executive Committee may defer action on the request, and it shall so notify the affected practitioner. A subsequent recommendation for any one or more of the actions provided in Section 8.1 5, Paragraphs (a) through (g) above must be made within the time specified by the Medical Executive Committee, and if no such time is specified, then within thirty (30) days of the deferral.

8.1-7 PROCEDURAL RIGHTS

Any recommendation by the Medical Executive Committee pursuant to Section 8.1-5 which constitutes grounds for a hearing as set forth in Section 9.2 shall entitle the practitioner to the procedural rights as provided in Article IX. In such cases, the chief of medical staff shall give the practitioner written notice of the adverse recommendation and of the right to request a hearing in the manner specified in Section 9.3 2.

8.1-8 OTHER ACTION

(a) If the Medical Executive Committee's recommended action is to recommend no corrective action, such recommendation, together with such supporting documentation as may be required by the Governing Board, shall be transmitted thereto. Thereafter, the procedure to be followed shall be the same as that provided for applicants in Sections 6.3-9 (Action by the Governing Board) and 6.3-10 (Notice of Final Decision), as applicable.

(b) If the Medical Executive Committee's recommended action is an admonition, reprimand, or warning to a practitioner, it shall, at the practitioner's request, grant the applicant an interview. Following the interview, if one is requested, if the Medical Executive Committee's final recommendation to the Hospital Director is an admonition, reprimand, or warning this shall conclude the matter when approved by the governing board without substantial modification, and notice of the final decision shall be given to the Governing Board, Hospital Director, Medical Executive Committee, the chair and vice chair of each department concerned, and the practitioner.

(c) If any proposed corrective action by the Governing Board will substantially modify the Medical Executive Committee's recommendation, the governing board may submit the matter to the Joint Conference Committee for review and recommendation before making its decision final. Any recommendation of the governing board which constitutes grounds for a hearing, as set forth in Section 9.2, shall entitle the practitioner to the procedural rights as provided in Article IX. In such cases, the governing board shall give the practitioner written notice of the tentative adverse recommendation and of the right to request a hearing in the manner specified in Section 9.3 2.

(d) Should the Governing Board determine that the Medical Executive Committee's failure to investigate, or initiate disciplinary action, is contrary to the weight of the evidence, the Governing Board may direct the Medical Executive Committee to initiate an investigation or a disciplinary action, but only after consultation with the Medical Executive Committee. In the event the Medical Executive Committee fails to take action in response to a direction from the Governing Board, the Governing Board, after notifying the Medical Executive Committee in writing, may take action on its own initiative. If such action is favorable to the practitioner, or constitutes an admonition, reprimand or warning to the practitioner, it shall become effective as the

final decision of the Governing Board. If such action is one of those set forth in Section 9.2, the Governing Board shall give the practitioner written notice of the adverse recommendation and of the right to request a hearing in the manner specified in Section 9.3 2 and the rights shall be as provided in Article IX.

8.2 SUMMARY RESTRICTION OR SUSPENSION

8.2-1 CRITERIA FOR INITIATION

Whenever a member's conduct appears to require that immediate action be taken to protect the life or well-being of patient(s) or to reduce a substantial and imminent likelihood of significant impairment of the life, health, safety of any patient, prospective patient, or other person, the medical director, the Medical Executive Committee, or the chair of department or designee in which the member holds privileges may summarily restrict or suspend the medical staff membership or clinical privileges of such member. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the person or body responsible shall promptly give written notice to the Governing Board, the Medical Executive Committee and the Hospital Director. In addition, the affected medical staff member shall be provided with a written notice of the action which notice fully complies with the requirement of Section 8.2-2 below. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the member's patients shall be promptly assigned to another member by the department chair or by the medical director, considering where feasible, the wishes of the patient in the choice of a substitute member.

8.2-2 WRITTEN NOTICE OF SUMMARY SUSPENSION

Within one (1) working day of imposition of a summary suspension, the affected medical staff member shall be provided with written notice of such suspension. This initial written notice shall include a statement of facts demonstrating that the suspension was necessary because failure to suspend or restrict the practitioner's privileges summarily could reasonably result in an imminent danger to the health of an individual. The statement of facts provided in this initial notice shall also include a summary of one or more particular incidents giving rise to the assessment of imminent danger. This initial notice shall not substitute for, but is in addition to, the notice required under Section 9.3-1 (which applies in all cases where the MEC does not immediately terminate the summary suspension). The notice under Section 9.3-1 may supplement the initial notice provided under this section, by including any additional relevant facts supporting the need for summary suspension or other corrective action.

8.2-3 MEDICAL EXECUTIVE COMMITTEE ACTION

Within one (1) week after such summary restriction or suspension has been imposed, a meeting of the Medical Executive Committee (or a subcommittee appointed by the chief of medical staff) shall be convened to review and consider the action. Upon request, the member may attend and make a statement concerning the issues under investigation, on such terms and conditions as the Medical Executive Committee may impose, although in no event shall any meeting of the Medical Executive Committee, with or without the member, constitute a "hearing" within the meaning of Article IX, nor shall any procedural rules apply. The Medical Executive Committee may modify, continue, or terminate the summary restriction or suspension, but in any event it shall furnish the member with notice of its decision within two (2) working days of the meeting.

8.2-4 PROCEDURAL RIGHTS

Unless the Medical Executive Committee terminates the summary restriction or suspension, within 14 days the member shall be entitled to the procedural rights afforded by Article IX. In addition, the affected practitioner shall have the following rights:

(a) Any affected practitioner shall have the right to challenge imposition of the summary suspension, particularly on the issue of whether or not the facts stated in the notice present a reasonable possibility of "imminent danger" to an individual. Initially, the practitioner may present this challenge to the Medical Executive Committee at the meeting held within one (1) week of imposition of the suspension. If the MEC's decision is to continue the summary suspension, beyond 14 days, then any practitioner who has properly requested a hearing under the medical staff bylaws may request that the hearing be bifurcated, with the first part of the hearing being devoted exclusively to procedural matters, including the propriety of summary suspension.

(b) At the conclusion of the procedural portion of the hearing, the hearing officer (or hearing panel) shall issue a written opinion on the issues raised, including whether or not the facts stated in the written notice to the affected practitioner adequately support a determination that failure to summarily restrict or suspend could reasonably result in "imminent danger" to an individual. Such written opinion shall be transmitted to both the affected practitioner and the Medical Executive Committee within one (1) week of the date of the procedural hearing.

(c) If the hearing officer's (or hearing panel's) determination is that the facts stated in the notice required by Section 8.2-2 do not support a reasonable determination that failure to summarily restrict or suspend the practitioner's privileges could result in imminent danger, the summary suspension shall be immediately stayed pending the outcome of the hearing and any appeal.

(d) If the hearing officer (or hearing panel) determines that the facts stated in the notice required by Section 8.2-2 support a reasonable determination that summary

suspension was necessary to avoid imminent danger to an individual, the summary suspension shall remain in effect pending conclusion of the hearing and any appellate review.

8.2-5 INITIATION BY THE GOVERNING BOARD

If the medical director, members of the Medical Executive Committee and the chair of the department (or designee) in which the member holds privileges are not available to summarily restrict or suspend the member's membership or clinical privileges, the governing board (or designee) may immediately suspend a member's privileges if a failure to suspend those privileges is likely to result in an imminent danger to the health of any patient, prospective patient, or other person, provided that the governing board (or designee) made reasonable attempts to contact the medical director, members of the Medical Executive Committee and the chair of the department (or designee) before the suspension. Such a suspension is subject to ratification by the Medical Executive Committee. If the Medical Executive Committee does not ratify such a summary suspension within two (2) working days, excluding weekends and holidays, the summary suspension shall terminate automatically. If the Medical Executive Committee does ratify the summary suspension, all other provision under Section 8.2 of these bylaws will apply. In this event, the date of imposition of the summary suspension shall be considered to be the date of ratification by the Medical Executive Committee for purposes of compliance with notice and hearing requirements.

8.3 AUTOMATIC AND IMMEDIATE SUSPENSION OR LIMITATION

In the following instances, the member's privileges or membership may be immediately suspended or limited as described, and all patient care activity shall immediately cease, if requested, shall be limited to the question of whether the grounds for automatic suspension or limitation as set forth below have occurred.

8.3-1 LICENSURE

(a) **Revocation and Suspension**: Whenever a member's license or other legal credential authorizing practice in this state is revoked or suspended, medical staff membership and clinical privileges shall be automatically revoked as of the date such action becomes effective.

(b) **Restriction**: Whenever 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 clinical privileges that the member has been granted at the hospital, which are within the scope of said 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**: Whenever a member is placed on probation by the applicable licensing or certifying authority, the member's membership status and clinical privileges shall

automatically become subject to the same terms and conditions of the probation, as of the date such action becomes effective and throughout its term.

(d) Expiration of License will be as communicated by the Medical Board of California and will result in immediate suspension, and if within (30) days after written warning of delinquency the member does not renew required license, the member's membership shall be automatically terminated

8.3-2 BOARD ELIGIBILITY/CERTIFICATION

(e) Expiration of board eligibility/certification will be as communicated by the ABMS and if within (30) days after written warning of delinquency the member does not present to the Credentialing Committee a resolution, the member's membership shall be automatically terminated.

8.3-3 CONTROLLED SUBSTANCES

(a) **Revocation, Limitation, Suspension**: Whenever a member's Drug Enforcement Administration (DEA) certificate is revoked, limited or suspended, 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:** Whenever a member's DEA certificate is subject to probation, the member's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

8.3-4 FAILURE TO SATISFY SPECIAL APPEARANCE REQUIREMENT

Failure of a member without good cause to appear and satisfy the requirements of Section 13.7-3 shall be a basis for corrective action.

8.3-5 MEDICAL RECORDS

Members of the medical staff are required to complete medical records within such reasonable time as may be prescribed in the Medical Staff Rules and Regulations. A limited suspension in the form of withdrawal of admitting and other related privileges until medical records are completed, shall be imposed by the Chief of Staff, Chief Medical Officer, or designee, after notice of delinquency for failure to complete medical records within such period. For the purpose of this Section, "related privileges" means scheduling surgery, assisting in surgery, consulting on hospital cases, and providing professional services at the hospital for future patients. Bona fide vacation or illness may constitute an excuse subject to approval by the Medical Executive Committee. Members whose privileges have been suspended for delinquent records may admit patients only in life-threatening situations. The suspension shall continue until lifted by the Chief of Staff, Chief Medical Officer, or designee.

8.3-6 FAILURE TO PAY DUES/ASSESSMENTS

Failure without good cause, as determined by the Medical Executive Committee, to pay fees, dues or assessments as required under Section 15.4 shall be grounds for automatic suspension of a member's clinical privileges, and if within thirty (30) days after written warning of delinquency the member does not pay the required dues or assessments, the member's membership shall be automatically terminated.

8.3-7 EXECUTIVE COMMITTEE DELIBERATION

As soon as practicable after action is taken or warranted as described in Section 8.3-1 (b) or (c), Section 8.3-2, 8.3-3, or 8.3-4, the Medical Executive Committee shall convene to review and consider the facts and may recommend such further corrective action as it may deem appropriate following the procedure generally set forth commencing at Section 9.3-1.

8.3-8 PROFESSIONAL LIABILITY INSURANCE

Failure to maintain professional liability insurance, if any is required, shall be grounds for automatic suspension of a member's clinical privileges, and if within thirty (30) days after written warnings of the delinquency the member does not provide evidence of required professional liability insurance, the member's membership shall be automatically terminated.

8.3-9 X-Ray Operator and Supervisor Certificates and Permits

Whenever a practitioner's X-ray Operator and Supervisor Certificate or permit is revoked, restricted, suspended or expired, the action and its terms shall automatically apply to the practitioner's clinical privileges to:

1) Actuate or energize X-ray equipment.
2) Directly control radiation exposure to the patient during X-ray procedures.
3) Supervise one or more persons who hold an appropriate certificate or permit.
4) Supervise students in an approved school when the student is operating Xray equipment.

8.3-10 Notification of Automatic Suspension and Reassignment of Patients

Upon the occurrence of an event which gives rise to automatic suspension or voluntary resignation from the Medical Staff, following such automatic suspension, as set forth in Article VIII, or as soon thereafter as reasonably practical, Medical Staff Services shall notify the practitioner, the Chair of the Department under which they serve, the Chief of Medical Staff, and the Chief Medical Officer of the resultant automatic suspension. Written confirmation of such automatic suspension shall be sent to the practitioner by email. Written confirmation of termination shall be sent to the practitioner by certified mail, return receipt requested, postage prepaid. In the event of any such automatic suspension, the practitioner's patients whose treatment by the affected practitioner is terminated by the automatic suspension shall be assigned to another practitioner by the appropriate Chief of Service, Department Chair or by the Chief of Medical Staff. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner.

ARTICLE IX – FAIR HEARINGS

9.1 GENERAL PROVISIONS

Review Philosophy

The intent in adopting these hearing and appellate review procedures is to provide for a fair review of decisions that adversely affect practitioners (as defined below), and at the same time to protect the peer review participants from liability. It is further the intent to establish flexible procedures which do not create burdens that will discourage the Medical Staff and Governing Body from carrying out peer review.

Accordingly, the intent of the Medical Staff and Governing Body is to create a hearing process which provides for the least burdensome level of formality in the process and yet still provides a fair hearing and to interpret these Bylaws in that light. Technical, insignificant or nonprejudicial deviations from the procedures set forth in these Bylaws shall not be grounds for invalidating the action taken.

The Medical Staff, the Governing Body, and their officers, committees and agents hereby constitute themselves as peer review bodies under the federal Health Care Quality Improvement Act of 1986 and the California peer review hearing laws and claim all privileges and immunities afforded by the federal and state laws.

9.1-1 EXHAUSTION OF REMEDIES

If adverse action described in Section 9.2 (Grounds for Hearing) is taken or recommended, the applicant or member must exhaust the procedures under this Article before resorting to legal action.

9.1-2 APPLICATION OF ARTICLE

For the purposes of this Article, the term “member” may include “applicant,” as it may be applicable under the circumstances, unless otherwise stated.

9.1-3 TIMELY COMPLETION OF PROCESS

The hearing and appeal process shall be completed within a reasonable time.

9.1-4 FINAL ACTION

Recommended adverse actions described in Section 9.2 shall become final only after the hearing and appellate rights set forth in these bylaws have either been exhausted or waived.

9.2 GROUNDS FOR HEARING

Except as otherwise specified in these bylaws, any one or more of the following actions or recommended actions shall be deemed actual or potential adverse action and constitute grounds for a hearing:

(a) denial of initial or reappointment applications for medical staff membership;
(b) denial of requested advancement in staff membership status, or category;
(c) involuntary change in medical staff category or membership status;
(d) suspension of medical staff membership;
(e) revocation of medical staff membership;
(f) denial of requested clinical privileges;
(g) involuntary restriction of clinical privileges;
(h) suspension of all clinical privileges;
(i) termination of all clinical privileges;
(j) involuntary imposition of significant consultation or monitoring requirements (excluding monitoring incidental to provisional status and Section 3.8) that cannot be completed prior to the time frame required for reporting the restriction to the Medical Board of California; or
(k) any other action which requires a report to be made to the Medical Board of California under the provision of Section 805 of the California Business and Professions Code.

9.3 REQUESTS FOR FAIR HEARING

9.3-1 NOTICE OF ACTION OR PROPOSED ACTION

In all cases in which action has been taken or a recommendation made as set forth in Section 9.2, said person or body shall give the member prompt written notice of:

(a) the recommendation or final proposed action and that such action, if adopted, shall be reported to the Medical Board of California pursuant to Section 805 of the California Business and Professions Code and to the National Practitioner Data Bank, , if required;
(b) the reasons for the proposed action including the acts or omissions with which the member is charged; the right to request a hearing pursuant to Section 9.3-2, and that such hearing must be requested within thirty (30) days; and
(c) that that the hearing will be conducted pursuant to these medical staff bylaws.
(d) the member's right to be represented by legal counsel at the hearing proceedings;
(e) that the Medical Staff will be represented by legal counsel at the hearing proceedings.

9.3-2 REQUEST FOR FAIR HEARING

The member shall have thirty (30) days following receipt of notice of such action to request a hearing. The request shall be in writing addressed to the Medical Executive Committee with a copy to the Governing Board. The request shall include the identity of any legal counsel that will represent the member at the hearing proceedings. In the event the member does not request a hearing within the time and in the manner described, the member shall be deemed to have waived any right to a hearing and accepted the recommendations or actions involved and, thereupon, said recommendations or actions shall be forwarded to the Governing Board.

9.3-3 TIME AND PLACE FOR FAIR HEARING

Upon receipt of a request for hearing, the Medical Executive Committee shall schedule a hearing and give notice to the member of the time, place, and date of the hearing;

9.3-4 NOTICE OF HEARING CONTENTS

Together with the notice stating the place, time and date of the hearing unless waived by a member under summary suspension, the Medical Executive Committee shall provide a list of the charts in question, where applicable, and a list of the witnesses (if any) expected to testify at the hearing on behalf of the Medical Executive Committee. The content of this list is subject to update pursuant to Section 9.4-1.

9.3-5 FAIR HEARING ARBITRATOR

When a hearing is requested, the Medical Executive Committee shall recommend a qualified Arbitrator to the governing board for appointment. The identity of the proposed arbitrator shall be disclosed the member along with a stated time within which the member may raise objections, if any, in writing as to the qualifications and independence of the arbitrator to the Medical Executive Committee. The governing board shall be deemed to approve the selection unless it provides written notice to the Medical Executive Committee stating the reasons for its objections within five (5) days.

The arbitrator shall be an attorney at law qualified to preside over a quasi-judicial hearing, but attorneys from a firm regularly utilized by the hospital, the medical staff or the involved medical staff member or applicant for membership, for legal advice regarding their affairs and activities shall not be eligible to serve arbitrator. The arbitrator shall gain no direct financial benefit from the outcome and must not act as a prosecuting officer or as an advocate. The arbitrator shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The arbitrator shall be entitled to determine the order of, or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence.
If the arbitrator determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the arbitrator may take such discretionary action as seems warranted by the circumstances. At the conclusion of the hearing the arbitrator will present to the Medical Executive Committee proposed findings of fact and conclusions of law related to all matters raised in the hearing.

9.3-6 FAILURE TO APPEAR OR PROCEED

Failure of the member to personally attend and proceed at a hearing in an efficient and orderly manner shall be deemed to constitute voluntary acceptance of the recommendations or actions involved.

9.3-7 POSTPONEMENTS AND EXTENSIONS

Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these bylaws and set forth in any Order by the Arbitrator may be permitted by the Arbitrator on a showing of good cause

9.4 HEARING PROCEDURE

9.4-1 PREHEARING PROCEDURE

(a) The appointed Arbitrator shall enter one or more prehearing orders including specific deadlines addressing the matters covered in this section, after providing an opportunity for hearing the parties or their representatives.

(b) If either side to the hearing requests in writing a list of witnesses, of such request, each party shall furnish to the other a written list of the names and addresses of the individuals, so far as is reasonably known or anticipated, who are anticipated to give testimony or evidence in support of that party at the hearing.

(c) The member shall have the right to inspect and copy documents or other evidence upon which the charges are based, and shall also have the right to receive, to the hearing, a copy of the evidence forming the basis of the charges, including all evidence which was considered by the Medical Executive Committee in determining whether to proceed with the adverse action, and any exculpatory evidence in the possession of the hospital or medical staff.

(c) The Medical Executive Committee shall have the right to inspect and copy at its expense any documents or other evidence relevant to the charges which the member has in his or her possession or control.

(d) The failure by either party to provide access to this information before the hearing shall constitute good cause for a continuance. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable members, other than the members under review.

(e) **Objections to Introduction of Evidence Previously Not Produced for the Medical Staff.** The Medical Executive Committee may object to the introduction of the evidence that was not provided during an appointment, reappointment or privilege application review or during corrective action despite the requests of the peer review body for such information. The information will be barred from the hearing by the Arbitrator unless the practitioner can prove he or she previously acted diligently and could not have submitted the information.

(f) The Arbitrator shall establish a schedule for the exchange of lists of witnesses, the inspection and copying of documents or other information; The Arbitrator shall consider and rule upon any objection to production of requested information and may impose any safeguards the protection of the peer review process and justice requires. In so doing, the Arbitrator shall consider:

(i) whether the information sought may be introduced to support or defend the charges.
(ii) the exculpatory or inculpatory nature of the information sought, if any.
(iii) the burden imposed on the party in possession of the information sought, if access is granted; and
(iv) any previous requests for access to information submitted or resisted by the parties to the same proceeding.

(g) Before the hearing, the member shall be entitled to a reasonable opportunity to question and challenge the impartiality of Arbitrator. Challenges to the impartiality of a Arbitrator shall be submitted in writing and decided by the Governing Board

(h) It shall be the duty of the member and the Medical Executive Committee or its designee to

exercise reasonable diligence in notifying the Arbitrator of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be succinctly made at the hearing.

9.4-2 REPRESENTATION

The hearings provided for in these bylaws are for the purpose of intra-professional resolution of matters bearing on professional conduct, professional competency, or character.

The member shall be entitled to representation by legal counsel in any phase of the hearing, should the member so choose. Instead of legal counsel, the member shall be entitled to be accompanied by and represented at the hearing by an individual, who is not an attorney, of the member's choosing, and the Medical Executive Committee shall appoint a representative, who is not an attorney, to present its action or recommendation, the materials in support thereof, examine witnesses, and respond to appropriate questions.

9.4-3 RECORD OF THE HEARING

A record of the hearing proceedings and any pre-hearing proceedings shall be created if deemed appropriate by the Arbitrator or requested by either party. The cost of the transcript, if any, shall be borne by the party requesting it. The Arbitrator may, but shall not be required to, order that oral evidence shall be taken only on oath administered by any person lawfully authorized to administer such oath.

9.4-4 RIGHTS OF THE PARTIES

Within reasonable limitations, both sides at the hearing may call and examine witnesses for relevant testimony, introduce relevant exhibits or other documents, cross-examine or impeach witnesses who shall have testified orally on any matter relevant to the issues, and otherwise rebut evidence, as long as these rights are exercised in an efficient and expeditious manner. The member may be called as a witness by the Medical Executive Committee and examined as if under cross- examination.

In addition, the affected practitioner who has been summarily suspended shall have the following rights:

(a) Any affected practitioner shall have the right to challenge imposition of the summary suspension, particularly on the issue of whether the facts stated in the notice present a reasonable possibility of "imminent danger" to an individual. Initially, the practitioner may present this challenge to the Medical Executive Committee at the meeting held within one (1) week of imposition of the suspension. If the MEC's decision is to continue the summary suspension, beyond 14 days, then any practitioner who has properly requested a hearing under the medical staff bylaws may request that the hearing be bifurcated, with the first part of the hearing being devoted exclusively to procedural matters, including the propriety of summary suspension.

(b) At the conclusion of the procedural portion of the hearing, the Arbitrator shall issue a written opinion on the issues raised, including whether the facts stated in the written notice to the affected practitioner adequately support a determination that failure to summarily restrict or suspend could reasonably result in "imminent danger" to an individual. Such written opinion shall be transmitted to both the affected practitioner and the Medical Executive Committee within one (1) week of the date of the procedural hearing.

(c) If the Arbitrator's determination is that the facts stated in the notice required by Section 8.2-2 do not support a reasonable determination that failure to summarily restrict or suspend the practitioner's privileges could result in imminent danger, the summary suspension shall be immediately stayed pending the outcome of the hearing and any appeal.

If the Arbitrator determines that the facts stated in the notice required by Section 8.2-2 support a reasonable determination that summary suspension was necessary to avoid imminent danger to an individual, the summary suspension shall remain in effect pending conclusion of the hearing and any appellate review

9.4-5 MISCELLANEOUS RULES

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under this Article. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to relying in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The Arbitrator may interrogate the witnesses or call additional witnesses if it deems such action appropriate. At its discretion, the Arbitrator may request or permit both sides to file written arguments.

9.4-6 BURDENS OF PRESENTING EVIDENCE AND PROOF

(a) At the hearing, the Medical Executive Committee shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. The member shall be obligated to present evidence in response.

(b) An applicant shall bear the burden of persuading the Arbitrator, by a preponderance of the evidence, of the applicant's qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning current qualifications for membership and privileges. An applicant shall not be permitted to introduce information requested by the medical staff, which was not produced during the application process, unless the applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

(c) Except as provided above for applicants, throughout the hearing, the Medical Executive Committee shall bear the burden of persuading the Arbitrator, by a preponderance of the evidence, that its action or recommendation is reasonable and warranted.

9.4-7 ADJOURNMENT AND CONCLUSION

After consultation with the parties, the Arbitrator may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted, with due consideration for reaching an expeditious conclusion to the hearing. . Upon conclusion of the presentation of oral and written evidence, or the receipt of closing arguments, if submitted, the

hearing shall be closed.

9.4-8 BASIS FOR DECISION

The decision of the Medical Executive Committee shall be based on the evidence introduced at the hearing, including logical and reasonable inferences from the evidence and the testimony. The decision of the Medical Executive Committee shall be subject to such rights of appeal as described in these bylaws but shall otherwise be affirmed by the governing board as the final action if it is supported by substantial evidence, arrived at by following a fair procedure.

9.4-9 DECISION OF THE MEDICAL EXECUTIVE COMMITTEE

Within thirty (30) days after final adjournment of the hearing, the Arbitrator shall render a report in writing of his / her findings of fact and proposed conclusions of law regarding the matters heard to the Medical Executive Committee. . A copy of said report also shall be forwarded to the hospital director, the governing board and to the member. The report shall contain a concise statement of the findings of fact and a proposed conclusion(s) articulating the connection between the evidence produced at the hearing and the conclusion reached. If the final proposed action adversely affects the clinical privileges of a physician or dentist for a period longer than thirty (30) days and is based on competence or professional conduct, the decision shall state that the action if adopted will be reported to the National Practitioner Data Bank and shall state the text of the report proposed by the Arbitrator. The Medical Executive Committee shall then meet to consider whether to adopt the findings of fact and related conclusions and the effect of the report on the original decision reached by the MEC. The MEC may also, upon review, request that the hearing be reopened, and additional findings be made by the Arbitrator upon matters not addressed in the original report. The member may provide the Medical Executive Committee and the Governing Board with a written response to the report and the final action recommended by the MEC.

9.5 EXCEPTIONS TO HEARING RIGHTS

9.5-1 MEDICO ADMINISTRATIVE OFFICER

The fair hearing rights of Articles VIII and IX do not apply to those persons serving the hospital in a medico administrative capacity. Removal from office of such persons shall instead be governed by the terms of their individual contracts and agreements with the hospital or Riverside County Ordinance 440 where applicable. However, the hearing rights of the preceding sections of this Article IX and of Article VIII shall apply to the extent that medical staff membership status or clinical privileges, which are independent of the practitioner's contract, are also removed or suspended, unless the contract includes a specific provision establishing alternative procedural rights applicable to such decisions.

9.5-2 FAIR HEARING AND APPEALS FOR ALLIED HEALTH PRACTITIONERS (AHPs)

AHPs are not entitled to the hearing and appeals procedures set forth in the medical staff bylaws. In the event one of these practitioners receives notice of a recommendation by the Medical Executive Committee that will adversely affect his/her exercise of clinical privileges, the practitioner and his/her supervising physician shall have the right to meet personally with two physicians and a peer assigned by the Chief of Staff to discuss the recommendation. The

practitioner and the supervising physician must request such a meeting in writing to the Medical Staff Office within 10 working days from the date of receipt of such notice. At the meeting, the practitioner and the supervising physician must be present to discuss, explain, or refute the recommendation, but such meeting shall not constitute a hearing and none of the procedural rules set forth in this Article lX of the medical staff bylaws with respect to hearings shall apply. Findings from this review body will be forwarded to the affected practitioner, the Medical Director and the Medical Executive Committee

The practitioner and the supervising physician may request an appeal in writing to the Medical Staff Office within 10 days of receipt of the findings of the review body. Two members of the Medical Executive Committee assigned by the President of the Medical Staff shall hear the appeal from the practitioner and the supervising physician. A representative from the medical staff leadership may be present. The decision of the appeal body will be forwarded to the Board for final decision. The practitioner and the supervising physician will be notified within 10 days of the final decision of the Board.

9.5-3 AHP AUTOMATIC SUSPENSION, LIMITATION OF PRACTICE PRIVILEGES, OR TERMINATION

In the following instances, the allied health professional privileges may be immediately suspended or limited as described, and all patient care activity shall immediately cease, if requested, shall be limited to the question of whether the grounds for automatic suspension as set forth below have occurred.

(a) The medical staff membership of the supervising physician, if any, is terminated, whether such termination is voluntary or involuntary.

(b) The supervising physician, if any, no longer agrees to act as the supervising physician, for any reason, or the relationship between the AHP and the supervising physician, if any, is otherwise terminated, regardless of the reason, therefore. If within thirty (30) days after written warnings of the "Failure to Secure a New Supervising Physician" and the AHP does not provide evidence of required supervising physician, the AHP's clinical privileges shall be automatically terminated.

(c) The AHP's certification or license expires, is revoked or suspended. If within thirty (30) days after written warnings of the AHP's suspension the AHP fails to renew certification or license and the AHP does not provide evidence of renewal, the AHP's clinical privileges shall be automatically terminated.

The AHP's board certification expires, is revoked or suspended. If within (30) days after written warning of delinquency the member does not present to the Credentialing Committee a resolution, the member's membership shall be automatically terminated

9.5 4 AUTOMATIC SUSPENSION OR LIMITATION OF PRACTICE PRIVILEGES

No hearing is required when a member's license or legal credential to practice has been revoked or suspended as set forth in Section 8.3-1 (a). In other cases described in Section 8.3-1 and 8.3-2, the issues which may be considered at a hearing, if requested, shall not include evidence designed to show that the determination by the licensing or credentialing authority of the DEA was unwarranted, but only whether the member may continue practice in the hospital with those limitations imposed.

ARTICLE X - CLINICAL DEPARTMENTS AND DIVISIONS

10.1 ORGANIZATION OF DEPARTMENTS AND DIVISIONS

The medical staff shall be organized into clinical departments. Each department shall be organized as a separate component of the medical staff and shall have a department chair selected and entrusted with authority, duties and responsibilities as specified in Section 11.3; and a department vice chair elected and entrusted with the authority, duties and responsibilities as specified in Section 11.4. A department may be further divided, as appropriate, into divisions which shall be directly responsible to the department within which it functions and shall have a division chair selected and entrusted with the authority, duties and responsibilities specified in Section 11.5. The clinical department or division may meet separately or jointly.

10.2 DESIGNATION

The departments and divisions are:

(a) Anesthesiology
(b) Emergency Medicine
(c) Family Medicine
(d) Medicine with Divisions of General Internal Medicine, Cardiology, Gastroenterology, Geriatrics, Hematology/Oncology, Nephrology, Neurology, Pulmonary & Critical Care Services, Inpatient Medicine Services, and Ambulatory Care Services with subdivisions of Dermatology, Endocrinology, Infectious Disease, and Rheumatology, Palliative Care.
(e) Clinical Neurological Sciences (Neurological Surgery)
(f) Obstetrics and Gynecology
(g) Ophthalmology
(h) Orthopaedic Surgery and Rehabilitation and Divisions of Spine Surgery and Podiatry
(i) Pathology, including Clinical Laboratory
(j) Pediatrics with Division of Neonatology and Division of Critical Care
(k) Psychiatry
(l) Radiology, including Diagnostic, Therapeutic, Nuclear Medicine, and Neuroradiology
(m) Surgery with Divisions of General Surgery/Trauma/ Acute Care, Thoracic Surgery, Vascular Surgery, Plastic Surgery, Oral & Maxillofacial Surgery, Head, Neck Surgery & Otolaryngology, Urology, Pediatric Surgery, Surgical Oncology

10.3 DEPARTMENT/DIVISION FORMATION OR ELIMINATION

A medical staff department/division can be formed or eliminated only following a determination by the medical staff of appropriateness of department/division elimination or formation. The governing board decision shall uphold the medical staff's determination unless the governing board makes specific written findings that the medical staff's determination is arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law.

The medical staff shall determine the formation or elimination of a department/division to be appropriate based upon consideration of its effects on quality of care in the facility and/or community. A determination of the appropriateness of formation or elimination of a department/division must be based upon the preponderance of the evidence, viewing the record as a whole, presented by any and all interested parties, following notice and opportunity for comment.

10.4 ASSIGNMENT TO DEPARTMENTS AND DIVISIONS

A member shall be assigned membership in at least one department or division, as applicable, and may also be granted membership and/or clinical privileges in other departments or divisions consistent with the practice privileges that have been granted. The exercise of clinical privileges in any department is subject to the rules and regulations of that department and to the authority of the relevant department chair and vice chair

10.4 FUNCTIONS OF DEPARTMENTS

The primary responsibility delegated to the department is to implement and conduct specific review and evaluation activities that contribute to the preservation and improvement of the quality and appropriateness of patient care provided in the department.

To carry out this responsibility the department shall:

(a) Conduct patient care reviews to analyze and evaluate the quality of care and appropriateness of treatment provided to patients within the department. The number of such reviews conducted during the year shall be reviewed by the Medical Executive Committee and shall be conducted in accordance with such procedures as may be adopted by the Professional Practice Evaluation Committee. Patient care reviews shall include all clinical work performed under the jurisdiction of the department, regardless of whether the member whose work subject to review is a member of that department. The criteria to be used in these reviews shall be objective and reflect current knowledge and clinical experience. The department shall also identify actions that should be taken in order to resolve identified problems in patient care and clinical performance and evaluate the effectiveness of actions which have been taken in resolving such problems.

(b) Submit written reports to the Medical Executive Committee concerning:
   (1) The department's review, monitoring and evaluation activities, actions taken thereon, and the result of such action taken.
   (2) Recommendations for maintaining and improving the quality of care provided in the department and the hospital.

(c) Meet at least quarterly to receive, review, and consider patient care review findings and the results of other department's review, evaluation, and monitoring activities, as well as reports about other departments and staff functions.

(d) Conduct, participate, and make recommendations regarding continuing education programs pertinent to the department's clinical practice, changes in state of the art, and findings of review, evaluation and monitoring activities.

(e) Review, evaluate and monitor on a continuous and concurrent basis, the department's adherence to:
   (1) Medical staff and hospital policies and procedures.
   (2) Requirements for alternate coverage and for consultations.
   (3) Sound principles of clinical practice.
   (4) Fire and other regulations designed to promote patient safety.

(f) Coordinate patient care provided by the department members with nursing and ancillary patient care services and administrative support services.

(g) Establish such committees or other mechanisms as necessary and desirable to perform properly the functions assigned to it, including clinical privileges and proctoring protocols.

(h) Formulate recommendations for departmental rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to the approval of the Medical Executive Committee

10.5 FUNCTIONS OF DIVISIONS/SUBDIVISIONS

Subject to approval of the Medical Executive Committee, the division/subdivision shall perform the functions assigned to it by the department chair. Such functions may include, without limitation, retrospective patient care reviews, continuous evaluation and monitoring of patient care practices, credentials review and privileges delineation, peer reviews, and continuing education programs.

The division/subdivision shall systematically transmit quality assessment/improvement reports and other pertinent reports to the department chair on the conduct of its assigned functions. The department shall specify the timetable for quality assessment/improvement reports in its departmental rules and regulations. Quality assessment/ improvement reports shall be submitted at least annually.

10.6 MODIFICATIONS IN CLINICAL ORGANIZATION UNIT

When deemed appropriate, the Medical Executive Committee may create, eliminate, subdivide, further subdivide, or combine departments, divisions and/or subdivisions as follows:

(a) Creation of a Division or Subdivision:
   (i) A sufficient number of practitioners are available for appointment to, and will be appointed to, and/or actively participate in the new organizational component to enable accomplishment of the functions generally assigned to such components in these bylaws, and relevant rules and regulations adopted pursuant hereto; and,
   (ii) the patient or service activity to be associated with the new component is substantial enough to impose on its members the responsibility to accomplish those functions.

(b) Elimination: The number of members available is no longer adequate, and will not be so in the foreseeable future, to accomplish assigned functions, or when the patient or service activity associated with the component to be dissolved is no longer substantial enough to warrant the responsibility imposed on members of each division/subdivision to accomplish those functions.

(c) Combination: The union of the two or more organizational components will result in more effective and efficient accomplishment of assigned functions and the patient or service activity to be associated with the combination is substantial enough, without being unwieldy, to warrant the responsibility imposed on the members of such combined components to accomplish those assigned functions.

In all instances of modification, the hospital's written plan of development, as currently being implemented, and any constraints or mandates imposed by external planning authorities, shall also be considered.

ARTICLE XI - OFFICERS

11.1 GENERAL OFFICERS OF THE MEDICAL STAFF

11.1-1 IDENTIFICATION

The general officers of the medical staff shall be the chief of medical staff, the chief of medical staff elect, the immediate past chief of medical staff, the secretary treasurer, and the medical director.

11.1-2 QUALIFICATIONS

General officers must be members of the active staff category at the time of nomination and election, and they must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved. All officers must be licensed as physicians and surgeons, given the nature of their duties in office.

11.1-3 NOMINATIONS

(a) Nominating Committee: Medical staff elections shall be held biennially. The Nominating Committee shall consist of seven (7) members of the medical staff: the chief of medical staff, the immediate past chief of medical staff, the chief of medical staff elect, the medical director, and three (3) active staff category members elected from the floor at the preceding year of nomination. The chief of medical staff-elect shall preside at this meeting. The nominations of the committee shall be delivered or mailed to the active staff category members at least twenty (20) days prior to the election.

(b) Slate of Nominees: The Nominating Committee shall prepare a slate of at least one (1) nominee for each of the elective officers of the medical staff: the chief of medical staff elect, the secretary treasurer, and the member at large of the Credentials Committee. Nominees for office should be selected on the basis of leadership and administrative ability, scientific achievement, and ability to work with confreres.

11.1-4 ELECTION

Officers shall be elected at the Annual Medical Staff Meeting. Only active staff category members shall be eligible to vote. Voting shall be by voice, show of hands, or if there are two (2) or more nominees for any office, by secret written ballot. The nominee receiving a majority of the valid votes cast shall be elected. If no candidate for the office receives a majority vote on the first ballot, a runoff election shall be held promptly between the two (2) candidates receiving the highest number of votes. If the second ballot is also a tie, the Medical Executive Committee, by majority vote, shall decide the election by secret ballot at its next meeting or at a special meeting called for that purpose.

11.1-5 CHIEF OF MEDICAL STAFF AND IMMEDIATE PAST CHIEF OF MEDICAL STAFF PROVISIONS

Sections 11.1 3 and 11.1 4 shall not apply to the chief of medical staff and the immediate past chief of medical staff. The chief of medical staff elect, upon completion of term of office, shall immediately succeed to the office of chief of medical staff and then to the office of immediate past chief of medical staff.

11.1-6 TERM OF ELECTED OFFICERS

Officers shall serve for a term of two (2) medical staff years, commencing on the first day of the medical staff year following their election. The officers shall serve until the end of their term and until successors are elected, unless they shall sooner resign or are removed from office. A general officer may not hold the same office for more than two (2) consecutive terms.

11.1-7 REMOVAL OF ELECTED OFFICERS

Any officer whose election is subject to these bylaws may be removed from office for valid cause, including, but not limited to, gross neglect or misfeasance in office, or serious acts of moral turpitude. Except as otherwise provided in these bylaws, removal of a general officer may be initiated by the Medical Executive Committee or by a petition signed by at least one third (1/3) of the medical staff members eligible to vote for officers. Removal shall be considered by the Medical Executive Committee or by a special meeting called for that purpose. Removal shall require a two- third (2/3) vote of the medical staff members eligible to vote for medical staff officers; who actually cast votes at the special meeting in person or by mail ballot. Voting on removal of an elected officer shall be by secret written mail ballot, as defined in Article XV, Section 15.10. The written mail ballots shall be sent to each voting member at least twenty one (21) days before the voting date and the ballots shall be counted by the secretary treasurer of the medical staff (except when the secretary-treasurer is the subject of the balloting, in which case the chief of medical staff shall count the ballots) and the medical staff services manager.

11.1-8 VACANCIES IN ELECTED OFFICE

Vacancies, other than the chief of medical staff, shall be appointed by the Medical Executive Committee until the next regular election. If there is a vacancy in the office of chief of medical staff, the existing chief of medical staff elect shall complete the remaining term and shall then serve as chief of medical staff the following year. If there is a vacancy in the office of immediate past chief of medical staff, that office need not be filled, except that the Medical Executive Committee may appoint a qualified successor to serve as the chair and/or member of any committee that the immediate past chief of medical staff is automatically appointed to pursuant to these bylaws or the Medical Staff Committees and Functions Manual.

11.2 DUTIES OF GENERAL OFFICERS

11.2-1 MEDICAL DIRECTOR

The hospital will appoint a physician as the medical director to act in a liaison capacity between hospital administration and medical staff departments and/or divisions.

The medical director shall:

(a) Plan, organize, direct and coordinate the medical staff services and medical training programs at the hospital.
(b) Cooperate with and assist the chief of medical staff in carrying out responsibility for the clinical organization functions of the hospital and supervision over clinical work in each department and division.
(c) Evaluate and transmit the appropriate recommendations concerning the qualifications of applicants who request initial adjunct staff appointments and biennial reappointments.
(d) Evaluate and transmit to the appropriate authorities, recommendations concerning initial medical membership appointment, clinical privileges, classification and reappointment of the department chair.
(e) Serve as a voting member of the Medical Executive Committee, the Medical Executive Committee Council, the Performance Improvement Committee, the Bylaws Committee, the Credentials Committee, and an ex-officio member of all other medical staff committees with the power to vote unless otherwise specified in these bylaws and in the Medical Staff Committees and Functions Manual.
(f) Perform such other functions as may be assigned by these bylaws, the Credentials Policies and Procedures Manual, the Medical Executive Committee, the Hospital Director or the governing board.

11.2-2 CHIEF OF MEDICAL STAFF

The chief of medical staff shall serve as the chief executive officer of the medical staff. The chief of medical staff shall:

(a) Act in coordination and cooperation with the Hospital Director and/or the medical director in all matters of mutual concern within the hospital.
(b) Call, preside at, and be responsible for the agenda of the Annual Medical Staff meeting and special meetings of the medical staff.
(c) Serve as chair of the Medical Executive Committee and the Medical Executive Committee Council, and a voting member of the Performance Improvement Committee, the Bylaws Committee, the Credentials Committee, and the Joint Conference Committee.
(d) Be responsible and serve as an ex officio member of all other medical staff committees with the power to vote unless otherwise specified in these Bylaws and in the Medical Staff Committees and Functions Manual.
(e) Appoint committee members to all standing, special, ad hoc and multidisciplinary medical staff committees, except the Medical Executive Committee or unless otherwise specified in these bylaws or in the Medical Staff Committees and Functions Manual.

(f) Enforce the medical staff bylaws and rules and regulations, implement sanctions when indicated, and promote compliance with procedural safeguards when corrective action has been requested or initiated against a practitioner.
(g) Present the views, policies, needs and grievances of the medical staff to the governing board and to hospital administration.
(h) Receive and interpret the policies of the governing board to the medical staff and report to the governing board on the performance and maintenance of quality with respect to the medical staff's delegated responsibility to provide medical care.
(i) Be a spokesperson for the medical staff in external, professional, and public relations.
(j) Be responsible for the educational activities of the medical staff.
(k) Perform such other functions as may be assigned by these bylaws, the Credentials Policies and Procedures Manual, the medical staff membership, the Medical Executive Committee or the governing board.

11.2-3 CHIEF OF MEDICAL STAFF ELECT

The chief of medical staff elect, in the absence of the chief of medical staff, shall assume all duties and authority of the chief of medical staff.

The chief of medical staff-elect shall:

(a) Chair the Bylaws Committee.
(b) Be a voting member of the Medical Executive Committee, the Medical Executive Committee Council, the Performance Improvement Committee, and the Credentials Committee.
(c) Serve as an ex-officio member of the Joint Conference Committee without the power to vote unless serving as the alternate for the chief of medical staff or the immediate past chief of medical staff.
(d) Be an ex officio member of all other medical staff committees with the power to vote, unless otherwise specified in these bylaws or in the Medical Staff Committees and Functions Manual.
(e) Perform other supervisory duties as assigned by the chief of medical staff.
(f) Automatically succeed the chief of medical staff if the chief of medical staff fails to serve for any reason.

11.22 IMMEDIATE PAST CHIEF OF MEDICAL STAFF

The immediate past chief of medical staff shall:

(a) Be a voting member of the Bylaws Committee, the Medical Executive Committee, and the Medical Executive Committee Council, the Credentials Committee, the Performance Improvement Committee and the Joint Conference Committee.
(b) Be an ex officio member of all other medical staff committees with the power to vote unless otherwise specified in these bylaws or in the Medical Staff Committees and Functions Manual.
(c) Perform such other functions and duties as assigned by the chief of medical staff or delegated by these bylaws, the medical staff membership or the Medical Executive Committee.

11.23 SECRETARY TREASURER

The secretary treasurer shall:

(a) Be a voting member of the Medical Executive Committee and the Medical Executive Committee Council.
(b) Maintain a roster of members.
(c) Keep accurate and complete minutes of all Medical Executive Committee and medical staff meetings.
(d) Call meetings on the order of the chief of medical staff or the Medical Executive Committee.
(e) Attend to all appropriate correspondence and notices on behalf of the medical staff.
(f) Receive, safeguard, and be accountable for all funds of the medical staff.
(g) Excuse absence from meetings on behalf of the Medical Executive Committee.
(h) Perform such other duties that ordinarily pertain to the office or are assigned by the chief of medical staff or the Medical Executive Committee.

11.2-6 MEMBER AT LARGE, CREDENTIALS COMMITTEE

The Member at Large, Credentials Committee shall:

(a) Be a voting member, who does not hold a defined position within the medical staff. Instead, they serve as a general committee member without specific committee responsibilities unless assigned by the chair. The purpose of the Member at Large position is to represent and advocate for the medical staff distinct from the Departmental Chairs / Vice Chairs. Member at Large is separate from ex officio committee members, who typically don't have voting rights."

11.3 DEPARTMENT CHAIR

11.3-1 QUALIFICATIONS

The department chair shall be a member of the active medical staff and a member of the department that the practitioner will head. The department chair shall be qualified by licensure, training, experience, interest, and demonstrated current ability in the clinical area covered by the department and shall be willing and able to discharge the administrative responsibilities of the office. The department chair shall be certified by an appropriate specialty board or recognized equivalent. In the event that there is no qualified active staff member, a provisional chair may be appointed to perform the functions of the department. The chief of medical staff, in consultation with the medical director, may assign an active staff member of a department to act as a mentor to the provisional chair.

11.3-2 SELECTION

The hospital will appoint a physician to act as the department chair, with the concurrence of the involved department and the Medical Executive Committee. The department chair shall be responsible to the medical director and work in cooperation with the department vice chair.

11.3-3 TERM OF OFFICE

The department chair shall serve commencing on appointment and shall serve until a successor is chosen, unless the department chair shall sooner resign or be removed from office. A department chair may be removed by the governing board or the Medical Executive Committee.

11.3-4 DUTIES

The department chair shall:

(a) Be responsible for all administratively related activities of the department, unless otherwise provided by the hospital, and be accountable to the medical director and to the Medical Executive Committee for the effective operation of the department.
(b) Develop, implement, and maintain the department's quality control programs as appropriate.
(c) Have continuing surveillance of the professional performance of all individuals who have delineated clinical or practice privileges in the department.
(d) Make recommendation for a sufficient number of qualified and competent persons to provide care, treatment, and services.
(e) Determine the qualifications and competency of department service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services and transmit information to appropriate authorities.
(f) Recommend to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department; participate in the evaluation of practitioners practicing within the department and transmit to the appropriate authorities the department's recommendations concerning membership appointment, clinical privileges, classification, reappointment, monitoring and proctoring, and corrective action. .
(g) Be responsible for orientation and continuing education of all persons in the department or service.
(h) Make an evaluation of the health status for initial appointments, reappointments and/or clinical privileges. In those instances where there is doubt about an applicant's health, an evaluation by someone other than the applicant's department chair or vice chair may be necessary to resolve the issue. The request for such an evaluation will rest with the Medical Executive Committee.

(i) Develop and implement policies and procedures that guide and support the provision of care, treatment, and services.
(j) Be responsible for all clinically related activities of the department and exercise general supervision of all clinical work performed within the department, including review of medical records.
(k) Act as the presiding officer at all departmental meetings.
(l) Have oversight responsibility for each of the department division's quality assessment/improvement activities if applicable.
(m) Assess and recommend to the relevant hospital authority off-site resources for needed patient care services not provided by the department/service or the hospital.
(n) Integration of the department or service into the primary function of the hospital.

(o) Recommends space and other resources needed by the department or service.
(p) Provides continuous assessment and improvement of the quality of care, treatment, and services.
(q) Coordination and integration of inter-department and intra-department services.
(r) Perform other duties commensurate with the office as may from time to time be reasonably requested by the medical director, the Medical Executive Committee or the governing board.

11.4 DEPARTMENT VICE CHAIR

11.4-1 QUALIFICATIONS

The department vice chair shall be a member of the active medical staff and shall be qualified by licensure, training, experience and demonstrated ability in at least one of the clinical areas covered by the department. The department vice chair shall be certified by an appropriate specialty board or recognized equivalent. The department vice chair shall be willing and able to faithfully discharge the functions of the position. In the event that there is no qualified active staff member, a provisional vice chair may be elected to perform the functions of the department.

11.4-2 SELECTION

The department vice chair shall be elected by the department members who are eligible to vote for general officers of the medical staff with the concurrence of hospital administration and the Medical Executive Committee. The election of the vice chair shall occur at the departmental meeting and only active staff members of the department may vote.

11.4-3 TERM OF OFFICE

The department vice chair shall serve a two (2) year term that coincides with the medical staff year or until a successor is chosen, unless the vice chair shall sooner resign, be removed from office, or lose medical staff membership in that department. A department vice chair shall be eligible to succeed himself/herself.

11.4-4 REMOVAL

A department vice chair may be removed from office for valid cause, including, but not limited to, gross neglect or misfeasance in office, or serious acts of moral turpitude. The request of the removal of a department vice chair from office may be initiated by the Medical Executive Committee or by written request from the majority members of that department who are eligible to vote. The request of the removal maybe effected by a majority vote of the Medical Executive Committee and a majority vote of the department members eligible to vote on department matters. Voting shall be by secret mail ballot as defined in Article XV, Section 15.10, and ballots shall be sent to those eligible to vote within forty-five (45) days after the initiation of removal pursuant to this section. The ballots must be received no later than twenty-one (21) days after they are mailed and shall be counted by the chief of medical staff, the secretary treasurer, and the medical staff services administrative supervisor. Removal shall be effective upon the approval of the Medical Executive Committee.

11.4-5 DUTIES

The department vice chair shall have the following authority, duties, and responsibilities:

(a) Serve on the Medical Executive Committee and give guidance on the overall medical policies of the medical staff and hospital and make specific recommendations and suggestions regarding the department.
(b) Assist the department chair in ongoing review of the professional performance of all practitioners granted clinical privileges in the department and report thereon to the Medical Executive Committee.
(c) Assist the department chair in the enforcement of the hospital and medical staff bylaws, rules and regulations, and policies within the department, including initiation of corrective action, and investigation of clinical performance and consultation orders when necessary.
(d) Assist the department chair in implementation of department actions taken by the Medical Executive Committee and the governing board.
(e) Assist the department chair in administration of the department, including cooperation with nursing service and hospital administration.
(f) Assist the department chair in the preparation of such annual reports, including budget planning, relating to the department as may be required by the Medical Executive Committee or the governing board.
(g) Serve as an ex officio member of all committees in the department and give guidance and help when needed.
(h) Available for consultation in the vice chair's field.
(i) Represent the department in a medical advisory capacity to hospital administration.
(j) Perform other duties commensurate with the office as may from time to time be reasonably requested by the department chair, the chief of medical staff, the Medical Executive Committee or the governing board.

11.5 DIVISION/SUBDIVISION CHAIR

11.5-1 QUALIFICATIONS

The division/subdivision chair shall be a member of the active medical staff and a member of the division/subdivision that the practitioner is to head. The chair shall be qualified by licensure, training, experience, interest and demonstrated current ability in the clinical area covered by the division/subdivision and shall be willing and able to discharge the administrative responsibilities of the office. The division/ subdivision chair shall be certified by an appropriate specialty board or affirmatively established through the Credentials Committee that the individual possesses comparable competence based on the practitioner's practice. In the event that there is no qualified active staff member, a provisional division/subdivision chair shall be appointed to perform the functions of the division/subdivision.

11.5-2 SELECTION

The department chair may, with the concurrence of administration, appoint a physician to act as the chair of a division or subdivision. The division/subdivision chair will be responsible to the department chair.

11.5-3 TERM OF OFFICE

The division/subdivision chair shall serve commencing on appointment and shall serve until a successor is chosen, unless the division/subdivision chair shall sooner resign or be removed from office.

11.5-4 DUTIES

The division/subdivision chair shall perform the functions assigned by the department chair. Such functions may include, without limitation:

(a) Retrospective patient care reviews.
(b) Continuous evaluation and monitoring of patient care practices.
(c) Credentials review and recommendation, privileges delineation, monitoring and proctoring.
(d) Continuing education programs.

ARTICLE XII – COMMITTEES

12.1 GENERAL

The medical staff organization shall have a Medical Executive Committee and such other committees as are necessary to carry out the functions of the medical staff. At a minimum these functions shall include executive review, credentialing, medical records, tissue review, utilization management, infection control, pharmacy and therapeutics, performance improvement and patient safety, and assisting the medical staff members impaired by chemical dependency and/or mental illness to obtain necessary rehabilitation services. The composition, officers, duties and meetings of the Medical Executive Committee are described in Section 12.2. Other medical staff committees are described in committee descriptions, which must be approved by the Medical Executive Committee. Committee descriptions are maintained in the Medical Staff Committees and Functions Manual. Committee descriptions must, at a minimum, describe the purpose of the committee, regulatory requirements, composition (including voting and non-voting members), reporting relationships, quorum requirements and committee responsibilities. The committees named in the Medical Staff Committees and Functions Manual shall be constituted as committees of the medical staff.

Unless otherwise specified in the committee description, the chairs and members of all medical staff committees shall be appointed by the chief of medical staff, after consultation with and approval by the Medical Executive Committee. Medical staff committees shall ultimately report to and be responsible to the Medical Executive Committee.

12.1-1 AD HOC COMMITTEES

Ad hoc committees may be created by the Medical Executive Committee to perform specified tasks. These committees shall terminate at the end of the medical staff year unless renewed by the Medical Executive Committee. The membership of an ad hoc committee shall be appointed by the chief of medical staff, after consultation with and approval by the Medical Executive Committee.

12.1-2 TERMS AND REMOVAL OF COMMITTEE CHAIRS

Unless otherwise specified in the committee description, committee chairs shall be appointed for a term of two (2) medical staff years and shall serve until the end of this period or until a successor is appointed, unless the chair shall sooner resign or be removed from the committee. Committee chairs may be reappointed. Committee chairs are encouraged to accrue expertise in the area of their committee purview.

12.1-3 TERMS AND REMOVAL OF COMMITTEE MEMBERS

Unless otherwise specified in these bylaws or in the committee description, a committee member's term shall be for two (2) medical staff years, and the member shall serve until the end of this period or until a successor is appointed, unless the member shall sooner resign or be removed from the committee. Any committee member appointed by the chief of medical staff may be removed by a majority vote of the Medical Executive Committee. The removal of any committee member who is automatically assigned to a committee because the individual is a general officer, or other official shall be governed by the provisions pertaining to removal of that officer or official.

12.1-4 VACANCIES

Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made; provided however, that of an individual who obtains membership by virtue of these bylaws is removed for cause, a successor may be selected by the Medical Executive Committee.

12.1-5 CONDUCT AND RECORDS OF MEETINGS

Committee meetings shall be conducted and documented in the manner specified in Article XIII (Meetings).

12.2 MEDICAL EXECUTIVE COMMITTEE (MEC)

12.2-1 COMPOSITION

The Medical Executive Committee shall consist of the chief of medical staff, the immediate past chief of medical staff, the chief of medical staff elect, the secretary-treasurer, the medical director, the and the vice chair and chair of clinical departments. When the department vice chair and chair are both present at the meeting, only one vote will be cast, with the vice chair having the vote. When either the chair or vice chair is also an elected officer of the medical staff (i.e., chief of medical staff, immediate past chief of medical staff, chief of medical staff-elect, or secretary-treasurer), their presence and vote will be counted as an elected officer of the medical staff. The chief executive officer or designee and the chief nursing officer shall be ex officio members without the power to vote. The associate medical director shall serve as medical director designee (with vote) in the absence of the medical director.

12.2-2 OFFICERS

The chief of medical staff, the chief of medical staff elect, and the secretary treasurer shall serve as chair, vice chair, and secretary treasurer of the Medical Executive Committee, respectively.

12.2-3 DUTIES

Duties of the Medical Executive Committee include, but are not limited to the following:

(a) Recommendations made directly to the governing board pertaining to the following:

  (1) The structure of the medical staff.
  (2) The mechanism used to review credentials and to delineate individual clinical privileges.
  (3) Recommendations regarding medical staff initial appointments, reappointments, and clinical privileges for eligible individuals.
  (4) The organization of quality care activities of the medical staff as well as the mechanism used to conduct, evaluate and revise such activities.
  (5) The mechanism in which membership on the medical staff may be terminated.
  (6) The mechanism for fair hearing procedures.
  (7) The MEC's review of actions on reports of medical staff committees, departments, and other assigned activity groups.

(b) Represent and empowered to act on behalf of the medical staff between meetings of the organized medical staff.
(c) Coordinate and implement the professional and organizational activities and policies of the medical staff.

(d) Upon good cause, and in consultation with hospital administration, eliminate, establish and determine the composition and duties of medical staff committees. Said actions shall be incorporated into the Medical Staff Committees and Functions Manual as approved by the Medical Executive Committee.

(e) Participate in the development of medical staff and hospital policy, practice and planning.

(f) Take reasonable steps to promote ethical conduct and competent clinical performance on part of all members and AHPs to the extent required by these bylaws, including the initiation of and participation in medical staff corrective or review measures when warranted.

(g) Fulfill the medical staff's accountability to the governing board for medical care rendered to patients at the hospital.

(h) Take reasonable steps to develop continuing education activities and programs for the medical staff.

(i) Report to the medical staff at the regular staff meeting.

(j) Assure the medical staff is informed about the accreditation program and status of the Hospital and assist in obtaining and maintaining of hospital accreditation.

(k) Evaluate the medical care provided to patients at the hospital.

(l) Receive and review reports and recommendations of the Environment of Care Committee, including methods for the protection and care of patients and others in the event of internal or external disaster.

(m) Appoint such special or ad hoc committees as may seem necessary or appropriate to assist the Medical Executive Committee in carrying out its functions and those of the medical staff.

(n) Request evaluation of practitioners privileged through the medical staff process in instances where there is doubt about a practitioner's ability to perform the privileges requested.

(o) Perform other functions as may be assigned to it by these bylaws, the medical staff or the governing board.

(p) Affirmatively implement, enforce, and safeguard the self-governance rights of the medical staff to the fullest extent permitted by law; such rights of the medical staff include, but are not limited to, the ability to retain and be represented by independent legal counsel at the expense of the medical staff.

By action of 2/3 of the medical staff members present and entitled to vote, the medical staff may, at a regular or special meeting, pursuant to Section 13.1, at which a quorum is achieved, remove and reassign a duty or duties delegated to the Medical Executive Committee for a stated period of time, for a reason identified and supported by the meeting.

12.2-4 MEETINGS

The MEC shall meet as often as necessary, but at least ten (10) times a year, and shall maintain a record of its proceedings and actions. Fifty (50) percent of the membership shall constitute a quorum. The requirements for a quorum of the Medical Executive Committee shall be bifurcated. In order to meet urgent requirements of any department for credentialing and granting of clinical privileges or when necessary to meet requirements of any regulatory agency, a meeting of the MEC may be called by any medical staff officer, and three (3) members will be sufficient to constitute a quorum. Any actions taken will be reported at the next regularly scheduled MEC meeting.

ARTICLE XIII – MEETINGS

13.1 MEETINGS

13.1-1 ANNUAL STAFF MEETING

There shall be an annual meeting of the medical staff held in June. The election of officers shall take place at this meeting on a biennial basis as required by these bylaws. The chief of medical staff shall report on actions taken by the Medical Executive Committee during the preceding year and on matters believed to be of interest and value to the members. Notice of this meeting shall be given to the members at least twenty (20) days prior to the meeting. The chief of medical staff shall preside at this meeting. Attendance at the Annual Staff Meeting will be strongly encouraged of all active staff members.

13.1-2 AGENDA

The order of business shall be determined by the chief of medical staff and the Medical Executive Committee. The agenda shall include, at a minimum:

(a) Review and acceptance of the minutes of the last Annual Staff Meeting and all special meetings held since the last Annual Staff Meeting.
(b) Administrative reports from the chief of medical staff, the medical director, departments, committees, and the Hospital Director.
(c) Election of officers when required by these bylaws.
(d) Reports by responsible officers, committees, and departments on the overall results of patient care audit and other quality review, evaluation, and monitoring activities of the medical staff and on the fulfillment of the other required staff functions.
(e) Recommendations for improving patient care at the hospital.
(f) Old Business.
(g) New Business.

13.1-3 SPECIAL MEETINGS

Special meetings of the medical staff may be called at any time by the chief of medical staff or the Medical Executive Committee or shall be called upon the request of ten percent (l0%) of the active medical staff members. The Medical Executive Committee, upon written request of the governing board, shall call a special meeting of the medical staff. The person calling or requesting the special meeting shall state the purpose of such a meeting in writing. The meeting shall be scheduled by the Medical Executive Committee within thirty (30) days after receipt of such request. No later than seven (7) days prior to the meeting, notice shall be mailed or delivered to the members of the staff which includes the stated purpose of the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

13.2 COMMITTEE AND DEPARTMENT MEETINGS

13.21 REGULAR MEETINGS

Committees and departments, by resolution, may be provided the time for holding regular meetings and no notice other than such resolution shall then be required.

13.22 SPECIAL MEETINGS

A special meeting of any medical staff committee, department or division may be called by the chair thereof, the Medical Executive Committee or the chief of medical staff and shall be called by written request of one third of the current members of the medical staff that are eligible to vote.

13.3 NOTICE OF MEETINGS

When notice stating the place, day, and hour of any regular or special medical staff meeting or of any regular or special committee or department meeting not held pursuant to resolution shall be delivered either personally or by mail to each person entitled to be present thereat not less than seven (7) days nor more than twenty (20) days before the date of such meeting, in the manner specified in Section 15.10, hereof. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

13.4 QUORUM

13.4-1 DEPARTMENT AND COMMITTEE MEETINGS

The number of active staff members present at any meeting shall constitute a quorum, said quorum shall apply to regular, department, division and committee meetings for which proper notification has been given to all voting members, except as otherwise specified in these bylaws or in the Medical Staff Committees and Functions Manual.

13.4-2 ANNUAL STAFF MEETING

The presence of 51% of the total members of the active medical staff at any regular or special meeting of the medical staff shall constitute a quorum for the purpose of removing and reassigning a duty or duties delegated to the Medical Executive Committee. For all other actions, the number of active staff members present at any regular or special meeting of the medical staff shall constitute a quorum.

13.5 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a meeting, at which a quorum is present, shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be specifically required by these bylaws. Committee action may be conducted by telephone, audio or video conference which shall be deemed to constitute a meeting for the matters discussed in that telephone, audio or video conference. Valid action may be taken without a meeting by a department, committee, or the Medical Executive Committee by a writing setting forth the action so taken which is signed by each member entitled to vote thereat.

13.6 MINUTES

Minutes of all meetings shall be prepared and retained as specified in these bylaws and in the Medical Staff Committee and Department Meetings Policy and Procedure. They shall include, at a minimum, a record of the attendance of members and the vote taken on significant matters. The minutes shall be signed by the presiding officer of the meeting and forwarded to the Medical Executive Committee. Each committee and department shall maintain a file copy of its minutes. The Medical Staff Services Office shall be responsible for maintaining the original set of department and standing committee minutes.

13.7 ATTENDANCE REQUIREMENT

13.7-1 REGULAR ATTENDANCE

The active staff member shall be strongly encouraged to attend:

(a) The Annual Medical Staff meeting.
(b) General medical staff meetings duly convened pursuant to these bylaws.
(c) Meetings of the department, division, and committee of which the practitioner is a member.

All members of the medical staff shall be encouraged to attend departmental meetings, the Annual Medical Staff meeting, and to participate in scientific presentations of the medical staff.

13.7-2 ABSENCE FROM MEETINGS

Any member who is compelled to be absent from any medical staff, department, division, or committee meeting shall promptly provide to its regular presiding officer thereof the reason for such absence.

13.7-3 SPECIAL APPEARANCE

A member shall be notified, in advance, when his/her patient's clinical course of treatment is scheduled for discussion at a regular department, division, or committee meeting. If an apparent or suspected deviation from standard clinical practice is involved, notice shall be sent to the member by certified mail, return receipt requested, at least seven (7) days prior to the meeting, Said notice shall include the time and place of the meeting, a statement of the issue involved and that the member's appearance is mandatory. If a member fails to appear at any meeting for which notice was given, unless excused by the Medical Executive Committee on a showing of good cause, all or such portion of the member's clinical privileges, as the Medical Executive Committee shall direct, shall be automatically suspended. This suspension shall remain in effect until the matter is resolved by subsequent action of the Medical Executive Committee as provided in Section 8.2 5.

13.8 CONDUCT OF MEETINGS

Unless otherwise specified, meetings shall be conducted according to Robert's Rules of Order, Newly Revised; however, technical or non-substantive departures from such rules shall not invalidate action taken at such a meeting.

ARTICLE XIV - CONFIDENTIALITY, IMMUNITY, AND RELEASES

14.1 AUTHORIZATION AND CONDITIONS

By applying for or exercising clinical privileges (or practice privileges) at this hospital, an applicant:

(a) Authorizes representatives of the hospital and the medical staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the applicant's professional ability and qualifications.

(b) Authorizes persons and organizations to provide information concerning such practitioner to the medical staff and hospital.

(c) Agrees to be bound by the provisions of this article and to waive all legal claims against any representatives of the medical staff or the hospital who acts in accordance with the provisions of this article. Acknowledges that the provisions of this article are express conditions to an application for medical staff membership, the continuation of such membership, and to the exercise of clinical privileges at this hospital.

(d) Acknowledges medical staff participation with the hospital in an Organized Health Care Arrangement (OHCA) under the privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA) and agrees to be bound by the provisions of the Notice of Privacy Practices given to hospital patients when they access care at any hospital and county affiliated facility.

14.2 CONFIDENTIALITY OF INFORMATION

14.2-1 GENERAL

Medical staff, department, division and committee minutes, files, records, and oral discussions, including information regarding staff members or applicants to this medical staff, including AHPs, collected or prepared for the purpose of achieving and maintaining quality patient care, reducing morbidity and mortality or contributing to clinical research, shall be confidential to the fullest extent permitted by law. Dissemination of this information and these records shall only be made when expressly required by law, pursuant to officially adopted policies of the medical staff and the hospital or, if no officially adopted policy exists, only with the express approval of the Medical Executive Committee or the governing board. This information shall be a part of the medical staff committee files and shall not become part of any particular patient's file or of the general hospital records.

14.2-2 BREACH OF CONFIDENTIALITY

Inasmuch as effective quality assessment, peer review and consideration of the qualifications of medical staff members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions, deliberations, or other communications of medical staff departments, divisions, or committees, except in conjunction with other hospital, professional society, or licensing authorities, is outside appropriate standards of conduct for this medical staff and will be deemed disruptive to the operations of the hospital. If it is determined that a breach has occurred, the Medical Executive Committee shall undertake such corrective action as it deems appropriate.

14.2-3 CONFIDENTIALITY AGREEMENT

By signing the application form for appointment or reappointment to the medical staff, or by participation in medical staff activities, a practitioner agrees to be bound by both this article and the following statement of hospital policy, which is in amplification, and not limitation, of other parts of this article.

Confidentiality is vital to the free, open and candid discussions necessary for medical staff quality assessment and peer review activities designed to improve the quality of care at the hospital. The medical staff member's participation in such activities is in reliance on the confidential treatment of those activities by all members of the medical staff and other individuals involved. For these reasons, a practitioner agrees to keep confidential all information (oral or written) communicated in connection with medical staff quality assessment and peer review activities. Disclosure of such information except as specifically required by law, pursuant to medical staff and hospital policy, to law enforcement agencies, or to professional or institutional licensing agencies, is prohibited.

Corrective action including suspension or termination of medical staff membership or eligibility to hold office, to serve on committees, or to hold clinical privileges may be taken against any practitioner who fails to maintain the confidentiality of such information. Agreement to keep medical staff information confidential is a material condition to appointment or reappointment to the medical staff. The practitioner agrees to notify the medical staff of any request or demand made (whether by subpoena or otherwise) to disclose confidential information related to the practitioner's participation as a member of the staff or any committee thereof and agrees to not voluntarily disclose confidential medical staff information except as specifically provided in this article. The practitioner further agrees that the medical staff or the hospital may seek to enjoin his/her violation of this article if necessary.

14.3 IMMUNITY FROM LIABILITY

14.3-1 FOR ACTION TAKEN

The representative of the medical staff and hospital shall be exempt from liability to an applicant or member for damages or other relief for any action taken or statements or recommendations made within the scope of duties exercised as a representative of the medical staff or hospital.

14.3-2 FOR PROVIDING INFORMATION

The representative of the medical staff and hospital and all third parties, acting pursuant to these bylaws, shall be exempt from liability to an applicant or member for damages or other relief by reason of providing information, actions taken or statements or recommendations made within the scope of duties, or for providing information concerning any person who is, or has been, an applicant to or member of the staff or who did, or does, exercise clinical privileges or provide services at this hospital.

14.4 ACTIVITIES AND INFORMATION COVERED

14.4-1 ACTIVITIES

The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health care facilities or organization's activities concerning, but not limited to:

(a) Applications for appointment and reappointment, clinical privileges (practice privileges) and prerogatives and periodic reappraisals of members' status, privileges, and/or prerogatives.
(b) Corrective action.
(c) Hearing and appellate reviews.
(d) Utilization reviews.
(e) Other department or division, committee, or medical staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct.

(f) The National Practitioner Data Bank queries and reports, peer review organizations, the Medical Board of California, and similar reports.

14.5 RELEASES

The applicant or member shall, on the request of the medical staff or hospital, execute general and specific releases in accordance with the express provisions and general intent of this article. The execution of such releases shall not be deemed a prerequisite to the effectiveness of this article.

ARTICLE XV - GENERAL PROVISIONS

15.1 BYLAWS, RULES AND REGULATIONS, POLICIES AND GOVERNING BOARD BYLAWS

The medical staff bylaws, rules and regulations, policies and procedures, and the Medical Center governing board bylaws do not conflict.

15.1-1 MEDICAL STAFF RULES AND REGULATIONS

The medical staff shall initiate and adopt such rules and regulations as it may deem necessary and shall periodically review and revise its rules and regulations to comply with current medical staff practice. Recommended changes to the rules shall be submitted to the Medical Executive Committee for review and approval. Following approval by the Medical Executive Committee, a rule and regulation shall become effective following approval of the governing board. Neither the medical staff nor the governing body may unilaterally amend the medical staff bylaws or rules and regulations. Applicants and members of the medical staff shall be governed by such rules and regulations as are properly initiated and adopted. If there is a conflict between the bylaws and the medical staff rules and regulations, the bylaws shall prevail. The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the medical staff rules and regulations. Copies of the Rules and Regulations documents / manual may be found on the intranet.

15. 1-2 DEPARTMENTAL RULES AND REGULATIONS

Each department shall formulate its own rules and regulations for the conduct of its affairs and for the supervision of the house staff. Departmental rules and regulations will be reviewed and amended periodically. Proposed changes to the departmental rules shall be submitted to the Medical Executive Committee for review and approval and then to the governing board for review and approval. Departmental rules and regulations shall be consistent with these bylaws, the general rules and regulations of the medical staff, and other policies of the hospital.

15.2 MEDICAL STAFF COMMITTEES AND FUNCTIONS DOCUMENT

The Medical Executive Committee shall initiate and adopt committee descriptions for all medical staff standing and ad hoc committees. The committee descriptions shall be periodically reviewed and revised to comply with current medical staff practice and regulatory requirements. Recommended changes to the Medical Staff Committees and Functions Manual shall be submitted to the Medical Executive Committee for review and approval.

15.3 FEES/DUES

All members of the medical staff and allied health staff, except for honorary staff, shall be required to pay biennial fees/dues, unless waived by the Medical Executive Committee. Fees/dues shall become delinquent if not paid within 30 days from when notice is sent for payment. A failure to pay fees/dues shall result in those actions specified in Section 8.3-5 (Failure to Pay Dues/Assessments). The Medical Executive Committee shall have the power to set the amount of fees/dues for each medical staff category, the amount of the processing fee for initial application, application for temporary privileges, and reapplication, and the amount to be paid by a practitioner whenever any unusual expenses are involved. The Medical Executive Committee shall determine the expenditure of all medical staff funds.

15.4 AUTHORITY TO ACT

Action of the medical staff in relation to any person other than the members thereof shall be expressed only through the chief of medical staff or the Medical Executive Committee, or its designee, and they shall first confer with the Hospital Director. Any member or members who act in the name of the medical staff without proper authority shall be subject to such disciplinary action as the Medical Executive Committee or governing board may deem appropriate.

15.5 ACCEPTANCE OF PRINCIPLES

The member regardless of class or category, by application for medical staff membership, agrees to be bound by the provisions of these bylaws, a copy of which shall be delivered to the member upon request for an initial medical staff application, and thereafter a copy of all amendments to be promptly delivered after adoption and made available at all times on the Medical Center Intranet site. Any violation of these bylaws shall subject the applicant or member to such disciplinary action as the Medical Executive Committee or governing board may deem appropriate.

15.6 DIVISION OF FEES

The practice of the division of professional fees under any guise whatsoever is forbidden, and any such division of fees shall be cause for exclusion or expulsion from the medical staff.

15.7 MEDICAL STAFF REPRESENTATION BY LEGAL COUNSEL

Upon the authorization of the medical staff or of the Medical Executive Committee acting on its behalf, the medical staff may retain and be represented by independent legal counsel at the expense of the medical staff.

15.8 NOTICES

Except where specific notice provisions are otherwise provided in these bylaws, any and all notices, demands, requests, or other communications required or permitted sent by email to the address

provided by each member for that purpose. In the case of notice to the medical staff or its officers or committees, the notice shall be addressed as follows:

Official MS email address

Notices to, applicant, or other party shall be to the addressee at the address as it last appears on the official records of the medical staff. If personally delivered, such notice shall be effective upon delivery. If sent via US postal mail, such notice shall be effective two (2) days after it is placed in the mail.

15.9 SECRET WRITTEN BALLOT

Whenever these bylaws require a secret, mail ballot vote, the mail ballots shall be returned in an unmarked envelope. The ballot shall be placed inside a properly identified return envelope and the staff member will print and sign his/her name. The staff member's name shall be verified against the medical staff records.

ARTICLE XVI - ADOPTION AND AMENDMENT OF BYLAWS

16.1 ADOPTION AND AMENDMENT

The medical staff adopts and amends medical staff bylaws, rules and regulations. The adoption or amendment of medical staff bylaws cannot be delegated.

The medical staff bylaws will be reviewed periodically. These bylaws may be adopted, amended, or repealed at any regular or special meeting of the medical staff, provided that notice of such business is sent to all members no later than twenty (20) days before such meeting. The notice shall include the exact wording of the proposed addition or amendment, if applicable, and the time and place of the meeting. In order to enact a change, the affirmative vote of a majority of the active medical staff members present at the meeting shall be required. The amendment shall become effective when approved by the governing board. Neither the medical staff nor the governing board may unilaterally amend the medical staff bylaws or rules and regulations. The governing board shall approve and comply with the medical staff bylaws. The organized medical staff shall comply with and enforce the medical staff bylaws, rules and regulations, and policies.

The organized medical staff has the ability to adopt medical staff bylaws, rules and regulations, policies, and amendments thereto, and to propose them directly to the governing board.

If the voting members of the organized medical staff propose to adopt a rule, regulation, or policy, or an amendment thereto, they first communicate the proposal to the Medical Executive Committee. If the Medical Executive Committee proposes to adopt a rule or regulation, or an amendment thereto, it first communicates the proposal to the medical staff; when it adopts a policy or an amendment thereto, it communicates this to the medical staff.

In cases of documented need for an urgent amendment to rules and regulations necessary to comply with law or regulation, the Medical Executive Committee, as delegated by the voting members of the organized medical staff, may provisionally adopt and the governing body may

provisionally approve an urgent amendment without prior notification of the medical staff. In such cases, the medical staff will be immediately notified by the Medical Executive Committee. The medical staff has the opportunity for retrospective review of and comment on the provisional amendment at the annual medical staff meeting. If there is no conflict between the organized medical staff and the Medical Executive Committee, the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict between the organized medical staff and the Medical Executive Committee is implemented. If necessary, a revised amendment is then submitted to the governing body for action.

The organized medical staff has a process which is implemented to manage conflict between the medical staff and the Medical Executive Committee on issues including, but not limited to, proposals to adopt a rule, regulation, or policy or an amendment thereto. This process begins with the Conflict Management Committee. Nothing in the foregoing is intended to prevent medical staff members from communicating with the governing body on a rule, regulation, or policy adopted by the organized medical staff or the Medical Executive Committee. The governing body determines the method of communication.

16.2 TECHNICAL AND EDITORIAL AMENDMENTS

The Medical Executive Committee shall have the power to adopt such amendments to the bylaws as are, in its judgment, technical modifications or clarifications, reorganization or renumbering of the bylaws, or amendments made necessary because of punctuation, spelling, or other errors of grammar or expression, or inaccurate cross-references. Such amendments shall be effective immediately and shall be permanent if not disapproved by the medical staff or the governing board within 90 days after adoption by the Medical Executive Committee. The action to amend may be taken by motion and acted upon in the same manner as any other motion before the Medical Executive Committee. After approval, such amendments shall be communicated in writing to the medical staff and to the governing board.

ADOPTED by the Medical Staff on June 5, 2025

Shunling Tsang, MD
Chief of Medical Staff

Sara Edwards, MD
Chief of Medical Staff-Elect

APPROVED by the Governing Board on 5/08/2025
Board of Supervisors of Riverside County

Chair, Riverside County Board of Supervisors

*Signature on file

RULES AND REGULATIONS

The medical staff shall adopt such rules and regulations as may be necessary for the proper conduct of its work. The rules and regulations of the medical staff shall be adopted by the medical staff and approved by the governing board prior to becoming effective. Neither the medical staff nor the governing board may unilaterally amend the medical staff bylaws or rules and regulations.

1. **Assignment of Patients**. Patients shall be admitted only upon the order and under the care of a member of the medical staff of the hospital who is lawfully authorized to diagnose, prescribe and treat patients. The patient's condition and provisional diagnosis shall be established at the time of admission by the member of the medical staff who admits the patient. The house staff may perform these functions as outlined in the Rules and Regulations, Graduate Education Programs. The medical staff member shall be responsible for the following: the medical care and treatment of the member's patient at the hospital; the prompt completeness and accuracy of the medical record, including medical history and physical examination to be done not more than thirty (30) days prior to admission or within 24 hours after admission; for necessary special instructions; and for transmitting reports of the patient's condition to the referring practitioner and to the patient's relatives. If these responsibilities are transferred to another staff member, a note documenting the transfer of responsibility shall be entered on the order form of the medical record. Assignment of patient care duties shall be in accordance with departmental rules and regulations.

2. **Attending Physician** – A patient's attending physician is the medical staff physician responsible for rendering, coordinating and directing care and services provided to a patient while hospitalized. Expertise and training relative to the principal diagnosis precipitating hospitalization generally determines initial pairing of patients to attending physicians.

   A patient may have more than one attending physician over the course of a hospitalization but should have only one attending physician at a time. One physician must be in charge. Transfer of responsibility from one attending physician to another must be clearly specified in the medical record, whether it will be for weekend or holiday coverage within a department, or whether it be a transfer from one medical service to another

3. **Attending Staff Notes**. Each department attending staff member should use the Multidisciplinary Note to chart his/her notes and recommendations.

4. **Attending Staff Private Patient Charges**.

   An attending staff member may admit and charge for identifiable services rendered to the member's private patients, including those under Medicare and Medi Cal. An attending staff member may not charge for County indigent patients except to the extent that these patients are covered by Medi Cal or other insurance. Identifiable medical services may be construed as those services normally provided to private patients, as evidenced by histories, physicals, progress notes, physician's orders, etc.

5. **Autopsies**. All autopsies shall be obtained as specified in the Policy No. 653, Autopsy Consent Documentation. An autopsy should not be performed without the proper written consent of the responsible relative or legal authorized agent. All autopsies shall be performed by the hospital pathologist or by a physician delegated this responsibility. Also, refer to the Laboratory Policy No. 3.1, Pathology Department for additional direction.

6. **Clinic Patients**. Service patients referred to the hospital clinic solely for diagnostic laboratory studies shall be followed as hospital clinic patients.

7. **Consultation Criteria**.

Inpatient Consultation Criteria. The primary service shall request consultation as required for optimal patient care. In addition, each consulting department may identify criteria that trigger automatic consultation to expedite care. Written consultation is considered complete only when signed/co-signed by the attending physician and placed in the medical record.
Routine Consults. The consult should be completed within 24 hours of request unless otherwise agreed upon by the Primary Attending Physician and/or Consultant. The primary service will place a written order in the chart and also verbally notify the consultant. Notification of consult completion must occur. The consultant may ask a non-physician (i.e. nurse, unit clerk, etc.) to contact the primary service.

Urgent/Emergent Consults
The consult will be performed as soon as possible to ensure patient safety but not to exceed 24 hours from time of request, unless specified by another policy. The primary service will place a written order in the chart and also verbally notify the consultant. The consultant will contact the primary attending or senior level resident and give verbal notification of consult completion and recommendations in addition to written recommendations.

8. **Drugs.** All drugs and medications administered to patients shall be those as listed in the latest edition of United States Pharmacopoeia, National Formulary, American Hospital Formulary Service or A.M.A. Drug Evaluation. Drugs for bona fide clinical investigations may be exceptions, and these shall be used in full accordance with the Statement of Principles Involved in the Use of Investigation Drugs in Hospitals and all regulations of the Federal Drug Administration. The hospital drug formulary is to be used for prescribing medicine. See RUHS Policy HW 842 Drug Formulary Process. When drugs that are not listed on the hospital formulary are ordered for private patients, as signed for by the attending medical staff physician, said drugs will be secured and a special charge will be made to the patient.

9. **Graduate Education Programs**: The following shall apply to the hospital's graduation education programs:

(a) The departments who participate in professional graduate education programs shall in their departmental rules and regulations and policies specify the mechanism by which house staff members are supervised by medical staff members in carrying out their patient care responsibilities.
(b) The hospital shall not permit any physician, dentist, podiatrist, or resident, intern or student to perform any service for which a license, certificate or registration or other form

of approval is required unless such person is licensed, registered, approved or exempted, unless such services are performed under the direct supervision of a licensed practitioner wherever so required by law.

(c) If patient care is provided by residents and medical students, such care shall be in accordance with the provisions of an approved program.

(d) Except in an emergency, all other patient care by, house officers, residents or persons with equivalent titles, not provided as specified in (c) of this section, must be provided by a practitioner with current license to practice in California.

(e) The departmental residency requirements are subject to review by the Graduate Medical Education (GME) Committee. The department shall present an annual report, outlining its residency requirements, to the GME Committee.

(f) House staff members may write orders as outlined in Records Authentication, Rule #28.

(g) The Family Medicine (FM) chair may assign residents to serve on medical staff committees. FM residents will serve on committees without the power to vote, unless otherwise specified in the Medical Staff Committees and Functions Manual.

10. **Medical History and Physical for Inpatient and Outpatient Services**. A medical history and physical examination includes the following: HPI, describing Chief Complaint, PMH, PSH, Allergies to medication, SH/FH, ROS and physical examination and, assessment and plan.

11. **Media Release**. Release of information concerning activities at Riverside University Health System Medical Center to the public media will be done only with the approval of hospital administration.

12. **Medical Record**. All patients' charts shall be completed fourteen (14) days after discharge. The summary of case is to be completed at the time of discharge. The house staff and attending staff will be notified of the time frame for record completion as noted in the HIM Policy, No. 701 Chart Completion. Also, see RUHS Policy No. 600.3, Patient Medical Records, for additional information regarding components of a complete patient medical record, record authentication, timeliness, urgent/emergent care services, operative and high-risk procedures, summary/problem lists, discharge information, etc.

13. **Medical Records Property of the Hospital**. All medical records are the property of the hospital and shall not be removed from the hospital's jurisdiction and safekeeping except in accordance with a court order, subpoena or statute.

14. **Medical Screening Examination**: The depth of evaluation and level of expertise required to fulfill the Federal requirements to perform a Medical Screening Examination (MSE) is dependent on the patient's condition. Screening may be performed by a RUHSMC medical staff physician or by appropriately trained personnel or resident with oversight from the supervising attending physician. Refer to RUHS HW Policy No. 656 EMTALA Screening, Stabilizing and Transfer of Patients with Emergency Medical Conditions.

15. **Medical Staff Requirement**. Each member of the medical staff shall be required to serve when called upon by the practitioner's department/division chair or vice chair. A staff member who

fails to serve, as requested, shall be reported to the MEC for action. A staff member who does not comply with this requirement may be dropped from the medical staff.

16. **Notification of Attending Staff**. All seriously ill patients shall be seen by a member of the attending medical staff as soon as possible after notification and, in all such cases, within 24 hours.

17. **Operative Record**. An operative report or a brief operative report must be completed immediately at the conclusion of a case by either an attending, resident, or intern participating in the case. A complete operative report must be dictated or completed in the EHR within 24 hours. The operative report includes at least: Name and hospital identification number of patient. Date and times of surgery. Name of surgeon(s) and assistants or other practitioners who performed surgical tasks (even when performing those tasks under supervision). Pre-operative and post-operative diagnosis, names of the specific surgical procedure(s) performed. Type of anesthesia administered, and complications if any. Description of techniques, findings, and tissues removed or altered. Surgeons or practitioners name(s) and a description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioners. Significant surgical procedures include opening and closing, harvesting or implanting grafts, dissecting tissue, removing tissue, implanting device(s) or prosthesis.

All tissues, excluding those exempted by the department of Health Services, Program Flexibility, under Section 70129 (a), Title 22, California Administrative Code, that are removed during the operation shall be sent to the hospital pathologist. The pathologist shall perform examinations that may be considered necessary to arrive at a pathological diagnosis. The report shall be signed by the pathologist. (See RUHS Perioperative Policy OR, Operating Room Scheduling and Block Time Utilization.)

18. **Orders, Standing**. Standing orders may be formulated and may be changed as deemed necessary with the approval of the appropriate committees. Standing orders shall be signed by the house staff. Standing orders shall be posted or circulated to all patient units at the hospital and shall be a part of hospital manuals.

19. **Orders, Verbal**. Verbal orders (oral or by telephone) for administration of medications may be received and recorded by licensed health professionals who are expressly authorized under their practice acts to receive orders to administer drugs. This includes registered nurses, (RNs), pharmacists, physicians, physician assistants from supervising physician only, physical therapists (for certain topical drugs only), and respiratory therapists when the orders relate specifically to respiratory therapy. These orders are to be countersigned by the physician or any physician by the team caring for the patient within forty-eight (48) hours. (See RUHS HW Policy No. 680 Telephone and Verbal Orders.)

20. **Orders, Written**. All orders shall be written, dated, timed and signed by the ordering physician. The physician's order must be written clearly, legibly and completely. Orders that are illegibly or improperly written will not be carried out until rewritten or understood by the nurse. All automatic cancellation of orders will be done in accordance with the policy of the Pharmacy & Therapeutic Committee.

21. **Patients' Bill of Rights**. In accordance with Section 70707 of the CA Administrative Code, the medical staff will agree to honor the list of Patients' Rights in California. See HW Policy No. 601 Patient Rights and Responsibilities.

22. **Pregnancy Test**.
    (a) A negative pregnancy test result on any patient is mandatory prior to any procedure that might adversely affect a pregnancy, e.g., hysterosalpingogram, hysteroscopy, hysterectomy.
    (b) A pregnancy test is desirable for any patient who might be pregnant prior to elective surgery, but may be waived at the attending physician's discretion.
    (c) No case with any urgency should be delayed awaiting a pregnancy test result.

23. **Preoperative Procedures**. A complete medical history and physical examination must be performed within thirty (30) days prior to the patient's admission or within 24 hours after inpatient admission. For a medical history and physical examination that was performed within thirty (30) days prior to inpatient admission, an update documenting any changes in the patient's condition shall be completed within 24 hours after inpatient admission or prior to surgery. Appropriate screening tests, based on the needs of the patient, shall be accomplished and recorded in the patient's chart within 72 hours prior to the patient's surgery. As in the ASA (American Society of Anesthesiology) Class I and II patients, appropriate screening tests will be considered acceptable if done within seven (7) days prior to the patient's surgery. (See RUHS MC Policies No. 600, Inpatient Admitting and Emergency Department Consultations, and No. 604, Surgery and Operating Room Scheduling.)

24. **Preoperative Record**. If a history and physical examination (to include blood pressure, urinalysis and blood count) is not completed and in the chart prior to the patient's operation, the operation shall be canceled unless the attending physician states, in writing, that such delay would constitute a hazard to the patient.

25. **Private Patients**. A private patient who is admitted to the hospital may be attended by the patient's private physician and by the resident assigned to the division or department. A physician, who admits a private patient to the hospital, shall provide information and orders necessary to adequately and completely record the management of the private patient. The hospital shall have the right, through the medical director or the chief of medical staff, to require the attending private physician to obtain a consultation through the chair of the relevant department or designee.

26. **Provisional Diagnosis**. Except in an emergency, a patient shall not be admitted to the hospital until after a provisional diagnosis has been stated. In the case of an emergency, the provisional diagnosis shall be stated as soon as possible after admission.

27. **Publications**. Case reports (documenting 1-3 cases) may be submitted to the chair of the appropriate department and the medical director rather than the Institutional Review Board (IRB). All requests for permission to publish scientific papers, books or reports and photographs arising out of work performed at the hospital shall be in writing, utilizing the approved forms, stating the specific purposes for which the material will be employed, and shall be approved in writing by the chair of the relevant department. Case reports may be submitted to the IRB if the

author(s) would like a letter from the IRB to accompany their journal submission. All publications arising out of work done at the hospital shall give credit to the hospital. A copy of every article or book approved for publication shall be furnished to the medical director for inclusion in the medical library file devoted to contributions from the attending medical staff. A violation of any of the regulations of this rule, in regard to research or publication, shall subject the offender to such disciplinary action as the Medical Executive Committee may deem appropriate. All newspaper and/or television releases must be approved by hospital administration. See IRB Policy 1 – Scope of IRB Authority

28. **Records Authentication**. The attending physician shall be identified on the history and physical, consultation note, operative report, discharge summary and labor and delivery note. These notes must also be signed by an attending physician. Medical records shall be authenticated in accordance with the laws and regulations applicable to the hospital.

29. **Research Projects**. Medical staff members, residents and medical students shall not undertake any type of biomedical or clinical research project within the jurisdiction of this hospital without first obtaining approval of the Riverside University Health System Medical Center (RUHS MC) Institutional Review Board (IRB) and the Medical Executive Committee (MEC). Research projects shall have the approval of the relevant department chair, the IRB, and the MEC respectively. . Closure of a research project must be reported to the IRB. within the during which the research was terminated. Retrospective Record Reviews with an outside source of funding shall not be undertaken without first obtaining approval of the RUHS MC IRB.

30. **Responsibility for Private Patients**. When a physician has a private patient in the hospital, a history and physical examination may be performed by a member of the house staff unless specifically not requested by the attending physician treating the case. The attending physician is required to provide a medical history and physical examination on the private patient. A physician who has a private patient in the hospital will be expected to abide by the bylaws, rules and regulations.

31. **Restraint and/or Seclusion**. The procedures relating to restraint and/or seclusion are in the RUHS MC HW Policy No. 630(Restraints and/or Seclusion) and shall apply to all units using restraint and/or seclusion.

32. **Sterilization.** The Obstetric Gynecology Department, Family Medicine Department, and the Urology Division will each have a policy regarding sterilization that will include appropriate informed consent, and it will also comply with all existing state and federal statutes pertaining to this procedure.

33. **Suicide.** An attempted suicide or chemical overdose patient shall be offered psychiatric consultation and it will be documented in the patient's medical record.

34. **Surgery Schedule**. When a surgical operation is scheduled by a resident physician, it shall be only after consultation with the attending member of the involved service.

35. **Surgical Assistants**. When it is necessary that two members of the attending medical staff scrub on the same case, one of them shall act as the second assistant if a resident is available as the first assistant, unless in the opinion of the operating surgeon such an arrangement would not be in the best interest of the patient.

36. **Symbols and Abbreviations**. Only symbols and abbreviations contained in Stedman's Medical Dictionary shall be regularly used. A list of symbols and abbreviations designated as "Do Not Use" by the Joint Commission because of potential dangerousness shall be maintained by the Medical Records Department and shall be available to those authorized to make entries in the medical record.

37. **Tissue**. No tissue shall be removed from the hospital without the consent or permission of the pathologist and the medical director or in response to a subpoena or Court Order.

38. **Release of Body**. In the event of a patient's death, the deceased shall be pronounced dead by a licensed physician within a reasonable time. Policies with respect to releases of the body shall conform to state law. Documentation of death will adhere to RUHS HIM policy 701 - Chart Completion.