West Jefferson Medical Center
LCMC Health

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ENABLING PROCEDURE AND PURPOSE

This Credentials Policy and Procedure Manual or Manual has been created by the Medical Staff of West Jefferson Medical Center under the authority of the Medical Staff Bylaws of West Jefferson Medical Center ("**WJMC**") and approved by the WJMC Board of Directors. This Manual governs credentialing, re-credentialing, appointment and reappointment of Practitioners to the Medical Staff of West Jefferson Medical Center.

APPROVAL AND MODIFICATION

Pursuant to the Medical Staff Bylaws, this Manual and its contents are subject to the approval of the Board of Directors of West Jefferson Medical Center. Once approved, this Manual and its contents become effective, subject to duly created amendments as may from time to time be adopted by the Medical Staff and approved by the Board.

The following terms and their respective definitions apply throughout this Manual. Furthermore, there are additional terms throughout this Manual which are defined in the text of this Manual.

DEFINITIONS

Active Appointee(s)	Appointee(s) to the Active Staff.
Active Clinical Appointee(s)	Appointee(s) to the Active Clinical Staff.
Active Provisional Appointee(s)	Appointee(s) to the Active Provisional Staff.
Administration	The Board and/or the officers of the Hospital.
Administrator	The individual appointed by the Board as President and Chief Executive Officer of the Hospital to act on its behalf in the overall administrative management of the Hospital.
Adverse Action or Recommendation	An action or recommendation which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual Practitioner (which conduct affects or could affect adversely the health or welfare of a patient) and which affects (or may affect) adversely the Clinical Privileges of a Practitioner.
Allied Health Professionals or AHPs	Any Health Care Provider other than Podiatrists, Doctors of Osteopathy, Medical Doctors, Dentists, or Clinical Psychologists.

Applicant	Any Practitioner who has requested an application from the Hospital to be granted to him any Privileges and/or Appointment at the Hospital.
Appointee	Any Physician, Dentist, Podiatrist and Clinical Psychologist appointed to the Staff or granted any Privileges at the Hospital.
Application	Documentation submitted by a Practitioner requesting the Hospital to grant to him Privileges and/or Appointment at the Hospital.
Appointment	Appointment, either Initial Appointment or Reappointment, to the Staff.
Approved Training Program	A program accredited by the American Board of Medical Specialties.
At Large Officer	One of two Electoral Appointees elected by the Staff at its Election Meeting who shall serve as members of the MEC for a two (2) year term; each of the two (2) At-Large Officers shall be regularly elected in alternate years unless, for some reason, an At-Large Officer is unable to complete his term, in which case another Electoral Appointee shall be elected at the next Election Meeting to serve the remainder of the term.
Automatic Restriction	Restriction of Privileges or Appointment resulting from an adverse action taken by an agency or organization outside of the Hospital**.**
Automatic Revocation	Revocation of Privileges or Appointment resulting from an adverse action taken by an agency or organization outside of the Hospital**.**
Automatic Suspension	Suspension of Privileges or Appointment resulting from an adverse action taken by an agency or organization outside of the Hospital.
Board	The Board of Directors of the Hospital.
BME	Louisiana State Board of Medical Examiners or its successor**.**
BNDD	Bureau of Narcotics and Dangerous Drugs
Bylaws a/k/a "these Bylaws"	The Medical Staff Bylaws including the Credentials Manual, the Organization and Functions Manual, and the Fair Hearing Plan and related documents that require adoption by the Medical Staff and approval of the Board.
Chief Elect	Electoral Appointee elected at an Election Meeting who automatically matriculates to Chief of Staff upon the expiration of the term of office of the Chief of Staff.

Chief of Staff or Chief	The current Chief of Staff previously elected as Chief Elect pursuant to these Bylaws.
Clinical Privileges or Privileges	The rights granted to a Practitioner to provide those diagnostic, therapeutic, medical, surgical, dental, osteopathic, podiatric, or psychological services specifically delineated to him.
Clinical Psychologist or Psychologist	An individual licensed to practice clinical psychology by the Louisiana State Board of Examiners of Psychologists and who possesses a doctoral degree in psychology from an organized, sequential program in a regionally accredited university or professional school accredited by the American Psychological Association ("**APA**").
CE	Continuing professional education relevant to a Practitioner's specialty and/or discipline and required and acceptable for relicensure.
Committee	Medical Staff Committee or Administrative Staff Committee.
Consulting Appointee(s)	Appointee(s) to the Consulting Staff.
Corrective Action or Recommendation	An action or recommendation which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual Practitioner (which conduct affects or could affect adversely the health or welfare of a patient) and which affects (or may affect) adversely the Clinical Privileges of a Practitioner.
Courtesy Appointee(s)	Appointee(s) to the Courtesy Staff.
Credentials Committee	Committee composed of Electoral Appointees with a Chairperson and members who are appointed by the Chief of Staff, whose function is to supervise Initial Appointments, Reappointments, and Privileges of all Appointees or Applicants.
Credentials Manual	The current Credentials Policy and Procedures Manual then adopted and in effect at the Hospital and made a part of these Bylaws.
DEA	U.S. Drug Enforcement Agency.
Dentist	An individual licensed to practice dentistry by the Louisiana State Board of Dentistry.
Department	A unit created within the Medical Staff composed of ten (10) or more Appointees who are not all members of a single professional group or corporation unless permitted by an exclusive contract.

D.O. or Doctor of Osteopathy	An individual granted a license by the BME to practice osteopathy and who holds a degree in osteopathy.
Electoral Appointee(s)	Appointee(s) to the Electoral Staff.
Electoral Staff	Active and Senior Attending Appointees.
Eligible Appointee	An Active Appointee; such Appointees are eligible to be elected Medical Staff Officers.
Exclusive Agreements or Contracts	Contracts or letters of agreement between Hospital and a Practitioner or group of Practitioners whereby such Practitioner or Practitioner group has the sole right to provide specific patient care services in the Hospital as more fully set forth in the Medical Staff Rules and Regulations.
Ex Officio	Service as an appointee of a body by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.
Faculty Member	An Active Appointee who has an appointment at a medical school of a University which has a contract with the Hospital pursuant to which a resident or fellow at such medical school is assigned to the Hospital for training under the direction of said Active Appointee.
Fair Hearing Plan or Plan	That current procedures adopted and in effect at the Hospital and made a part of these Bylaws
General Criteria	Those General Criteria defined in the Credentials Manual, in Part 3.3 thereof.
General Criteria for Ongoing Appointment	Those General Criteria for ongoing appointment defined in the Credentials Manual.
General Officers	Chief of Staff, Chief Elect, the two At Large Officers, and the Immediate Past Chief.
Greater New Orleans Area	Shall include the following Parishes in the State of Louisiana: Jefferson, Lafourche, Orleans, Plaquemines, St. Bernard, St. Charles, St. James, St. John the Baptist, St. Tammany, Tangipahoa, and Terrebonne.
Health Care Providers	Shall include Practitioners, Allied Healthcare Professionals, Licensed Independent Practitioners and licensed and/or certified persons performing health care services at the Hospital.
Health Care Quality Improvement Act or HCQIA	The Health Care Quality Improvement Act of 1986 codified at Title 42, United States Code, Sections 11101, et seq. or any successor(s).

Honorary Appointee(s)	Appointee(s) to the Honorary Staff.
Hospital	Hospital District No. 1 of the Parish of Jefferson, State of Louisiana d/b/a West Jefferson Medical Center, including all of its inpatient, outpatient and other health care facilities services located in Jefferson Parish, Louisiana.
Hospital Bylaws	The bylaws of the Hospital then adopted and in effect.
Immediate Past Chief or Past Chief	The Chief of Staff to have last completed his term as Chief of Staff.
Initial Appointment	An Appointment for an Applicant who, upon his Application being submitted to the Hospital, is not currently an Appointee.
License	A permit or other form of authorization issued by an appropriate entity or body as authorized and/or created by law for the purpose of issuing such permission and authorization to provide health care services within the scope of such license, and the regulation thereof.
Licensed Independent Practitioner	A member of a profession who is permitted both by state law and these Bylaws to practice in a hospital without medical direction or supervision.
LSMS	Louisiana State Medical Society.
Locum Tenens	A Practitioner who is working temporarily in place of a specific Appointee.
Medical Doctor or M.D.	An individual granted a license by the BME to practice medicine and who holds a degree in medicine.
Medical Executive Committee (MEC)	That group of Active Appointees designated pursuant to these Bylaws to represent and coordinate all activities and policies of the Staff and its subdivisions; it is also the professional review body as defined in the HCQIA.
Medical Staff or Staff	The formal organization created by the Board composed of Medical Doctors, Podiatrists, Doctors of Osteopathy, Dentists, and/or Clinical Psychologists who have been appointed by the Board to assist the Hospital in carrying out Patient care and certain administrative responsibilities.
Medical Staff Committee	A committee whose membership, other than ad hoc membership, consists only of Staff members.
Medical Staff Office or MSO	An office or suite of offices maintained by the Hospital to provide assistance to the Staff concerning these Bylaws.
Medical Staff Officers	Chief of Staff, Immediate Past Chief, Chief Elect, Department Chairperson, Credentials Committee Chairperson and the Two At

	Large Officers.
Medical Staff Year	The period from January 1 to December 31.
Minimum Threshold Criteria	The minimum criteria to be considered for medical staff appointment.
MSC	The Medical Staff Coordinator.
Nominating Committee	A Medical Staff Committee consisting of the Chief, the two immediate Past Chiefs, and two Electoral Appointees who have been elected at the Third Quarter Staff Meeting; this Committee's purpose is to submit names of Eligible Appointees to be candidates for vacant offices, the election for which is to be held at that year's Election Meeting.
Oral Surgeon	A licensed dentist with advanced training qualifying him for board certification by the American Board of Oral and Maxillofacial Surgery.
Organization and Functions Manual or O&FM	The current Organization and Functions Manual then adopted and in effect at the Hospital and made a part of these Bylaws.
Past Chief	That Appointee who served as Chief prior to the current Chief.
Patient	An individual admitted to, treated at, or diagnosed at the Hospital.
Patient Contacts	Admissions, consultations, procedures (inpatient or outpatient), and/or evaluations; and services performed in the Emergency Department.
Performance Improvement or PI	The periodic assessment of patient care information to evaluate the quality and appropriateness of care, to identify opportunities to improve care, and to identify problems in patient care.
Physician	An individual with an M.D. or D.O. degree and who is licensed by the BME.
Podiatrist	An individual licensed by the BME and holding a certificate to practice the profession of podiatry.
Practitioner	Unless otherwise expressly provided, any Physician, Dentist, Podiatrist, Clinical Psychologist, or Licensed Independent Practitioner applying for or exercising clinical Privileges or providing other diagnostic, therapeutic, teaching or research services in the Hospital.
Prerogative	A participatory right granted, by virtue of Staff category or otherwise, to an Appointee, and exercisable subject to the conditions and limitations imposed in these Bylaws, the Medical Staff Rules and Regulations and other Hospital and Staff policies.
Primary Hospital	The medical facility where the Appointee performs the plurality

	of his in house care.
Privileges	See Clinical Privileges.
Medical Staff Rules and Regulations	Those current details, processes and procedures not set forth in the Bylaws which are adopted by the Medical Executive Committee, approved by the Board, and in effect at the Hospital.
Reappointment	An Appointment for an Applicant who, upon his Application being submitted to the Hospital, is currently an Appointee.
Required Malpractice Insurance	The Practitioner's Appointment is automatically, contemporaneously suspended and voluntarily relinquished when the Practitioner fails to maintain malpractice insurance as required by the Bylaws, this Manual, the Organization and Functions Manual or related Hospital rules and regulations, or applicable law (hereafter the "Required Malpractice Insurance").
Senior Attending Appointee(s)	Appointee(s) to the Senior Attending Staff.
Special Notice	Written notification sent by certified or registered mail, return receipt requested.
Staff or Medical Staff	See "Medical Staff."
Staff Year	January 1 through December 31 of each calendar year.
Unassigned Patients	A Patient that presents to the Hospital who has no current professional relationship with any Appointee.
Westbank	The territory within the Parish of Jefferson, State of Louisiana, west of the Mississippi River exclusive of Grand Isle.

SECTION I CONFIDENTIALITY POLICY

All members of any and all Medical Staff Committees shall maintain, to the fullest extent reasonable, the confidentiality of all records and all discussions and/or deliberations relating to credentialing, quality assessment, performance improvement and peer review activities. Disclosure of any such records, information, and/or communications or deliberations shall be permitted only as described in this Manual, HCQIA or as ordered by a Court of competent jurisdiction.

Accordingly, in order to be eligible to serve as a member of any Medical Staff Committee, each and every Appointee must execute the written acknowledgment of an agreement concerning confidentiality and conflict of interest then in use by the Hospital.

All Appointees recognize and acknowledge that failure of such members to maintain the appropriate confidentiality of all records, discussions and/or deliberations relating to credentialing, quality assessment, performance improvement or peer review activities may result in the following:

1) Dismissal from the relevant Committee and/or as a Medical Staff Officer;

2) Loss of available legal protections (including loss of indemnification for any litigation costs and expenses);

3) Disciplinary action as deemed appropriate by the Board or MEC pursuant to these Bylaws; and/or

4) Other appropriate action.

In addition, Credentials Committee members may be provided materials and information to review before each regularly scheduled meeting of the Credentials Committee. Such materials and information are confidential and must be returned to the MSC at that meeting. A master copy of each item will be maintained by the MSC.

SECTION II STAFF PRIVILEGES: GENERAL REQUIREMENTS AND LIMITATIONS

2.1 No person shall have, enjoy or exercise any organizational rights or Privileges within the Staff or the Hospital except pursuant and subject to the limitations of Appointment to the Staff and/or delineation of Clinical Privileges in accordance with the provisions of this Manual and these Bylaws.

2.2 Any Applicant's Appointment is conditional upon satisfactory demonstration of minimum qualifications and requirements as specified below, and the absence of the specifically defined grounds for denial or Corrective Action further set forth in this Manual and these Bylaws.

SECTION III PRE APPLICATION PROCESS AND GENERAL REQUIREMENTS

3.1 All requests for Application, Appointment or Privileges will be received by the MSC.

3.2 Upon receipt of such request, the MSC will provide the potential Applicant with a “Request for Application” form.

3.3 The potential Applicant must satisfy the following General Criteria for Initial Appointment:

3.3-1 If a Medical Doctor, has completed (or is in the last 6 months of) an approved residency program accredited by the American Board of Medical Specialties of at least 3 years duration, or is board certified or board admissible as defined by the rules for admissibility as promulgated by his specialty board and be applying for Privileges in the specialty of training and/or Board Certification; if a Podiatrist, has graduated from an accredited podiatric school, followed by a hospital-based residency program; if a Doctor of

Osteopathy, has graduated from an accredited school of osteopathic medicine and completed an approved 12-month internship; if a Dentist, has graduated from an accredited school of dentistry and completed an advanced training program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation; and if a Clinical Psychologist, holds a doctoral degree in psychology from an organized, sequential program in a regionally accredited university or professional school accredited by the American Psychological Association.

3.3-2 Have actively practiced at least six (6) of the last twelve (12) months (residency, fellowship, or private practice).

3.3-3 Have established or plan to establish an office and residence in accordance with the Bylaws. (Exception may be made by the Board upon recommendation of the MEC).

3.3-4 Have a current unrestricted license or application pending to practice medicine, dentistry, osteopathy, podiatry, or clinical psychology in Louisiana and a current Federal Drug Enforcement Agency (DEA) number (if required by his specialty). These licenses must be unrestricted and unencumbered to the fullest extent permitted by law.

3.3-5 Currently have or will be accepted for professional liability insurance in the amount specified by the Board.

3.3-6 Possess a willingness and capacity to work in professional cooperation with and relate to other members of the Staff and Allied Health Professionals in a manner appropriate to quality patient care and to the purposes, objectives and goals of the Staff and the Hospital and to adhere to generally recognized standards of professional ethics.

3.3-7 No conviction of a criminal offense related to health care or listed as debarred, excluded or otherwise ineligible for participation in Federal Health Care programs (as defined by 42 USC 1320a-7b (F)).

3.3-8 No felony conviction of any type.

3.3-9 No record of denial, revocation, restriction or termination of appointment of clinical privileges by any hospital for reasons related to professional competence or conduct.

3.3-10 No record of denial, suspension, revocation, probation or restriction of medical, dental, podiatric or psychology licensure by any state, with the exception of a Physician who has entered the Physician Health Program and has fulfilled the requirements of the program and whose license has been reinstated.

3.3-11 No voluntary resignation on the part of the potential Applicant while an investigation or administrative proceeding was pending or threatened or in return for not conducting such an investigation or proceeding.

3.3-12 No record of denial of membership on the staff of any hospital or equivalent medical institution, or if such membership, once held, has been suspended (other than for routine

medical record incompletion), terminated, or revoked by the medical staff or governing body of such hospital, or by voluntary action on the part of the potential applicant while an investigation or corrective action was pending or threatened or in return for not conducting such an investigation or action;

3.3-13 No record of fraud, deceit, perjury, misrepresentation or omission in obtaining any diploma, license, permit or other credential required by this Section or in his Application or during the Application process.

3.3-14 If sections 3.3-11 or 3.3-12 are not met, the Credentials Committee may undertake an investigation of the action in the Applicant's file. The potential Applicant shall provide to the Credentials Committee information sufficient to demonstrate current clinical competency. If the Credentials Committee finds such information sufficient, it shall forward such information to the MEC. If the MEC finds the information sufficient and all other paragraphs of section 3.3 are met, the Application process may proceed.

These requirements set forth in Section 3.3 hereinabove are referred to herein as the "General Criteria for Initial Appointment."

3.4 Upon receipt of a completed "Request for Application" form, the MSC and the Credentials Chairperson will verify that the requirements of Section 3.3 have been met.

3.4-1 However, upon request, the potential Applicant must furnish any additional information/documentation to the MSC within 30 days of that request. Failure by the potential Applicant to satisfy such request will result in the voluntary abandonment by the potential Applicant of his attempts to apply to the Staff or for Privileges. Such voluntary abandonment will not entitle the potential Applicant to a fair hearing under HCQIA, any state law or these Bylaws.

3.4-2 In the event that any of the requirements of this Section III are not met, the potential Applicant will be notified of the deficiencies and resulting ineligibility to receive an Application. Under such circumstances, the potential Applicant is not entitled to a fair hearing under HCQIA, any state law or these Bylaws.

3.5 If subsequent to Appointment or the granting of Privileges, the Credentials Committee, MEC, Board, or designee thereof, determines that a misrepresentation, misstatement, or omission, whether intentional or innocent, occurred during the Application process, the Appointee shall automatically and voluntarily relinquish his Appointment and Privileges and any relationships the Appointee has with the Hospital shall be deemed to automatically cease, including Appointment, Privileges, participating provider status or contracts. There shall be no entitlement to a fair hearing under the HCQIA, any state law, or these Bylaws.

3.6 If during the credentialing process the Credentials Committee, MEC, Board, or designee thereof, discovers that the Applicant or potential Applicant did not satisfy the General Criteria for Initial Appointment, or any other criteria for Application, his Application automatically ceases to be processed. There shall be no entitlement to a fair hearing under the HCQIA, any state law, or these Bylaws.

SECTION IV APPLICATION PROCESS

4.1 POLICY

The Hospital shall receive Applications only from a licensed Medical Doctors (M.D.s), Doctors of Osteopathy (D.O.s), Doctors of Dental Surgery (D.D.S.s), Doctors of Podiatric Medicine (D.P.M.s) and Clinical Psychologists (Ph.D.s or Psy.D.s).

4.1-1 Non-Physician Practitioners may not apply for specific clinical Privileges unless clearly permitted by existing Hospital policy.

4.1-2 Prior to submission of his Application, the Applicant will be provided with access to or a copy of these Bylaws. The Applicant will be required to sign an acknowledgment of receipt for or access to these documents, with the receipt acknowledging the Applicant's duty to read them and to be bound by them.

4.1-3 If, at any time, the Credentials Committee, MEC or Board, or designee thereof, determines that a misrepresentation, misstatement, or omission occurred during the Application process, whether intentional or unintentional, the Application process shall cease. The Applicant shall thereby voluntarily relinquish and forfeit his Application and shall automatically acknowledge that he is ineligible to apply for Appointment or Privileges. The Applicant acknowledges that in such instance he is not entitled to a fair hearing under HCQIA, any state law, or these Bylaws.

4.2 QUALIFICATIONS

The Applicant must:

4.2-1 Satisfy all General Criteria for Initial Appointment.

4.2-2 Explain in writing his plans for office location and for utilizing this Hospital. The Applicant must plan to establish an office and residence as defined in and consistent with these Bylaws.

4.2-3 Be physically and mentally capable of practicing competently, professionally and with safety to patients, to himself and to other Practitioners.

4.2-4 Not request Appointment or Privileges in a facility or service provided on an exclusive contract basis by a Practitioner or Practitioner group unless the Application is submitted in accordance with the existing Exclusive Contract or Agreement with the Hospital.

4.2-5 Adhere to his applicable Code of Ethics.

4.2-6 In addition to the qualifications set forth above, Appointment shall be subject to and conditioned upon such other qualifications and requirements as may be expressed or implied elsewhere in this Manual or these Bylaws.

SECTION V APPLICATION PROCESS FOR INITIAL APPOINTMENT

5.1 The Application must be typed or printed (not handwritten) and on the form designated by the Credentials Committee and approved by the Board.

5.2 The Applicant is to submit the Application to the Medical Staff Office.

5.3 The Applicant must sign the Application and in so doing:

5.3-1 Signifies his willingness to appear for interviews in regard to his Application;

5.3-2 Authorizes Hospital representatives to consult with others who have been associated with him and/or who have information bearing on his competence and qualifications;

5.3-3 Consents to Hospital representatives' inspection of all records and documents that may be relevant to an evaluation of his:

1. Professional qualifications and competence to carry out the clinical Privileges he requests,

2. Physical and mental health status, and

3. Professional and ethical qualifications;

5.3-4 Releases from any and all liability all Hospital representatives and employees for any and all of their acts performed in connection with evaluation of his credentials and qualifications;

5.3-5 Releases from any and all liability all individuals and organizations who provide information to Hospital representatives (including otherwise privileged or confidential information) concerning his competence, professional ethics, character, physical and mental health, emotional stability, and other qualifications for Appointment and clinical Privileges;

5.3-6 Authorizes and consents to Hospital representatives providing to other hospitals, professional associations, licensing boards, and other organizations concerned with provider performance and the quality and efficiency of patient care any relevant information that the Hospital may have concerning him. He releases Hospital and its employees and representatives, including Appointees, from any and all liability for so doing;

5.3-7 Signifies that he agrees to be bound by these Bylaws, the Medical Staff Rules and Regulations and all other applicable Hospital rules and policies, in regard to his Application for Appointment and for Clinical Privileges;

5.3-8 Agrees to provide and update all information requested on the original Application, (including each and every internship, residency and fellowship training program begun or

completed), and any subsequent Reapplication or Privilege request forms when any such information changes. Notification must be made within 60 days of such information becoming inaccurate, except as otherwise specifically and expressly provided for in these Bylaws. Such information includes, but is not limited to, hospital appointments; voluntary relinquishment of medical staff membership or clinical privileges or licensure status; voluntary or involuntary limitation, reduction or loss of clinical privileges at another hospital; involvement in liability claims resulting in settlement or final judgment in which the Practitioner is found liable; or license/DEA restrictions.

5.3-9 Agrees to submit to appropriate medical, drug screening, or similar examination and testing when reasonably requested by the Board, MEC, the Administrator or his designees, at the Applicant's expense.

5.3-10 For purposes of this Section, the term "Hospital representative" includes:

1. The Board, its directors and committees, and/or any member thereof;

2. The Administrator or his designee;

3. All members of all Medical Staff Committees or the designees of said Committees and their members;

4. Committees which have responsibility for collecting and evaluating the Applicant's credentials or acting upon his Application and their members; and

5. Any authorized representative of any of the foregoing.

5.4 PROCEDURE FOR PROCESSING APPLICATIONS FOR APPOINTMENT

5.4-1 As part of the Application process, eligible Applicants will be provided:

1. An Application for Appointment to the Staff, and a release of information form;

2. A Privileges delineation overview;

3. A Privileges request form and threshold criteria;

4. A detailed list of requirements for completion of the Application; and

5. A complete set of Medical Staff Bylaws.

6. A copy of the current Medical Staff Rules and Regulations.

5.4-2 It is the Applicant's sole responsibility to accumulate and provide to the Hospital the information and documentation as required in this Section or any other requested information. It is not the responsibility of the Hospital or Staff to acquire any missing

information or documentation. Failure to provide such information or documentation renders the Application incomplete.

5.4-3 It is the Applicant's responsibility to provide or have provided the following documentation necessary to complete an Application:

1. The typed (or printed), completed, and signed Application, Privileges request form(s), and release of information form;

2. A copy of his current state license and, where applicable, DEA certificate and BNDD certificate;

3. A copy of his current professional liability insurance policy;

4. Copies of certificates or letters confirming completion of an approved residency/training program or other educational curriculum;

5. Board status (copy of certificates or a copy of a letter from appropriate specialty board indicating board admissibility, eligibility or board certification);

6. Three (3) letters of recommendation from persons who have recently worked with the Applicant, have directly observed his professional performance over a reasonable period of time and who can and will provide reliable information regarding current clinical ability, ethical character and ability to work with others (references must be from individuals practicing in a field similar to the Applicant); and

7. Payment of the Application fee.

5.4-4 In certain instances, the Hospital may require of an Applicant a certified and notarized translation of a diploma, the original of which is in a foreign language.

5.4-5 A completed Application must include the following additional information:

1. Information from all prior and current insurance carriers concerning claims, suits and settlements (if any) during the past five (5) years;

2. Administrative and clinical reference questionnaires from all significant practice settings for the previous ten (10) years;

3. A verified report documenting the Applicant's clinical work during the past six (6) to twelve (12) months;

4. Verification of licensure status in all current or past states of licensure;

5. Information regarding Medicare / Medicaid Sanctions (OIG);

6. Information from the National Practitioner Data Bank (NPDB);

7. Information from the Healthcare Integrity and Protection Data Bank (HIPDB); and

8. Other information deemed necessary.

5.4-6 If all the required information listed above is not received within ninety (90) days of receipt of the Application, the Credentials Committee may consider the incomplete Application void and abandoned by the Applicant and no further processing will take place.

5.4-7 When the information items listed above have been obtained, the file will then be summarized and presented to the appropriate Department Chairperson and the Credentials Committee Chairperson.

5.4-8 The appropriate Department Chairperson or a member of the Credentials Committee may solicit additional information from past practice settings. Documentation of this contact will be placed in the Applicant's credentials file.

5.4-9 Upon receipt of a completed Application, as determined in the sole discretion of the Credentials Committee, the Medical Staff Office will send the Applicant a letter of acknowledgment.

5.5 DEPARTMENT CHAIRPERSON REPORT

5.5-1 The applicable Department Chairperson shall prepare a report concerning the Applicant and/or his Application. In so doing, the Department Chairperson shall review the Applicant's entire file.

5.5-2 If the Department Chairperson determines, in his sole discretion, that additional information is required of the Applicant, then he shall inform the Applicant of the required information, who is then under an obligation to provide to the requesting Department Chairperson the requested additional information as soon as possible.

5.5-3 If the Department Chairperson determines, in his sole discretion, that the Application in the Applicant's file contains information sufficient to render a report, then the Department Chairperson shall render a report on the Applicant's Application in a reasonable time. This report shall include documentation pertaining to the adequacy, or inadequacy, of the Applicant's education, training, experience, and current clinical competence for all Privileges requested. These reports should also refer, where applicable, to the Applicant's credentials file. Finally, the Department Chairperson must document any determinations, which he makes, in his sole discretion, that criteria for requested clinical Privileges are not met.

5.6 CLINICAL INTERVIEW POLICY AND PROCEDURE

5.6-1 It is the Staff's policy to conduct a personal interview of all new Applicants. The MSC will contact the Applicant to inform him of the need for a clinical interview. It is the Applicant's responsibility to schedule a clinical interview with the appropriate Department Chairperson.

5.6-2 The interview is to be clinical in nature and will be conducted by the Department Chairperson.

5.6-3 The interview may also be used to solicit information required to complete the credentials file or to clarify information previously provided, such as malpractice history, reasons for leaving hospitals' staffs, or other matters bearing on the Applicant's ability to render care.

5.6-4 The appropriate Department Chairperson who conducts the interview will document a permanent record of the interview, including the date and time of the interview, as well as documents reviewed, in addition to the general nature of the questions asked, adequacy of answers, and past practice history. A copy of the interview record will be placed in the Applicant's credentials file.

5.6-5 The Department Chairperson must submit the interview report to the Credentials Committee, who will review the report at its next regularly scheduled meeting.

5.7 CREDENTIALS COMMITTEE ACTION

5.7-1 Categorization of Applicants: Individual Applicants will be categorized by the Medical Staff Office and Credentials Committee according to the complexity of their education, training, and experience as follows:

A. Category One: A Category One Applicant is a recently trained Physician who is no more than two (2) years beyond completion of a residency or fellowship program for whom there was no difficulty in verifying information on the Application or obtaining references. No references suggested potential problems, and the Applicant has had no significant prior malpractice actions, very few prior hospital affiliations, and no reports of disciplinary action, licensure restrictions, or any type of investigation.
References are returned within a reasonable time with no prompting by the Medical Staff Office and contain no hint that the Applicant is anyone other than a highly qualified Physician capable of exercising good clinical judgment. Additionally, the Applicant generally requests Privileges consistent with the specialty and the rules previously established by the Hospital.

B. Category Two:
1. Rapid Appointment Candidates
A Rapid Appointment Candidate Applicant is a Physician for whom:
a) there is no difficulty in verifying information;
b) here is no difficulty obtaining references;
c) the references do not suggest any problems;
d) there has been no significant malpractice actions;

e) malpractice claims have not exceeded the expected per LAMMICO and other commercial malpractice insurers' frequency table;
f) there have been few prior hospital affiliations;
g) the most recent major hospital affiliation occurred more than 5 years ago;
h) there has been no prior disciplinary action;
i) there has been no prior license restriction; and
j) there has been no prior investigation of medical practice.

2. All Other Applicants

All other Applications will always be processed with a methodical review by the Department Chairperson, a review by the entire Credentials Committee, possibly coupled with a second interview, a separate independent critical analysis by the MEC, and a final review and action by the Board or an appropriately constituted Board subcommittee.

5.7-2 Processing Procedure

A. For Category One and Category Two Rapid Appointment Candidates: Processing an Application for Appointment to the Staff and Clinical Privileges should flow as follows:

1. The MSO receives and processes the Application.

2. The MSO and the Credentials Committee Chairperson, acting on behalf of the Credentials Committee, review the verified Application, and pursuant to 5.7 1 of this Manual determine and verify whether appropriate criteria are met.

3. The appropriate Department Chairperson acting on behalf of the appropriate Department, pursuant to this Manual, conducts an interview and provides a report for the Applicant's credentials file.

4. The Chief of Staff, acting on behalf of the MEC, reviews verified Applicants receiving favorable findings from the Departmental Chairperson, acting on behalf of the Department.

5. Favorable recommendations by the Chief of Staff, acting on behalf of the MEC, and documentation that the applicant has completed electronic medical record training including computerized physician order entry are then forwarded to the Board designee, which may grant Appointment and clinical Privileges. The MEC Chairperson or his representative will make an informational report to the Board at its next regular meeting. The Board has ultimate authority to approve Appointment and Privileges as recommended by the MEC to the Board.

6. If the Chief of Staff, Department Chairperson or Board designee disagrees with the recommendation of the Chairperson of the Credentials Committee, the Applicant is recategorized as "Category Two, All Other Applicants," and his Application is processed accordingly.

B. The processing of All Other Applicants must go through the entire credentialing process. The findings and recommendations of the Credentials Committee will be set out in a report signed by the Chairperson of the Credentials Committee or his designee. A member of the Credentials Committee will present a summary of the Applicant's file to the MEC at its next regularly scheduled meeting, Thereafter, there shall be review and final action by the Board.

5.7-3 An Applicant has no right to challenge the categorization by the Medical Staff Office and Credentials Committee, The Medical Staff Office and Credentials Committee have the sole and absolute discretion to categorize any and all Applicants.

5.8 MEC APPOINTMENT RECOMMENDATION

5.8-1 Following the review process by the MEC according to the appropriate category, one of the following actions may take place:

A. **Favorable Recommendation:** Whatever category process is followed, if the recommendation is favorable to the Applicant in all respects, the favorable recommendation will be forwarded to the Board.

B. **Deferral:** When the action is to defer the Application for further consideration, it is the Applicant's responsibility to clarify and answer any questions which have arisen concerning his Application and he is responsible to provide any information requested. The Applicant shall be notified in writing of the action to defer and the reasons for deferral.

C. **Adverse Recommendation:** If the MEC, after receiving the report of the Credentials Committee and any other information submitted by the Applicant or otherwise acquired, decides to give an Adverse Recommendation to the Board, the Applicant may be entitled to a fair hearing under the Fair Hearing Plan. An Adverse Recommendation in the Application context or Reapplication context is defined as a recommendation to deny Appointment, Reappointment, or to deny or restrict any substantive request for Clinical Privileges.

5.8-2 When applicable, at the next regularly scheduled meetings of the MEC and Board, a member of the Credentials Committee will present a summary of the Applicant's file, the Department Chairperson's findings, and the Credentials Committee's recommendation.

5.9 BOARD ACTION

5.9-1 **On a Favorable Recommendation of the MEC:** The Board or its authorized representative may adopt or reject, in whole or in part, the MEC's favorable recommendation, or may refer the recommendation back to the MEC or Credentials Committee for further consideration.

A. Favorable action by the Board is effective as its final decision. The Board may act to approve the MEC's recommendation contingent upon the completion of the electronic medical record training. The Administrator will notify the Applicant in writing of the Board's favorable action and provisional Appointment to the indicated Staff category and specified Privileges. Any pertinent information regarding Appointment will be forwarded or made available to the Appointee at this time.

B. If the Board refers the recommendation for further consideration, the Board should state the reasons for such referral and set a time limit for the Committee(s) to make a subsequent recommendation.

5.9-2 **On an Adverse Recommendation of the MEC:** In the case of an Adverse Recommendation by the MEC, the Board may accept or reject the Adverse Recommendation. If the Board does not accept the MEC's Adverse Recommendation, then the Board shall refer the matter back to the MEC for further reconsideration. If the Board accepts the Adverse Recommendation of the MEC, it will deny Appointment, Reappointment or deny or restrict any substantive request for Clinical Privileges.

5.9-3 **Notification:** If the Board's final action is an Adverse Action, notice will be sent to the Applicant. The Applicant is not entitled to the procedural rights provided in the Fair Hearing Plan prior to the final Adverse Action and notification thereof by the Board.

5.10 REASONS FOR ADVERSE ACTION OR RECOMMENDATION

Each individual's or group's report, including the Board's, must state the reasons for each recommendation or action taken, with specific reference to the completed Application and any other documentation that was considered. Any dissenting views at any point in the process must be documented, supported by reasons and references, and transmitted with the majority report.

5.11 NOTICE OF FINAL DECISION

5.11-1 In addition to notifying the Applicant, the Administrator shall notify each applicable Department Chairperson and the MEC of the Board's final decision.

5.11-2 A decision and notice of Appointment includes:

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. The term of his Appointment, and any special conditions that may apply.

5.11-3 A decision and notice of denial or restriction of any substantive request for Clinical Privileges includes the reasons for the denial or restriction, with specific reference to the completed Application and any other documentation that was considered.

5.12 TIME PERIODS FOR PROCESSING

When a completed Application is received, the Board will consider, but need not act upon, the Application within seventy-five (75) days of receipt of the completed Application; the Credentials Committee Chairperson has the sole discretion to determine whether an Application is complete. This time period is deemed a guideline - it is not an Applicant's right to have his Application processed within this precise period. If the provisions of the Fair Hearing Plan are activated, the time requirements provided therein govern the continued processing of an Application.

5.13 GROUNDS FOR DENIAL

5.13-1 An Appointment may be denied to an Applicant who is otherwise completely qualified if the Applicant:

A. Has been denied membership in any county, parish or state medical, dental, podiatric or psychological society, or if such membership, once held, has been suspended, terminated or revoked by such society or by voluntary action on the part of the Applicant while an investigation or corrective proceeding was pending or threatened or in return for not conducting such an investigation or proceeding.

B. Has been denied any state license or permit, or federal registration to prescribe, dispense or administer controlled substances, or if such license, permit or registration, once held, has been suspended, revoked or restricted either by action of the issuing agency or by voluntary action on the part of the applicant while an administrative investigation or proceeding is pending or threatened or in return for not conducting such an investigation or proceeding;

C. Is or has been physiologically or psychologically addicted to or dependent on mood altering substances, including alcohol, or is or has been subject to recurring use or abuse of such substances, unless the Applicant is receiving or has completed effective and successful treatment in a treatment or recovery program and can document adherence to such program;

D. Is unable to practice medicine, dentistry, podiatry or psychology with reasonable skill or safety to Patients because of mental or physical illness or deficiency

including but not limited to deterioration or loss of mental or motor skills through the aging process or through excessive use or abuse of drugs, including alcohol;

E. Is professionally incompetent, as evidenced by inability or repeated, continuing or recurring failure to satisfy prevailing and commonly accepted standards of medical, dental, podiatric or psychology practice;

F. Has willfully and unreasonably failed or refused to timely provide information or documentation reasonably requested as part of the application process;

G. Has failed or refused to submit to medical examination, drug screening, or other evaluation or testing as reasonably requested by Hospital representatives as part of the Application process.

5.13-2 Notwithstanding the existence of one or more of the grounds for denial of Appointment enumerated in the preceding subsection, an Applicant may nonetheless be appointed to the Staff if the Staff and Board determine that such grounds are not likely to materially affect the Applicant's capacity to practice medicine, dentistry, podiatry or psychology competently and professionally. Appointment is and shall be deemed a privilege accorded in the discretion of the Board. No Applicant is entitled to or has any right to membership on the Staff or to the exercise of clinical Privileges within the Hospital solely because the Applicant is licensed to practice medicine, dentistry, podiatry or psychology in Louisiana or in any other state, or because he is a member of any professional organization, or because he is certified by any clinical board, or because he is a member of the faculty of a medical, dental, podiatric or psychology school, or because he possesses, or did possess, Staff membership or Privileges at any other health care facility or this Hospital.

SECTION VI PROVISIONAL STATUS

6.1 PROVISIONAL PERIOD: All: (1) initial Appointments, (2) grants of clinical Privileges, or (3) any new clinical Privileges granted to an existing Appointee are provisional for a period of twenty-four (24) months.

6.1-1 The applicable Department Chairperson is responsible for reviewing the clinical performance of an individual with provisional privileges.

6.1-2 Any request by an appointee with Provisional Privileges to reduce the category of his Privileges will not be granted prior to the conclusion of the provisional period of twenty-four (24) months unless the Credentials Committee and the MEC find that such special circumstances exist which warrant such a reduction.

6.2 SUCCESSFUL CONCLUSION: At least 120 days prior to the end of a provisional period, the MSC will notify the Practitioner indicating the date the provisional period may expire. To document the successful conclusion of the provisional period, the following must be submitted to the Credentials Committee at least ninety (90) days prior to the end of the provisional period.

6.2-1 Statements from the Chairperson of each Department in which the Practitioner was granted initial or increased Privileges indicating that the Practitioner has satisfactorily demonstrated competence.

6.3 ACTION REQUIRED: The Credentials Committee will consider the requests and statement(s) and either defer action for not more than thirty (30) days or prepare a written report with recommendations and supporting documentation for transmittal to the MEC. Final processing follows the procedures set forth in the Initial Appointment process.

6.4 TERMINATION BY PRACTITIONER: If the Practitioner no longer wishes the Privilege(s) at issue, then either the Practitioner's request for the removal of the Privilege(s) or his lack of timely response to the letter of notification will initiate the expiration of the Privilege(s), without creating an Adverse Action or triggering the Fair Hearing Plan.

6.5 ADVERSE CONCLUSIONS PROCEDURAL RIGHTS: Whenever a provisional period (including any period of extension) expires with an Adverse Recommendation or Adverse Action or Corrective Action, the Administrator will notify the Practitioner of the adverse result and of his entitlement (if any) to procedural rights provided in the Fair Hearing Plan.

SECTION VII REAPPOINTMENT PROCESS AND CRITERIA

7.1 All Reappointments are for a period not to exceed two (2) years.

7.1-1 The MSC must notify the Appointee of his Appointment expiration date at least 120 days prior to the expiration date.

7.1-2 The Appointee will be given a list of his current clinical Privileges discerned from the Appointee's credentials file. The Appointee shall review the list and request any changes.

7.1-3 Applicants for Reappointment must fulfill the following “general criteria for ongoing appointment:”

A. Be board certified or board admissible (as defined by the rules for admissibility as promulgated by his specialty board) or have sufficient clinical experience at the Hospital so that his clinical competence can be evaluated and assured. Whether Applicant has sufficient clinical experience at the Hospital is solely within the Hospital's discretion.

B. Have actively practiced at least six (6) of the last twelve (12) months.

C. Have established an office and residence in accordance with the By-Laws. (Exception may be made by the Board upon recommendation of the MEC.)

D. Have a current unrestricted license to practice medicine, dentistry, osteopathy, podiatry or psychology in Louisiana and a current Federal Drug Enforcement Agency (DEA) number (if required by his specialty or discipline).

E. Currently have professional liability insurance in the amount specified by the governing board.

F. Possess a willingness and capacity to work in professional cooperation with and relate to other members of the Staff and Allied Health Professionals in a manner appropriate to quality Patient care and to the purposes, objectives and goals of the Staff and the Hospital and to adhere to generally recognized standards of professional ethics.

G. No conviction of criminal offense related to health care or listed as debarred, excluded or otherwise ineligible for participation in Federal Health Care programs (as defined by 42 USC 1320a -7b (f)).

7.1-4 If, during the Reappointment process the Staff member does not satisfy the "general criteria for ongoing appointment," the Reappointment process will be interrupted until the criteria are met. If the criteria are not met within 30-days, the Reappointment process will automatically cease and the Applicant shall have no right to a fair hearing under the HCQIA, state law, or these Bylaws.

7.1-5 Any request of an Appointee to reduce the category of his Privileges will not be granted prior to the conclusion of his reappointment period of two (2) years unless the Credentials Committee and the MEC find that such special circumstances exist which warrant such a reduction.

7.2 INFORMATION COLLECTION AND VERIFICATION

7.2-1 **From Staff Appointees:** At least 90 days prior to the expiration date of the current Appointment, the Appointee must furnish the following in writing:

A. Complete information to update the original Application.

B. Documentation of CE, further training and fellowships since last Appointment or Reappointment.

C. A specific request for any modification of clinical Privileges sought on Reappointment, accompanied by information demonstrating current clinical competence in the specific Privileges requested.

D. In addition to A, B, and C above, the Practitioner requesting Reappointment by virtue of said request agrees to submit to appropriate medical examination, drug screening, or similar examination and testing where reasonably requested by Hospital representatives. The cost of examination and testing shall be borne by the Practitioner requesting Reappointment.

7.2-2 The MSC shall verify all information and notify the Appointee of any information inadequacies. In such a case, the Appointee has the burden of producing adequate information and resolving any doubts about the data.

7.2-3 A Practitioner's failure to timely provide the above information, without good cause, results in automatic termination, expiration and voluntary relinquishment of Appointment at the current expiration date of the Appointment and Privileges, unless explicitly extended by the Hospital for not more than two (2) thirty (30) day periods.

7.2-4 **From Internal and/or External Sources:** The MSC collects from the Appointee's credentials file and other relevant sources information regarding the Appointee's professional and collegial activities, and his performance and conduct in this Hospital and/or other hospitals and health care organizations. Such information includes, without limitation:

A. Patterns of care, as demonstrated in findings of quality/utilization monitoring activities;

B. Medical records/hospital reports;

C. Continuing education activities;

D. Attendance at Staff and Department meetings as required by the O&FM;

E. Service on Staff, Department, and Hospital committees;

F. Timely and accurate completion of medical records;

G. Compliance with all applicable Bylaws, Rules and Regulations of the Medical Staff and other rules, policies and procedures of the Hospital.

7.2-5 In the event that questionnaires sent to other practice settings are not returned promptly, the MSC will request the Appointee's assistance and will indicate a date by which all information must be received. If the information is not received by the specified date, the Reappointment request will not be processed and the Appointment will terminate.

7.2-6 The MSC must also request and obtain a complete copy of all information on the Applicant for Reappointment maintained on said Applicant by the National Practitioners Data Bank and the Healthcare Integrity and Protection Data Bank. Any adverse information contained therein shall be included in the administrative summary and/or report prepared

by the MSC, which is then to be forwarded to the applicable Department Chairperson for review and will form a permanent part of the Appointees' credentials file.

7.2-7 All returned documents shall be reviewed and verified as described in the Initial Appointment Section of this Manual.

7.2-8 Once all information has been collected, verified, and reviewed, the MSC or appropriate administrative representative shall compile an administrative summary to be used for Reappointment decisions.

7.2-9 The completed file, including all documentation mentioned above, shall be sent to the applicable Department Chairperson for review.

7.2-10 Department Chairperson Recommendation

A. Each Chairperson of a Department in which the Appointee requests Privileges (or has exercised Privileges) shall review the Appointee's file, as described above, and forward a written report and recommendation to the Credentials Committee.

B. The Department Chairperson must include a statement indicating whether he knows of any present or potential physical or behavioral problem affecting the Practitioner's ability to perform professional and Staff duties appropriately. The report must also indicate the Practitioner's current clinical competence and ability to safely exercise requested clinical Privileges.

7.2-11 Credentials Committee and MEC Action

The Credentials Committee and MEC review the Appointee's file, Department reports, and all relevant information and forward to the Board a written report with recommendations for Reappointment, including Staff category, Department assignment, and Clinical Privileges or non-reappointment.

7.3 FINAL PROCESSING AND GOVERNING BOARD ACTION

The final processing of requests for Reappointment follows the same procedure as for Initial Appointment.

7.4 EFFECT OF STAFF APPOINTMENT TERMINATION: Because practice and any activities at the Hospital are always contingent upon continued Appointment and are also constrained by the extent of clinical Privileges enjoyed, a Practitioner's right to use Hospital facilities is automatically terminated when his Appointment expires, is terminated or is voluntarily relinquished as provided hereinabove. Similarly, the extent of his clinical Privileges is automatically limited to the extent the pertinent clinical Privileges are diminished.

SECTION VIII CLINICAL PRIVILEGES

8.1 GUIDELINES: The following guidelines are established and will be followed to insure a successful Privilege delineation system:

8.1-1 Predefined criteria, including minimum threshold criteria, will be specialty and/or discipline specific in order to ensure that Privileges are specific to each Practitioner's education, training, and experience.

8.1-2 Description of Clinical Privileges will be accurate, detailed, comprehensive, and specific.

8.1-3 The system will be designed to avoid denials by clearly stating the minimum education, training, and experience needed to apply for specific clinical Privileges.

8.1-4 Only Practitioners who meet the predefined minimal threshold criteria for specific clinical Privileges are eligible to apply for such.

8.1-5 The Credentials Committee will maintain customized Privilege request forms for specific Clinical Privileges as well as for specially requested Privileges. These forms will be given to each Applicant requesting specific Clinical Privileges or special request Privileges. These forms will also outline the "minimum threshold criteria" needed to apply for specific Clinical Privileges and special request Privileges. The minimal threshold criteria will include, at a minimum, specified levels of the following:

A. Education: *i.e*., medical degree, osteopathic degree, dental degree, or other applicable degree;

B. Formal Training: *i.e.*, residency, fellowship, CE, or other relevant training;

C. Previous Experience, *i.e.*, direct or indirect clinical experience; and

D. Current Clinical Competence: *i.e.*, as indicated in recent practice.

8.2 DELINEATION OF PRIVILEGES

8.2-1 **Requests:** Each Application to the Staff must contain a request for the Applicant's desired clinical Privileges. The Applicant must submit special requests for modification of Privileges between Reappointments.

8.2-2 **New Procedures or privileges not currently offered by the Hospital:** An Application will neither be provided nor processed when the Hospital has no governing policy for the new request. If the Hospital does not have specific criteria for a submitted request, the request will be tabled for a period, during which time the Board will consult with the Credentials Committee, the MEC, and other appropriate individuals and may formulate the necessary criteria.

8.2-3 **Minimum Requirements:** All potential Applicants will be provided with the current approved description of minimum threshold criteria that specify the amount of education, training, experience, and evidence of competency required to request privileges. Requests will be processed only when the applicant has met these requirements.

8.2-4 **Basis for Privileges Determination:** Requests for Clinical Privileges will be evaluated on the basis of education, training, experience and current clinical competence, ability, and judgment. Decisions regarding Privileges delineation will also be based on pertinent information from other sources, especially other institutions and health care settings where a Practitioner has exercised clinical privileges. All information used for a Privilege decision will be maintained in the Applicant's credential file.

Privilege requests in connection with periodic Reappointment or a change in Privileges must include observed clinical performance and documented results of the Hospital's Performance Improvement activities.

To be considered, all Applications must be on the prescribed form and accompanying information must cover all the most current required criteria. In the event all required or requested information is not provided, the Application for clinical Privileges will be considered incomplete and will not be processed. The Applicant will be notified of the incomplete status of his request.

A request for modification of Privileges prior to Reappointment is processed in the same manner as a request for Reappointment. A request for modification of Privileges within the specialty or discipline may be recommended by the Chairperson of the Credentials Committee in conjunction with the Department Chairperson and Chief of Staff following evaluation of documentation submitted to support the request. The Board or its designee must approve the privileges prior to their being implemented.

8.3 DENTAL, PODIATRIC AND PSYCHOLOGY

Requests from Dentists, Podiatrists and Clinical Psychologists for clinical Privileges are processed in the same manner as requests from M.D.s. and D.O.s. Dentists, Podiatrists and Clinical Psychologists who are granted privileges will be supervised as follows:

8.3-1 The Surgery Department Chairperson will supervise surgical procedures performed by Dentists and Podiatrists and the Medicine Department will supervise the diagnostic testing and therapy performed by Clinical Psychologists; and

8.3-2 A designated Appointee will provide all dental, podiatric and psychology patients a basic history & physical and will be responsible for the care of any medical problem that is present on admission or develops during admission. This Appointee will be responsible for the overall medical care of the Patient, and must know of and concur with any surgical procedure performed.

8.3-3 Clinical psychologist may not be granted or exercise prescriptive authority in the Hospital or hold admitting privileges.

8.4 CONDITIONAL PRIVILEGES

Conditional Privileges: Conditional privileges may be granted under circumstances listed below:

8.4-1 Non-Staff Practitioner

A. An Active Appointee requests conditional privileges for a non-Staff Practitioner in his specialty and/or discipline.

B. Upon receipt of such request, the Medical Staff Coordinator will forward to the Active Appointee sponsoring the request a form to be signed by the Active Appointee and the requesting Practitioner confirming the request and acknowledging:

1. The Applicant is an appropriately licensed Practitioner;

2. Verified information supports a favorable determination regarding the Applicant's qualifications, ability, and judgment to exercise the Privileges requested;

3. The Practitioner has satisfied the Board's professional liability insurance requirement; and

4. The Practitioner has agreed in writing to abide by the Staff and Hospital Bylaws, the Medical Staff Rules and Regulations, as well as other rules, regulations, and policies relating to conditional privileges.

C. No conditional privileges will be granted until the completely executed form is returned to the Medical Staff Coordinator, and all information has been verified and the information has been reviewed by the Chief of Staff or his designee.

1. The privileges may be granted by the Board or its designee.

2. Conditional privileges granted to any Practitioner shall not be valid for more than (5) patients in any 12 month period.

8.4-2 **Locum Tenens:** A Locum Tenens is a Practitioner who is working temporarily in place of a specific Appointee. In such cases, the Administrator may grant a conditional time limited Appointment and conditional limited Privileges for a 30-day period, which may be renewed for two (2) additional 30-day periods. Such Privileges limit the Locum Tenens Practitioner to treating only those patients of a specific Appointee for whom he is serving as Locum Tenens, (i.e. taking the place of, or a temporary substitute for the Appointee, unless there is a need as deemed urgent or emergent by the Administrator or any member of the MEC) and do not entitle the Locum Tenens Practitioner to admit his own Patients as opposed to Patients of the Appointee for whom he is acting as Locum Tenens to the Hospital. However, the Locum Tenens Practitioner's service on the emergency room

specialty coverage program may be required. A $100.00 fee for each 30-day period is payable by or on behalf of the Practitioner at the time of the request for Locum Tenens.

8.4-3 **Medical Residents & Fellows:** Conditional Privileges may be granted to residents and fellows in a training program accredited by the American Board of Medical Specialties. The parent institution must have an affiliation with the Hospital. These residents function under the supervision of an Active Appointee agreed on by the Hospital and the parent institution. Residents and fellows apply to the GME Coordinator and must provide documentation of residency training, licensure, prior training, and malpractice coverage. Such privileges end at the completion of their training.

8.4-4 **Termination of Conditional Privileges:** If any information that raises questions about a Practitioner's professional qualifications is uncovered, the Chief of Staff or Administrator, generally after consultation with the appropriate Department Chairperson, may terminate any or all of the Practitioner's conditional privileges. The Administrator must terminate the Practitioner's conditional privileges after receipt of such a recommendation from the Credentials Committee Chairperson or Department Chairperson, or upon the presentation of information suggesting that the Practitioner's acts have compromised the safety of any patient, staff, visitors, or others.

Any person entitled to impose any Suspension under this Manual may also terminate conditional privileges.

8.4-5 **Rights of the Practitioner with Conditional Privileges:** A Practitioner whose request for conditional privileges is refused or whose conditional privileges are terminated or suspended is not entitled to the procedural rights afforded by the Fair Hearing Plan.

8.5 EMERGENCY PRIVILEGES: In the case of an emergency, any Appointee is authorized to do everything possible to save a Patient from serious harm, to the degree permitted by the Appointee's license, regardless of Department affiliation, Staff category, or level of Privileges. A Practitioner exercising emergency privileges is obligated to summon all consultative assistance deemed necessary and to arrange appropriate follow up.

8.6 EXERCISE OF PRIVILEGES: A Practitioner who provides clinical services may only exercise those Privileges the Hospital has granted to him as described herein.

8.7 SPECIAL PRIVILEGE REQUEST FORMS:

8.7-1 The Credentials Committee will develop special requests for those procedures or conditions that cross specialty or discipline lines or need further documentation of experience and training beyond the minimum threshold criteria.

8.7-2 Each special request should have its own Privileges request form that outlines the minimum threshold criteria for requesting the Privileges.

8.8 DISTRIBUTION OF INFORMATION: The MSC shall timely distribute current approved Privileges for individual Appointees to the appropriate care areas and nursing administration within the Hospital.

SECTION IX LEAVE OF ABSENCE

9.1 LEAVE STATUS: An Appointee may obtain a voluntary leave of absence by giving written notice to the Chief of Staff for transmittal to the appropriate Chairperson and the Administrator. The notice must state the approximate period of time of the leave, which may not extend beyond the current Appointment. If the leave of absence is not terminated prior to the end of the current Appointment, the Appointee's Appointment is considered to be voluntarily relinquished at the expiration of the current Appointment. During the period of time of the leave, the Appointee's Clinical Privileges, prerogatives and responsibilities are suspended. Active-Provisional appointees may not be granted a Leave of Absence except for a medical condition.

9.1.1 TERMINATION OF LEAVE: The Appointee must comply with all terms of this Policy concerning Appointment and Reappointment and, in addition, at least thirty (30) days prior to the termination of the leave, request reinstatement by sending a written notice to the MEC. The Appointee must submit a written summary of relevant activities during the leave if the MEC or Board so requests. The MEC must make a recommendation to the Board concerning reinstatement, and the applicable procedures are followed.

9.1.2 In order to be eligible for a leave of absence, the Appointee must possess an Appointment and meet all of the criteria for ongoing Appointment.

9.2 VOLUNTARY RELINQUISHMENT: Any practitioner who wishes to resign his/her privileges prior to their expiration shall notify the medical staff office in writing of such a request.

Any practitioner who ceases to practice medicine at the hospital prior to the expiration of their current privileges, must notify the medical staff of their desire to resign their privileges. If a practitioner closes his/her practice or is otherwise unable to meet the needs of patients and fails to notify the medical staff office in writing, his/her privileges will automatically be voluntarily relinquished. This relinquishment will occur no later than 60 days after the Medical Staff Office is notified or becomes aware of the practitioners status.

Any practitioner who plans on returning to the area to practice at this hospital, after his/her privileges expire may request a leave of absence; however this must be done in writing prior to the expiration of their current privileges. Granting of a leave of absence will be done by the Medical Executive Committee at its sole discretion.

SECTION X ALLIED HEALTH PROFESSIONALS POLICY

10.1 The Staff retains for itself the right to review Allied Health Professionals (AHP) in Hospital patient care activities, and further reserves the right to recommend approval or denial of requested authority to provide clinical services during credentialing or reappointment of AHP's by the Hospital.

10.2 Additional rules, regulations and policies concerning AHP may be found in an AHP Policy/Manual.

SECTION XI PROCEDURE FOR THE DEVELOPMENT OF CLINICAL PRIVILEGES CRITERIA

In the event a request for a privilege is submitted for use of a new technology, a procedure new to the hospital, an existing procedure used in a significantly different manner, or involving a cross-specialty privilege for which no criteria have been established, the request will be tabled for a reasonable period of time. During this time the following will occur:

11.1 A review of the community, patient and hospital need for the privilege to confirm that the resources (sufficient space, equipment, financial resources, and personnel) necessary to support the requested privilege are currently available or will be available within specified time frame;

11.2 Confirmation by hospital administration that the new privilege, procedure or device is consistent with the hospital's mission and values and strategic, operating, capital, information and staffing plans;

11.3 Review by members of the credentials committee of the efficacy and clinical viability of the requested privilege and confirm that this privilege is approved for use in the setting-specific area of the hospital by appropriate regulatory agencies (FDA, OSHA, etc.);

11.4 Ensure that any/all exclusive contract issues are addressed. If the privilege, upon agreement, is to be granted to specialties outside the exclusive contract, then cross-specialty criteria will need to be developed. Upon recommendation from the departments and the credentials committee and appropriate clinical service/specialty or subject matter experts (as determined by the credentials committee), the MEC will approve the necessary criteria and recommend these to the Board. Once objective criteria have been established, the original request will be processed as described herein:

11.4.1. For the development of criteria, the medical staff office (or designee) will compile information relevant to the privileges requested which may include, but need not be limited to, position and opinion papers from specialty organizations, white papers from the Credentialing Resource Center and others as available, position and opinion statements from interested individuals or groups, and documentation from other hospitals in the region as appropriate;

11.4.2. Criteria to be established for the privilege(s) in question include education, training, board status, certification (if applicable), experience, and evidence of current competence. Proctoring requirements will be addressed including who may serve as proctor and how many proctored cases will be required. Hospital related issues such as exclusive contracts, equipment, clinical support staff and management will be referred to the appropriate hospital administrator and/or department director; and

11.4.3. If the privileges requested overlap two or more specialty disciplines, an ad hoc committee will be appointed by the credentials chair to recommend criteria for the privilege(s) in question. This committee will consist of at least one, but not more than two, members from each involved discipline. The chair of the ad hoc committee will be a member of the shared credentials committee who has no vested interest in the issue.

SECTION XII PROCEDURE FOR PROCESSING CLINICAL PRIVILEGES REQUESTS

The Medical Staff Coordinator or Administrative representative will be responsible for ensuring that each Applicant receives the appropriate Privileges request forms.

12.1 The Privileges request forms should accompany the Application and should include:

12.1-1 The Hospital's Privileges delineation overview;

12.1-2 Instructions for completion of the Privileges request forms;

12.1-3 Privileges threshold criteria;

12.1-4 The appropriate requested section; and

12.1-5 A special procedures section (if applicable).

12.2 All requests for clinical Privileges must be submitted, with supporting material, to the MSC or Administrative representative, who will:

12.2-1 Verify the supporting material;

12.2-2 Compile current privileges (if any) and administrative review (if any) with the application;

12.2-3 Make two copies of the completed Privilege request package: one for the file, and another for the applicable Department Chairperson; and

12.2-4 Submit the application package, with supporting material, to the applicable Department Chairperson.

12.3 The Department Chairperson will:

12.3-1 Review the request and all supporting material against threshold criteria for granting clinical privileges and, where necessary, conduct a personal clinical interview with the requester; and

12.3-2 Formulate a written report and forward it to the Credentials Committee.

12.4 The Credentials Committee's recommendation is forwarded to the MEC.

12.5 The MEC considers the Credential Committee's recommendation and forwards its recommendation to the Board.

12.6 Once the MEC and Board approve the Credentials Committee's recommendation, the Administrator will notify the Applicant of his Appointment and Privileges.

SECTION XIII AMENDMENT

13.1 AMENDMENT: This Manual may be amended or repealed, in whole or in part, by a resolution of the Medical Staff recommended to and approved by the Board.

13.2 RESPONSIBILITIES AND AUTHORITY: The procedures outlined in the Bylaws and the Hospital Bylaws regarding Staff responsibility and authority to recommend Bylaws and amendments thereto apply as well as to the recommendation of this Manual provided that the MEC may act for the Staff in making the necessary recommendations of the Medical Staff to the Board.

13.3 A request for modification of privileges prior to reappointment is processed in the same manner as a request for reappointment. A request for modification of privileges may be temporarily approved by the Chairman of the Credentials Committee following evaluation of documentation submitted to support the request.

Focused Professional Practice Evaluation (FPPE) & Ongoing Professional Practice Evaluation (OPPE)

A. Focused Professional Practice Evaluation (FPPE)

1. Purpose:

To establish a systematic process to evaluate and confirm the current competency of a provider's performance of privileges at West Jefferson Medical Center. This process is known as focused professional practice evaluation ("FPPE" or "focused evaluation").

2. Definition of FPPE:

Focused professional practice evaluation is defined as a time limited period during which the Hospital and Medical Staff evaluate and determine the adequacy of a provider's professional performance. FPPE will occur for all initially requested privileges (at initial appointment and when new privileges are requested). Provider includes any physician dentist, podiatrist, clinical or medical psychologist, Certified Registered Nurse Anesthetists (CRNA), Advanced Practice Nurse (APN), Physician Assistant (PA), Midwife or other practitioner currently credentialed by the Medical Staff to evaluate, perform consultations on, or treat patients within the hospital.

3. Process:

a. FPPE is performed in accordance with the Medical Staff Peer Review Policy when there are concerns regarding a provider's ability to provide safe, quality care and upon initial appointment and credentialing. FPPE is also performed when an on-going evaluation (OPPE) indicates a significant trend or opportunity for improvement.

b. Specific indicators will be assessed using data available through the currently used Quality Assurance software (ie. Crimson or other service), from WJMC Decision Support, or through direct chart audit. This data will be reviewed by the CMO and presented to the Medical Staff Quality Committee. The MSQ may then recommend that the FPPE results:

1. be included in the physician's credentials file for consideration at recredentialling. Or,
2. be forwarded to P-PIC for further investigation and action. Or,
3. be forwarded to the MEC for further consideration.

c. For initially requested privileges, the FPPE process includes an assessment for proficiency in the following six areas of general competencies. At initial appointment, this is accomplished through peer review references and by verification of competency from the Department Chairman of the training program, if recent graduate or from Section Chief of the practitioner's last current primary facility, if the provider has been in practice two years or more.

Focused Professional Practice Evaluation (FPPE) Six Competencies:

1. Medical and Clinical Knowledge (ex. board certification, CME, chart reviews)
2. Practice Based Learning/Improvement (ex. Compliance w/guidelines)
3. Patient Care (ex. Mortality rate, complications, peer reviewed cases, inappropriate transfusions)
4. Systems Based Practice (ex. LOS, CPOE, e-prescribing rate)
5. Interpersonal Skills (ex. Event reports, uncooperative, patient satisfaction, staff complaints)
6. Professionalism (ex. Response to ED calls, inappropriate behavior events, Records suspensions/delinquencies, meeting attendance)

a) The FPPE process for initially requested privileges is intended to be no more than a six month process and shall begin with the applicant's first admission or performance of a procedure and extend throughout the first 6 months of the appointment period. The attached Current Cognitive Diagnosis/Medical Focused Professional Practice Evaluation Form (Attachment A) and the Concurrent Procedure Focused Professional Practice Evaluation Form (Attachment B) may be used for the case/chart review. Initial FPPE may also be accomplished by reviewing data available through the currently used Quality Assurance software (ie. Crimson or other service). In the event that WJMC is not the practitioner's primary facility, and a practitioner does not have adequate case volume at WJMC to complete FPPE in six months, the physician's primary facility where he/she holds active privileges will be required to provide competency assessment. If the practitioner's primary facility is West Jefferson Medical Center and he/she does not have sufficient activity at WJMC to complete the FPPE process within six months, the FPPE may be extended to 12 months at the discretion of the medical staff.

b) Specific indicators will be assessed using data available through the currently used Quality Assurance software (ie. Crimson or other service), from WJMC Decision Support, or through direct chart audit. This data will be reviewed by the CMO and presented to the Credentials Committee. The Credentials Committee may then recommend one of the following:

(1) Continued FPPE for a specified time period
(2) No further action
(3) Referral to Dept Chair, MSQ, P-PIC or MEC for further investigation.

c) **External Assessment of Competency:** If the practitioner is performing a procedure or a diagnosis that no one else in the organization has privileges for, a practitioner not on the medical staff, but one who has the privilege at his primary hospital, which is a Joint Commission accredited hospital, may be used to assess the practitioner's competency for that

privilege.

d) **Reciprocal Assessment of Competency:** The Medical Staff may accept evidence of competency from another facility that is Joint Commission accredited at the discretion of the Department Chairman.

e) **Duration of FPPE:** The duration of the initial FFPE will be for 6 months. If, in the opinion of the Department Chair, Credentials Committee or MEC, an insufficient volume of activity has occurred to allow adequate assessment of performance, or if the practitioner's performance is deemed unacceptable, an extension of the initial FPPE may be recommended in addition to other recommendations about the physician's privileges depending on the nature of the unacceptable performance.

B. Ongoing Professional Practice Evaluation (OPPE):

Purpose:

To establish a systematic process for assessing a provider's clinical competence and professional behavior at West Jefferson Medical Center. This process is known as ongoing professional practice evaluation ("OPPE" or "ongoing evaluation").

Definition:

OPPE is a documented summary of ongoing data collected for the purpose of assessing a provider's clinical competence and professional behavior. Provider includes any physician dentist, podiatrist, clinical or medical psychologist, Certified Registered Nurse Anesthetists (CRNA), Advanced Practice Nurse, (APN), Physician Assistant (PA), or Midwife.

Process:

a. Ongoing Physician Practice Evaluation with specific identified metrics will be reviewed by the appropriate Department Chair at least every 9 months for his/her review and recommendations. If potential problems with a provider's performance are identified during the OPPE process, resolution can be collegial intervention by the Chief Medical Officer or the Department Chairman for mentoring and educational purposes. Or, if the OPPE process indicates a significant trend or opportunity for improvement (as noted in the FPPE section of this document); the OPPE may result in an FPPE.

b. Results of the OPPE will be sent to the Medical Staff Office and to the Credentials Committee for use in the credentialing process. The information gathered during the OPPE process will be a factor in decisions to maintain, revise or revoke existing privileges prior to or at the end of the two-year privilege renewal cycle. This not only allows any potential problems with a provider's performance to be identified and resolved as soon as possible, but also fosters a more efficient, evidence-based privilege renewal process.

ATTACHMENT "A"

Concurrent Cognitive Diagnosis/Medical Focused Professional Practice Evaluation

Confidential for file of: _____

(Practitioner's name)

Reviewer's Name: _____

Patient account number: _____

Diagnosis:

_____

Procedure:

_____

Complications:

_____

_____

PLEASE ANSWER ALL OF THE FOLLOWING: If the answer to any of the following questions is "no", please attach an explanation on a separate sheet.

Procedure Review

1. Was there adequate evidence to support the patient's admission? Yes __ No__ N/A__
2. Was the initial level of care appropriate? Yes __ No__ N/A__
3. Was the practitioner's problem formulation (e.g., initial impressions, rules outs, assessment, etc.) Appropriate? Yes __ No__ N/A__
4. Were patient rounds made daily? Yes __ No__ N/A__
5. Did the practitioner cooperate with you concerning this review? Yes __ No__ N/A__
6. Was all necessary information (e.g., history, physical, progress notes, procedures note, and summery) recorded by practitioner in a timely manner in the patient's medical record? Yes __ No__ N/A__
7. Was the above information recorded in a legible manner? Yes __ No__ N/A__
8. Were the entries made in the patient's record by practitioner informative? Yes __ No__ N/A__
9. Were the entries made in the patient's record by practitioner appropriate? Yes __ No__ N/A__
10. Was the practitioner's proposed use of diagnostic services (e.g., lab, x-ray, and invasive diagnostic procedures) appropriate? Yes __ No__ N/A__
11. Were the practitioner's initial orders appropriate? Yes __ No__ N/A__

Patient management

12. Was the practitioner's drug use appropriate? Yes __ No__ N/A__
13. Was the practitioner's use of blood and blood components appropriate? Yes __ No__ N/A__
14. Was the practitioner's use of ancillary services (physical therapy, respiratory therapy, social service, etc.) appropriate? Yes __ No__ N/A__
15. Were complications anticipated, recognized promptly, and dealt with appropriately? Yes __ No__ N/A__
16. Was the patient's length of stay appropriate? Yes __ No__ N/A__
17. Was the patient discharged to an appropriate level of care? Yes __ No__ N/A__
18. Was there any evidence that the practitioner exhibited any disruptive or inappropriate behavior? Yes __ No__ N/A__
19. Was there any evidence of patient dissatisfaction with the practitioner? Yes __ No__ N/A__

Overall Assessment Satisfactory___ Unsatisfactory ___
1. Patient care Satisfactory___ Unsatisfactory ___
2. Medical knowledge Satisfactory___ Unsatisfactory ___
3. Practice based learning Satisfactory___ Unsatisfactory ___
4. Interpersonal/communication skills Satisfactory___ Unsatisfactory ___
5. Professionalism Satisfactory___ Unsatisfactory ___
6. System Based Practice Satisfactory___ Unsatisfactory___

Generally, how would you rate this practitioner's skills and competence in performing this examination?
Acceptable ___ Unacceptable ___ Unable to evaluate because
_____

General comments:
_____
_____

Evaluated by:
Signature: _____ Date: _____
Printed Name: _____

ATTACHMENT "B"

Concurrent Procedure Focused Professional Practice Evaluation
Confidential for file of: _____
(Practitioner's name)
Reviewer's Name: _____
Patient account number: _____
Diagnosis: _____
_____
Procedure: _____
_____
Complications: _____
_____

PLEASE ANSWER ALL OF THE FOLLOWING: If the answer to any of the following questions is "no", please attach an explanation on a separate sheet.
Procedure Review
1. Was there pre-operative justification for the procedure documented?
Yes __ No__ N/A__
2. Were patient rounds made daily? Yes __ No__ N/A__
3. Were calls answered promptly by the practitioner? Yes __ No__ N/A__
4. Did the practitioner cooperate with you concerning this review? Yes __ No__ N/A__

5. Was all necessary information (e.g., history, physical, progress notes, procedures note, and summary) recorded by practitioner in a timely manner in the patient's medical record? Yes___ No___ N/A___
6. Were the entries made in the patient's record by practitioner informative? Yes __ No__ N/A__
&. Were the entries made in the patient's record by practitioner appropriate? Yes __ No__ N/A__
8. Was the practitioner's use of diagnostic services (e.g., lab, x-ray, and invasive diagnostic procedures) appropriate? Yes __ No__ N/A__
9. Was the practitioner's procedural technique appropriate? Yes __ No__ N/A__
10. Did the pre-operative diagnosis coincide with the postoperative findings? Yes __ No__ N/A__
11. Was postoperative care adequate? Yes __ No__ N/A__
12. Was the operative report complete, accurate, and timely? Yes __ No__ N/A__
13. Were complications, if any, recognized and managed appropriately? Yes __ No__ N/A__
14. Was there any evidence that the practitioner exhibited any disruptive or inappropriate behavior? Yes __ No__ N/A__
15. Was there any evidence of patient dissatisfaction with the practitioner? Yes __ No__ N/A__

Overall Assessment
1. Patient care Satisfactory___ Unsatisfactory___
2. Medical knowledge Satisfactory___ Unsatisfactory___
3. Practice based learning Satisfactory___ Unsatisfactory___
4. Interpersonal/communication skills Satisfactory___ Unsatisfactory___
5. Professionalism Satisfactory___ Unsatisfactory___
6. System Based Practice Satisfactory___ Unsatisfactory___

Generally, how would you rate this practitioner's skills and competence in performing this examination? Acceptable___ Unacceptable ___Unable to evaluate because_____
_____

General comments: _____
_____

Evaluated by:
Signature: _____ Date: _____
Printed Name: _____

ATTACHMENT "C"

WEST JEFFERSON MEDICAL CENTER
LOW-VOLUME COMPETENCY ASSESSMENT

HOSPITAL VERIFICATION:

West Jefferson Medical Center

Practitioner Name: _____

Hospital Name:_____

DATA FROM PREVIOUS 12-MONTH PERIOD:

_____ Number of admissions _____ Number of consults (inpt., obs., ED, etc.)
_____ Number of procedures (surgery, cath lab, GI, *etc.*)

GENERAL COMPETENCIES:
Were the quality and completeness of the practitioner's medical records acceptable? ___ Yes ___ No

Was there adequate evidence to support the practitioner's justification for the procedures performed? ___ Yes ___ No

Does the practitioner possess adequate clinical knowledge and technical skill to justify the privileges requested? ___ Yes ___ No

Was the practitioner's communication with patients, families, and staff appropriate? ___ Yes ___ No

DISCIPLINARY ACTIONS:
Was this practitioner ever subject to non-routine monitoring while at your facility? ___ Yes ___ No

Was this practitioner involuntarily removed from a call schedule for cause? ___ Yes ___ No

Have any disciplinary actions been initiated or pending against this practitioner or has the practitioner ever attempted procedures beyond his skill or training? ___ Yes ___ No

Did the practitioner ever, voluntarily, or involuntarily, terminate or restrict his status in lieu of formal action or to avoid an investigation? ___ Yes ___ No

Have there been repeated written complaints about the practitioner by patients or hospital staff? ___ Yes ___ No

HEALTH STATUS:
Are there any existing health problems that could affect this practitioner's ability to perform the privileges requested? ___ Yes ___ No

Has the practitioner's behavior been disruptive to patient care? ___ Yes ___ No

RECOMMENDATION:
__ Recommend __ Recommend with comment __ Do not recommend

__ I would like a physician to contact me by telephone for additional information at _____

Comments:

_____

ATTESTATION: By my signature below, I attest to the appropriateness of this practitioner's privileges at this facility and clinical outcomes.

SIGNATURE: _____ DATE: _____

PRINTED NAME: _____ TITLE: _____

RETURN THIS FORM TO: WJMC, MEDICAL STAFF OFFICE, 1101 MEDICAL CENTER BLVD., MARRERO, LA 70072 OR BY FAX 504-349-1146

REVIEWED AND APPROVED:

Chairperson, Credentials Committee	Date
Chief of Staff	Date
Chairperson, Board of Directors	Date

Approved By: Robert Chugden