SALEM HOSPITAL

MEDICAL STAFF
CREDENTIALS PROCEDURE MANUAL

Approved by Board of Trustees
10/7/04
for implementation
beginning January 1, 2005

•	Amendment approved by Board of Trustees	12/3/13
•	Amendment approved by Board of Trustees	02/5/15
•	Amendment approved by Board of Trustees	06/4/15
•	Amendment approved by Board of Trustees	11/5/15
•	Amendment approved by Board of Trustees	04/7/16
•	Amendment approved by Board of Trustees	01/1/16

Reviewed by the Medical Executive Committee on:

Section 1. Credentials Committee

1.1 Composition: The Credentials Committee shall consist of at least six (6) members of the active staff, who preferably have been involved in medical staff leadership. The immediate Past President of the Medical Staff, shall serve on the Credentials Committee for two years and a minimum of five members serving a staggered three-year term, shall be elected by the active staff. The President of the Medical Staff shall appoint, from among the five elected committee members, the Chair of the Credentials Committee, subject to approval of the Medical Executive Committee. A representative from the Board of Trustees shall serve on the committee without vote. The chair and members of the committee may be reelected for additional terms without limit. Service on this committee shall be considered as the primary medical staff leadership obligation of each member of the committee, and other medical staff leadership duties shall not interfere.

1.2 Meetings: The Credentials Committee shall meet on call of the Chair of the Committee or of the President of the Medical Staff.

1.3 Responsibilities:

1.3.1 To review and recommend action on all applications and reapplications for membership and/or privileges on all credentialed practitioners.

1.3.2 To review and recommend action on all voluntary requests for changes in privileges for credentialed practitioners granted privileges at Salem Hospital.

1.3.3 To recommend criteria for the granting of medical staff membership and clinical privileges for Salem Hospital.

1.3.4 To develop, recommend, and consistently implement policies, procedures and privilege forms for all credentialing activities at Salem Hospital.

1.3.5 To perform such other functions as requested by the Medical Executive Committee and the Board of Trustees.

1.4 Confidentiality: This committee shall function as a peer review committee consistent with federal and state law. All members of the Credentials Committee shall, consistent with the medical staff and hospital confidentiality policies, keep in strict confidence all papers, reports, and information obtained by virtue of membership on the committee. See additional provisions for confidentiality, immunity and releases in Section 3 of the medical staff Organization and Functions Manual.

Section 2. Qualifications for Membership to Medical Staff

2.1 No practitioner shall be entitled to membership on the medical staff or to clinical privileges merely by virtue of licensure, membership in any professional organization, or

privileges at any other healthcare organization. Granting of membership and/or privileges shall be at the sole discretion of the Board of Trustees.

2.2 The following qualifications must be met by all applicants for appointment to the medical staff before an application will be processed. For reappointment see Section 5

2.2.1 Demonstrate that he/she has successfully graduated from an approved school of medicine, osteopathy, dentistry, or podiatry;

2.2.2 Have a current unrestricted license as a physician, dentist or podiatrist required for the practice of his/her profession within the state of Oregon;

2.2.3 Possess a current, valid, unrestricted drug enforcement administration (DEA) number with an Oregon address, if applicable;

2.2.4 Demonstrate recent clinical performance and competence with an active clinical practice in the clinical area in which clinical privileges are sought, for purposes of ascertaining current clinical competence;

2.2.5 Provide evidence of skills to provide a type of service that the Board of Trustees has determined to be appropriate for the performance within the hospital and for which a need exists;

2.2.6 Provide evidence of professional liability insurance of a type and in an amount established by the Board of Trustees in collaboration with the Medical Executive Committee;

2.2.7 Have a record that is free from current Medicare/Medicaid sanctions and felony convictions. An exception to this requirement may be made only in exceptional circumstances upon recommendation of the Medical Executive Committee and at the sole discretion of the Board of Trustees.

2.2.8 A physician applicant, MD or DO, must have successfully completed an allopathic or osteopathic residency program, approved by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) and be currently board certified or board eligible by an approved board of the American Board of Medical Specialties or the American Osteopathic Association in the specialty of application. Applicant must be board certified in the specialty appropriate to the privileges granted or obtain board certification within five years from completion of the applicable Residency and/or Fellowship program for the privileges being requested at Salem Hospital.[1] Ongoing maintenance of board certification is required to maintain privileges.[1]

[1] Members of the Medical Staff on staff as of (date of adoption of CPM) shall meet the criteria in the Credentials Procedure Manual dated 04/04/2019 which stated as follows: Applicant must be board certified in the specialty appropriate to the privileges granted within five years of appointment to the Medical Staff.

2.2.9 Dentists must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation;

2.2.10 Oral and maxillofacial surgeons must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation and successfully completed an American Dental Association approved residency program and be board certified or board eligible by the American Board of Oral and Maxillofacial Surgery. Applicant must be board certified or obtain board certification within five years from completion of the applicable Residency and/or Fellowship program for the privileges being requested at Salem Hospital.[1] Ongoing maintenance of board certification is required to maintain privileges[1]; and

2.2.11 A podiatric physician, DPM, must have successfully completed a two (2) year residency program in surgical, orthopedic, or podiatric medicine approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association (APMA), and be board certified or board eligible by the American Board of Foot and Ankle Surgery or the American Board of Podiatric Orthopedic and Primary Podiatric Medicine. Applicant must be board certified or obtain board certification within five years from completion of the applicable Residency and/or Fellowship program for the privileges being requested at Salem Hospital.[1] Ongoing maintenance of board certification is required to maintain privileges.[1]

2.2.12 The amendments to Section 2.2.8, 2.2.10 and 2.2.11, approved by the Board of Trustees on (date of adoption of CPM) shall be applicable to credentialed practitioners whose applications are received after the date of approval of the amendments.

2.3 Exceptions:

2.3.1 Only the Board of Trustees, based upon recommendation of the Medical Executive Committee, may create additional exceptions to the above Section 2.2.

2.3.2 Residents or fellows credentialed for clinical privileges, only while acting in these limited roles, shall be exempt from meeting qualification 2.2.8.

2.4 It is the policy of Salem Hospital to grant and maintain medical staff membership and clinical privileges only to individuals who continuously meet the following criteria:

2.4.1 Fulfill the criteria as identified in Section 2.2 above.

2.4.2 Demonstrate his/her background, experience and training, current competence, knowledge, judgment, ability to perform, and technique in his/her specialty for all privileges requested.

2.4.3 Upon request provide evidence of both physical and mental fitness that does not impair the fulfillment of his/her responsibilities of medical staff membership and the specific privileges requested by and granted to the applicant.

2.4.4 Have appropriate personal qualifications, including applicant's consistent observance of ethical and professional standards. These standards include, at a minimum:

a. Abstinence from any participation in fee splitting or other illegal payment, receipt, or remuneration with respect to referral or patient service opportunities; and

b. A history of consistently acting in a professional, appropriate and collegial manner with others in clinical and professional settings.

2.4.5 Appropriate written and verbal communication skills.

2.5 Clinical Advisor Category

2.5.1 Members of the Clincal Advisor Category must meet the following criteria unless otherwise approved by the Chief Executive Officer and Medical Staff President or their designees:

a. Must have an active, unrestricted license to practice as a physician
b. Must have a National Practitioner Data Bank summary free from all concerning reports
c. Must have a criminal background check free from concerning reports
d. Must have a record that is free from current Medicare/Medicaid sanctions and felony convictions
e. Must be able to document malpractice insurance in accordance to hospital standards
f. Must agree and adhere to all hospital policies, bylaws and other medical staff governing documents
g. Must have an established relationship and necessary training with the applicable vendor in which they will serve as a Clinical Advisor
h. Must have appropriate documentation of TB screening and flu vaccine in accordance with the Fitness for Duty Policy
i. Must provide three peer references that can attest to his/her clinical skills

Section 3. Initial Appointment Procedure

3.1 All requests for applications for appointment to the medical staff and requests for clinical privileges will be forwarded to the Medical Staff Office. Upon receipt of a request for an application, the Medical Staff Office will provide the potential applicant with an

application form; a letter setting forth basic threshold criteria; a description of responsibilities for medical staff members and credentialed practitioners; a privilege delineation overview; a privilege request form(s), including criteria for privileges, and a detailed list of requirements for completion of the application. The Medical Staff Office will provide or make available to the applicant a copy of the Medical Staff Bylaws overview or a complete set of Medical Staff Bylaws and Rules and Regulations including notification of Applicant Rights via Credentials Procedural Manual Sections 3.3.8 through 3.3.10.

3.2 The applicant must sign the application form. This signature will signify the applicant's agreement to all of the following listed below and on the Oregon Practitioner Credentialing application:

3.2.1 Attestation to the accuracy and completeness of all information on the application or accompanying documents and agreement that any substantive inaccuracy, omission, or misrepresentation, whether intentional or not, will be grounds for termination of the application process without the right to a fair hearing or appeal. Whether or not an inaccuracy is substantive will be determined by an ad hoc committee composed of the Vice President of Medical Affairs, Chief Medical Officer, Credentials Committee Chair, and a Board designee . If the substantive inaccuracy, omission or misstatement is discovered after an individual has been granted appointment and/or clinical privileges, the individual's appointment and privileges shall lapse effective immediately upon notification of the individual without the right to a fair hearing or appeal.

3.2.2 His/her willingness to appear for any requested interviews in regard to his/her application.

3.2.3 Authorization of hospital and medical staff representatives to consult with prior and current associates and others who may have information bearing on his/her professional competence, character, ability to perform the privileges requested, ethical qualifications, ability to work cooperatively with others, and other qualifications for membership and the clinical privileges requested.

3.2.4 Consent for hospital and medical staff representatives' inspection of all records and documents that may be material to an evaluation of his/her professional qualifications and competence to carry out the clinical privileges requested, of his/her fitness to practice status to the extent relevant to the capacity to fulfill requested privileges, and of his/her professional and ethical qualifications.

3.2.5 Practitioner releases from liability, promises not to sue and grants immunity to the hospital, its medical staff, and its representatives for acts performed and statements made in connection with evaluation of the application and his/her credentials and qualifications to the fullest extent permitted by the law.

3.2.6 Practitioner releases from liability and promises not to sue, all individuals and organizations who provide information to the hospital or the medical staff, including otherwise privileged or confidential information to Salem Hospital representatives concerning his/her background; experience; competence; professional ethics; character; physical and mental fitness to the extent relevant to the capacity to fulfill requested privileges; emotional stability; utilization practice patterns; and other qualifications for staff appointment and clinical privileges. Practitioner also agrees to execute any additional releases as requested or required to complete the application process consistent with the requirements of this manual.

3.2.7 Authorization of Salem Hospital medical staff and administrative representatives to release to other hospitals, medical associations, licensing boards, and other organizations concerned with this practitioner's performance and the quality and efficiency of this practitioner's patient care any information relevant to such matters that Salem Hospital may have concerning him/her and release of Salem Hospital representatives from liability for so doing. For the purposes of this provision, the term "Hospital representatives" includes the Board of Trustees, its directors and committees, the Chief Executive Officer or his/her designee, registered nurses and other employees of Salem Hospital, the medical staff organization, and all medical staff appointees, clinical units, and committees which have responsibility for collecting and evaluating the applicant's credentials or acting upon his/her application, and any authorized representative of any of the foregoing.

3.2.8 He/she has been oriented to the current medical staff bylaws and associated manuals and policies and agrees to abide by their provisions. Such orientation will include at least one of the following: receiving a copy of the bylaws and associated manuals, or receiving a summary of the expectations of medical staff members and having the bylaws and manuals made available to the applicant.

3.2.9 The Oregon Practitioner Credentialing Application requires the applicant to answer a series of attestation questions. The applicant shall agree to immediately notify the Medical Staff Office in writing should any of the information regarding these items change during the period of their medical staff membership or privileges. If the applicant answers any of the questions affirmatively provides information identifying a problem with any of the items, the applicant will be required to submit a written explanation of the circumstances involved.

3.3 Procedure for Processing Applicants for Initial Staff Appointment

3.3.1 A completed application must include, at a minimum, a signed and dated application form and request for privileges, a photo of the applicant, copies of all documents and information necessary to confirm applicant meets criteria for membership and privileges, all applicable fees, and references. An application shall be deemed incomplete if any of the above items are missing or if the need arises for new, additional, or clarifying

information in the course of reviewing an application. Determination as to whether an application is complete shall be in the sole discretion of the Medical Staff Office. An incomplete application will not be processed.

3.3.2 The burden is on the applicant to provide all required information. It is the applicant's responsibility to ensure that the Medical Staff Office receives all required supporting documents verifying information on the application and providing sufficient evidence, as required in the sole discretion of the hospital, that the applicant meets the requirements for medical staff membership and the privileges requested. If information is missing from the application, or new, additional, or clarifying information is required, a letter request for such information will be sent to the applicant. It is the responsibility of the applicant to correct or respond to erroneous information, and to supplement incomplete information at the time it is first requested. If the requested information is not returned to the Medical Staff Office within thirty (30) days of mailing of the request letter, this will be deemed a voluntary withdrawal of the application.

3.3.3 Upon receipt of a completed application the Chief Medical Officer, Vice President of Medical Affairs, Chair of the Credentials Committee or designee, in collaboration with the Medical Staff Office, will determine if the requirements of Section 2.2 are met. In the event the requirements of Section 2.2 are not met, the potential applicant will be notified that he/she is ineligible to apply for membership on the Salem Hospital medical staff, and the application will not be processed. If the requirements of Section 2.2 are met, the application will be accepted for further processing.

3.3.4 Upon receipt of a completed application as defined above, the Medical Staff Office will notify the applicant that the application will be further processed. Individuals seeking appointment and reappointment have the burden of producing information deemed adequate by the hospital for a proper evaluation of current competence, character, ethics, and other qualifications, and of resolving any doubts.

3.3.5 Any applicant not meeting the minimum objective requirements for membership to the medical staff will not have his/her application processed and will not be entitled to a fair hearing.

3.3.6 Upon receipt of a completed application, the Medical Staff Office will verify its contents from acceptable sources and collect additional information, which includes but is not limited to the following:

a. Information from all prior and current liability insurance carriers concerning claims, suits, settlements and judgments, filed against the practitioner (if any) during the past five (5) years;

b. Documentation of the applicant's past clinical work experience;

c. Licensure status in all current or past states of licensure;

d. Information from the American Medical Association or American Osteopathic Assocation Physician Profile, Federation of State Medical Board, HHS/OIG list of excluded individuals, FACIS (Fraud and Abuse Control Information System), or other such data banks including criminal background check;

e. Completion of professional training programs, including residency and fellowship programs;

f. Information from the National Practitioner Data Bank;

g. Other information about adverse credentialing and privileging decisions;

h. Three peer recommendations addressing the applicant's current clinical competence within the past 24 months, ethical character and ability to work with others; Note: a peer is defined as a practitioner in the same general specialty as the applicant;

i. Additional Information as may be requested to ensure applicant meets the criteria for medical staff membership;

j. Recent photograph of the applicant to verify identity [for initial appointment]; and

k. Results of any mandated drug testing and other mandated health testing by Salem Hospital.

Note: In the event there is undue delay in obtaining required information, the Medical Staff Office will request assistance from the applicant. It will be the responsibility of the applicant to respond to all such requests. Failure of an applicant to adequately respond to a request for assistance after thirty (30) days of notification will be deemed a withdrawal of the application without a right to a fair hearing.

3.3.7 When the items identified in 3.3.6 above have been obtained, the file will then be reviewed by the Section Chief (if applicable), Department Chair, Chief Nursing Officer (if applicable), Chair of Credentials Committee, and the Medical Staff Office Professional (or their designees), who will categorize the application as follows:

a. The Credentials Committee, Medical Executive Committee and Board Professional Review Committee will determine which are subject to Board Professional Review Committee approval and those which are subject to Board of Trustees approval.

Category 1: A verified application[1] that does not raise concerns as identified in the criteria for category 2. Applicants in category 1 will be granted medical staff membership and/or privileges following approval by the following: Chief Nursing

[1] *"Verified application" – definition – indicates that the primary source verification has been completed and all items listed under Section 3.3.6 have been received and verified.*

Officer (if applicable), Section Chief (if applicable), Department Chair, Credentials Committee, Medical Executive Committee and a Board Committee consisting of at least two Board Members.*

Note:
* Board Bylaws must delineate the composition and authority of this committee.

Category 2: If one or more of the following criteria are identified in the course of review of a completed file, the application will be treated as category 2. The Chief Nursing Officer (if applicable), Section Chief (if applicable), Department Chair, Credentials Committee, Medical Executive Committee, Board Professional Review Committee and the Board of Trustees, reviews applications in category 2. The Credentials Committee or Medical Executive Committee may request that an appropriate subject matter expert[2] assess selected applications. At all stages in this review process, the burden is upon the applicant to provide evidence that he/she meets the criteria for membership on the medical staff and for the granting of requested privileges. Criteria for category 2 applications include but are not necessarily limited to the following:

a. The applicant is found to have experienced an involuntary termination of medical staff membership, resignation in lieu of termination or restriction of privileges, or involuntary restriction, limitation, reduction, denial, or loss of clinical privileges at another organization.

b. Applicant is, or has been, under investigation by a state medical board or has prior disciplinary actions or legal sanctions.

c. Applicant has had one (1) or more malpractice cases filed within the past five (5) years or one (1) final adverse judgment or a settlement in a professional liability action at any time.

d. Applicant changed medical schools or residency programs or has gaps in training or practice. An applicant with a gap in practice which does not raise concerns and occured more than 10 years from the application date may be considered a Category 1 applicant. Note: An applicant may be considered a Category 1 applicant if the applicant is a foreign medical graduate and the only gap in question is no more than six (6) months in duration and is attributed to a time lag between the issuance of the ECFMG Certificate and the applicant's entry into an Internship/Residency training program. Nurse Practitioner (NP) and Physician Assistant (PA) applicants may also be deemed Category 1 applicants if the only gap in question is no more than six (6) months in duration and is attributed to a

---

2 *Subject matter expert is an individual chosen by the Credentials Committee, or Medical Executive Committee to assist and advise them in evaluation of recommendations for clinical privileges for their peers.*

time lag between completion of education/training and applicant's first position providing clinical care in their NP or PA discipline.[3]

e. Applicant has one or more reference responses that raise concerns or questions.

f. Discrepancy found between information received from the applicant and references or verified information.

g. Applicant has an adverse National Practitioner Data Bank report.

h. The request for clinical privileges is not reasonable based upon applicant's experience, training, and competence, and/or is not in compliance with applicable criteria.

i. Applicant has been removed from an insurance or provider panel for reasons of professional conduct or quality.

j. Applicant has potentially relevant fitness to practice issues.

k. Applicant cannot demonstrate recent clinical performance and competence within the last twelve (12) months with an active clinical practice in the area in which clinical privileges are sought, for purposes of ascertaining current clinical competence.

l. Applicant has had felony convictions.

m. Applicant has an adverse background investigation report. Note: An applicant may be considered as a Category 1 applicant if the adverse report involves any motor vehicle violation which may be classified as a misdemeanor and does not include driving while under the influence, leaving the scene of an accident, reckless driving, attempting to elude, and careless driving, or any other motor vehicle violation that may be considered to merit consideration as a Category 2 applicant.

n. Other as determined by the Department Chair or other representative of the institution.

3.3.8 Applicant Rights: The applicant has the right to be informed of the status of his/her credentialing or recredentialing application upon request of the Medical Staff Office Professional or his/her designee.

---

[3] *"Gap" – definition – Gaps of two (2) months or greater, whether or not explained or primary source verified, where the practitioner was not providing clinical care in the discipline for which he/she holds a license and/or has been trained/educated.*

3.3.9 At the time of application, the applicant will be notified in writing by the Medical Staff Office Professional or his/her designee of the applicant's right to review the elements in his/her credentials file. The applicant shall have the right to see the following documents in his/her credentials file upon request. The applicant shall give Salem Hospital 48 hours' notice of intent to review this information.

(a) Action on license;

(b) Board certification decisions. If not applicable, information on highest level of training;

(c) DEA registration/correspondence;

(d) Malpractice claims history.

All other information in the credentials file shall be available to the applicant in conformance with the Salem Hospital Medical Staff Confidentiality policy and protections under ORS 41.675.

3.3.10 The applicant shall have the right to provide a written response to correct erroneous information in his/her application.

3.4 Department Chair Action

3.4.1 All completed applications are presented to the Chief Nursing Officer, if applicable, Section Chief, if applicable and Department Chair for review, interview, if requested, and recommendation. The Chief Nursing Officer (if applicable), Section Chief (if applicable) and the Department Chair reviews the application to ensure that it fulfills the established standards for membership and/or clinical privileges. The Medical Staff Office in consultation with the Chief Nursing Officer, if applicable, Section Chief, if applicable, Department Chair, Chief Medical Officer, Vice President of Medical Affairs and Credentials Chair or their designees determines whether the application is forwarded as a category 1 or category 2. The Department Chair may obtain input if necessary from an appropriate subject matter expert[2]. The Department Chair takes action as follows:

(a) Deferral: In the event a Department Chair is unable to formulate a recommendation for any reason, the Department Chair must inform the Credentials Committee.

(b) Favorable recommendation: The Department Chair must document his/her findings pertaining to adequacy of education, training, and experience for all privileges requested. Reference to any criteria for clinical privileges must be documented and included in the credentials file. When the Department Chair's recommendation is favorable to the applicant in all respects, the application shall

[2] *Subject matter expert is an individual chosen by the Credentials Committee, or Medical Executive Committee to assist and advise them in evaluation of recommendations for clinical privileges for their peers.*

be promptly forwarded, together with all supporting documentation, to the Credentials Committee.

(c) Adverse recommendation: The Department Chair will document the rationale for all unfavorable findings. Reference to any criteria for clinical privileges not met will be documented and included in the credentials file. The application, along with the Department Chair's adverse recommendation and supporting documentation, will be forwarded to the Credentials Committee.

3.5 Applicant Interview

3.5.1 All applicants may be required to participate in an interview as part of the application for appointment to the medical staff at the discretion of the Credentials Committee. The interview is to be conducted by the Credentials Committee. A permanent record of the interview may be documented using the Salem Hospital questionnaire. The interview may be used to solicit information required to complete the credentials file or clarify information previously provided, e.g., malpractice history, reasons for leaving past healthcare organizations, or other matters bearing on the applicant's ability to render care at the generally recognized level for the community.

3.5.2 Procedure: When an interview is required, the applicant will be notified by the Credentials Committee Chair or designee with dates and times for upcoming meetings of the Credentials Committee. Failure of the applicant to schedule an interview with the designated medical staff leader or Medical Staff Office within thirty (30) days will be deemed a withdrawal of the application.

3.6 Credentials Committee Action

3.6.1 If the application is designated category 1, it is presented to the Credentials Chair for review and recommendation. The Credentials Chair reviews the application to ensure that it fulfills the established standards for membership and/or clinical privileges. The Credentials Chair has the opportunity to determine whether the application is forwarded as a category 1 or may change the designation to a category 2. If forwarded as a category 1, the Credentials Chair will forward the application to the Credentials Committee for recommendation and to the Medical Executive Committee for review and recommendation. If designated category 2, the Credentials Committee reviews the application and votes for one of the following actions:

(a) Deferral: Action by the Credentials Committee to defer the application for further consideration or gathering of information from the applicant or other sources must be followed within thirty (30) days by subsequent recommendations as to approval or denial of, or any special limitations to, staff appointment, category of staff and prerogatives, department affiliations, and scope of clinical privileges.

(b) Favorable recommendation: When the Credentials Committee's recommendation is favorable to the applicant in all respects, the application shall be promptly forwarded, together will all supporting documentation, to the Medical Executive Committee. The Credentials Committee may recommend the imposition of specific conditions. These conditions may relate to behavior or to clinical issues. The Credentials Committee may also recommend that appointment be granted for a period of less than two (2) years in order to permit closer monitoring of an individual's compliance with any conditions.

(c) Adverse recommendation: When the Credentials Committee's recommendation is adverse to the applicant, the application, shall be forwarded to the Medical Executive Committee.

3.7 Medical Executive Committee Action

3.7.1 If the application is designated category 1, it is presented to the Medical Executive Committee, where the application is reviewed to ensure that it fulfills the established standards for membership and/or clinical privileges. The President of the Medical Staff has the opportunity to determine whether the application is forwarded as a category 1, or may change the designation to a category 2. If forwarded as a category 1, the Medical Executive Committee acts and the application is presented to the Board Professinal Review Committee and Board of Trustees. If designated as a category 2, the Medical Executive Committee reviews the application and votes for one of the following actions:

(a) Deferral: Action by the Medical Executive Committee to defer the application for further consideration must be followed within thirty (30) days by subsequent recommendations as to approval or denial of, or any special limitations to, staff appointment, category of staff and prerogatives, department affiliations, and clinical privileges. The Chief Executive Officer shall promptly notify the applicant by special, written notice of the action to defer.

(b) Favorable recommendation: When the Medical Executive Committee's recommendation is favorable to the applicant in all respects, the application shall be forwarded, together with all supporting documentation, to the Board of Trustees. The Medical Executive Committee may recommend the imposition of specific conditions. These conditions may relate to behavior or to clinical issues. The Medical Executive Committee may also recommend that appointment be granted for a period of less than two (2) years in order to permit closer monitoring of an individual's compliance with any conditions.

(c) Adverse recommendation: When the Medical Executive Committee's recommendation is adverse to the applicant, a special notice shall be sent to the applicant. No such adverse recommendation will be acted upon by the Board of Trustees until after the practitioner has exercised or has waived his/her right to a hearing as provided in the Bylaws. A recommendation shall not be considered adverse to the applicant if clinical privileges not central and directly related to the

applicant's prior training and practice are deferred until such time as the hospital has had sufficient opportunity (after initial appointment) to observe the applicant's practice and qualifications to exercise the deferred privileges.

3.8 Board of Trustees Action

3.8.1 All applications will be forwarded to the Board of Trustees which will review the information and vote for one of the following actions. The Board, at its discretion, may establish different processes for the Board's handling of Category 1 applications.

3.8.2

(a) Board Approval: The Board of Trustees may adopt a favorable recommendation of the Medical Executive Committee, thereby approving the application. The Board of Trustees may impose specific conditions as determined appropriate by the Board. The Board of Trustees may also stipulate that appointment is granted for a period of less than two (2) years in order to permit closer monitoring of an individual's compliance with any conditions.

(b) Board Denial: The Board of Trustees may deny the application, in which case the Board shall cause written notice of the denial to be sent to the applicant, and the applicant shall then be entitled to the procedural rights provided in the Bylaws.

(c) Remand to Medical Executive Committee: The Board of Trustees may remand the application to the Medical Executive Committee for further proceedings and consideration as directed by the Board. The remand shall state the reason(s) for the remand.

3.8.3 In the case of an adverse Medical Executive Committee recommendation, and after the exercise of any procedural rights by the applicant, the Board of Trustees shall take final action in the matter as provided in the Bylaws.

3.8.4 All appointments to medical staff membership and the granting of privileges are for a period not to exceed twenty-four (24) months.

3.8.5 Basis for recommendation and action: The report of each individual or group required to act on an application, including the Board of Trustees, must state in writing the reasons for each recommendation or action taken.

3.8.6 Notice of final decision: Notice of the Board of Trustees final decision shall be given, through the Chief Executive Officer, to the Medical Executive Committee and to the Chair of each department concerned. The applicant shall receive written notice of appointment and written notice of any adverse final decisions within 10 calendar days of the final decision. A decision and notice of appointment includes the staff category to which the applicant is appointed, the clinical privileges he/she may exercise, and any special conditions attached to the appointment.

3.8.7 Time periods for processing: All individuals and groups required to act on an application for staff appointment will strive to do so in a timely and good faith manner, and, except for good cause, each application will be processed within the following time periods:

- Medical Staff Office (to collect, verify, and summarize) 60 days from receipt of completed application
- Department Chairs (to review and report) 15 days from receipt of verified application
- Credentials Committee (analyze and recommend) 30 days from receipt of report from Department Chair
- Medical Executive Committee (to reach final recommendation) 30 days from receipt of recommendation from Credentials Committee
- Board of Trustees (render final decision) 30 days from receipt of recommendation from Medical Executive Committee
- Board of Trustees (notification of decision) 10 days from date of Board of Trustees final decision regarding granting of privileges and/or membership. The offer of privileges and/or membership is conditional upon the practitioner's attendance at the mandated Medical Staff Orientation. Should the practitioner not attend orientation within the first three (3) months of notification, the offer shall expire.

These time periods are deemed guidelines and do not create any right to have an application processed within these precise periods. In addition, the above timelines are separate from any statewide common credentialing system that may be adopted in the state of Oregon.

Section 4. Provisional Period

4.1 Provisional period: All initial appointments and clinical privileges as well as any new clinical privileges granted to an existing medical staff appointee, are granted for a provisional period during which time all individuals with provisional privileges shall be subject to review of their performance via monitoring based on Focused Professional Practice Evaluation (FPPE).

Section 5. Reappointment

5.1 All reappointments and renewals of clinical privileges are for a period not to exceed twenty-four (24) months. The granting of new clinical privileges to existing medical staff members will follow the steps described in Section 3 above concerning the initial granting of new clinical privileges and Section 4 above concerning provisional status for those privileges. A suitable peer shall substitute for the Department Chair in the evaluation of current competency of the Department Chair, and recommend appropriate action to the Credentials Committee.

5.2 Information collection and verification:

5.2.1 From appointee: On or before six (6) months prior to the date of expiration of a medical staff appointment, a representative from the Medical Staff Office notifies the appointee of the date of expiration and supplies him/her with an application for reappointment. At least four (4) months prior to this expiration date, the appointee furnishes, in writing:

(a) A completed reapplication form, which includes complete information to update his/her file on items listed in his/her original application, any required new, additional, or clarifying information, and any required fees or dues.

(b) Information concerning continuing training and education, internal and external to the hospital, during the preceding period.

(c) Specific requests for clinical privileges sought on reappointment, with any basis for changes.

(d) By signing the reapplication form, the appointee agrees to the same terms as identified in Section 3.2 above.

5.2.2 Failure, without good cause, to provide all requested information at least four (4) months prior to the expiration of appointment may result in a cessation of processing of the application and automatic expiration of appointment. Once the information is received, the Medical Staff Office verifies this information and notifies the staff appointee of any further information required. The burden is on the applicant to provide all required information. It is the applicant's responsibility to ensure that the Medical Staff Office receives all required supporting documents verifying information on the application and providing sufficient evidence, as required in the sole discretion of the hospital, that the applicant meets the requirements for medical staff membership and the privileges requested. If information is missing from the application, or new, additional, or clarifying information is required, a request for such information will be sent to the applicant. It is the responsibility of the applicant to correct or respond to erroneous information, and to supplement incomplete information at the time it is first requested. If the requested information is not returned to the Medical Staff Office within the time frame specified, this will be deemed a voluntary withdrawal of the reappointment application.

5.2.3 The Medical Staff Office collects information regarding each staff appointee's professional and collegial activities from internal and/or external sources.

5.2.4 The information to be collected by the Medical Staff Office includes but is not limited to:

(a) A summary of clinical activity at this hospital for each appointee due for reappointment including ongoing and if applicable, focused professional practice evaluation reports.

(b) Performance and conduct in this hospital and other healthcare organizations in which the practitioner has provided substantial clinical care since the last reappointment, including, without limitation, patterns of care as demonstrated in findings of quality assessment/performance improvement activities, his/her clinical judgment and skills in the treatment of patients, and his/her behavior and cooperation with hospital and other healthcare organization's personnel, patients, and visitors.

(c) Verification of the required hours, if any, of category 1 continuing medical education activities.

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

(e) Timely and accurate completion of medical records.

(f) Compliance with all applicable bylaws, policies, rules, regulations, and procedures of the hospital and medical staff.

(g) Any gaps in employment or practice since the previous appointment or reappointment.

(h) National Practitioner Data Bank query.

(i) A peer recommendation to evaluate current competence, ethical character, and ability to work with others.

(j) Professional liability claims history for the past two (2) years which is primary source verified by the malpractice carrier(s).

(k) Review of fulfillment of requirement for board certification in specialty appropriate to privileges granted within five (5) years from completion of the applicable Residency and/or Fellowship program for the privileges held at Salem Hospital.[3]

(l) Board eligibility information regarding the practitioner from a licensing board, specialty board and professional affiliations.

[3] Members of the Medical Staff on staff as of (date of adoption of CPM) shall meet the criteria in the Credentials Procedure Manual dated 04/04/2019 which stated as follows: Applicant must be board certified in the specialty appropriate to the privileges granted within five years of appointment to the Medical Staff.

5.3 Procedure for Processing Reappointment Applications

When the items identified in 5.2.1, 5.2.3, and 5.2.4 above have been obtained, the file will then be reviewed for categorization as follows:

All completed applications are presented to the Section Chief, if applicable and Department Chair for review and recommendation. The Section Chief, if applicable and the Department Chair reviews the application to ensure that it fulfills the established standards for membership and/or clinical privileges. The Medical Staff Office, in consultation with the appropriate Section Chief (if applicable), Department Chair, Chief Medical Officer, Vice President of Medical Affairs and Credentials Chair determines whether the application is forwarded as a category 1 or category 2. The Department Chair may obtain input if necessary from an appropriate subject matter expert[4].

The Department Chair takes action as follows:

(a) Deferral: In the event a Department Chair is unable to formulate a recommendation for any reason, the Department Chair must so inform the Credentials Committee.

(b) Favorable recommendation: The Department Chair must document his/her findings pertaining to adequacy of education, training, and experience for all privileges requested. Reference to any criteria for clinical privileges must be documented and included in the credentials file. When the Department Chair's recommendation is favorable to the applicant in all respects, the application shall be promptly forwarded, together with all supporting documentation, to the Credentials Committee.

(c) Adverse recommendation: The Department Chair will document the rationale for all unfavorable findings. Reference to any criteria for clinical privileges not met will be documented and included in the credentials file. The application, along with the department chair's adverse recommendation and supporting documentation, will be forwarded to the Credentials Committee.

5.3.1 Category 1: A completed reapplication that does not raise concerns as identified in the criteria for category 2. Re-applicants in category 1 will be reviewed through the same process as for category 1 initial applicants as described in Section 3.3.6.

5.3.2 Category 2: If one or more of the following criteria is identified in the course of review of a completed reapplication, the reapplication will be treated as category 2. Reapplications in category 2 shall be processed through the same procedure as category 2 initial

[4] *Subject matter expert is an individual chosen by the Credentials Committee, or Medical Executive Committee to assist and advise them in evaluation of recommendations for clinical privileges for their peers.*

applications. Criteria for category 2 reapplications include but are not necessarily limited to the following:

(a) The application is deemed to be incomplete.

(b) The final recommendation of the Medical Executive Committee is adverse or with limitation.

(c) The applicant is found to have experienced an involuntary termination of medical staff membership or involuntary limitation, restriction, reduction, denial, or loss of clinical privileges at another organization.

(d) Applicant is, or has been, under investigation by a state medical board or has had prior disciplinary actions or legal sanctions.

(e) Applicant has had two (2) or more malpractice cases filed within the past two (2) years or one (1) final adverse judgment in a professional liability action.

(f) Applicant has gaps in practice since the most recent credentialing.

(g) Applicant has one or more reference responses which raise concern or questions.

(h) Discrepancy found between information received from the applicant and references or verified information.

(i) Applicant has a National Practitioner Data Bank report with adverse information entered since the time of the applicant's previous appointment or reappointment.

(j) The request for clinical privileges is not reasonable based upon applicant's experience, training, and competence, and/or is not in compliance with applicable criteria.

(k) Removal from an insurance or provider panel for reasons of professional conduct or quality.

(l) Applicant has potentially relevant fitness to practice issues.

(m) Applicant has a record that is not free from current Medicare/Medicaid sanctions or felony convictions. An exception to this requirement may be made only in exceptional circumstances upon recommendation of the Medical Executive Committee and at the sole discretion of the Board of Trustees.

(n) Information from the quality monitoring and improvement program at Salem Hospital raises possible concerns with the applicant's quality of care or capacity to fulfill the responsibilities of medical staff membership and the requested privileges.

(o) Applicant has not demonstrated sufficient exercise of a privilege during the previous appointment period.

(p) Concerns regarding behavior in the hospital and/or cooperation and demonstrated ability to work with medical and hospital personnel as it relates to patient care or the orderly operation of the hospital.

5.4 All applications for reappointment will be processed through the same procedure described in Section 3 above for initial appointment. In addition, as part of the assessment of the appointee's performance, the Department Chair or one or more subject matter experts[5] or another member of the healthcare team may be asked to provide relevant information concerning practitioner's clinical and professional qualifications for reappointment for staff category and clinical privileges and to evaluate the credentials application. Such evaluation will include providing information as to whether or not he/she knows of, or has observed or been informed of any conduct which indicates significant present or potential physical or behavioral problems affecting the practitioner's ability to perform professional and medical staff duties appropriately, as well as relevant information concerning practitioner's clinical and professional qualifications for reappointment for staff category and clinical privileges.

5.5 For the purpose of reappointment, an "adverse action" by the Board of Trustees as used in Section 3 means an action to deny reappointment, or to deny or restrict requested clinical privileges. The terms "applicant" and "appointment" as used in these sections shall be read respectively, as "staff appointee" and "reappointment".

5.6 Criteria for reappointment: It is the policy of Salem Hospital to approve for reappointment only those individuals who meet the criteria for initial appointment as identified in Section 2 and have been determined by the Medical Executive Committee to be providers of effective care that is consistent with Salem medical community standards of ongoing quality as determined by the Medical Executive Committee.

[5] *Subject matter expert is an individual chosen by the Credentials Committee, or Medical Executive Committee to assist and advise them in evaluation of recommendations for clinical privileges for their peers.*

5.7 Conditional Reappointments: Recommendations for reappointment may be subject to an individual's compliance with specific conditions. These conditions may relate to behavior (e.g., professional code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring, completion of CME requirements). Reappointments may be recommended for periods of less than two years in order to permit closer monitoring of an individual's compliance with any conditions that may be imposed. A recommendation of a conditional reappointment or for reappointment for a period of less than two years does not, in and of itself, entitle an individual to request a hearing or appeal. In the event the applicant for reappointment is the subject of an investigation or a hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two years may be granted pending the completion of that process.

5.8 Potential Adverse Recommendation: If the Credentials Committee or the Medical Executive Committee is considering a recommendation to deny reappointment or to reduce clinical privileges, the committee chair will notify the individual of the possible recommendation and invite the member to meet prior to any final recommendation being made. Prior to this meeting, the individual will be notified of the general nature of the information supporting the recommendation contemplated. At the meeting, the individual will be invited to discuss, explain, or refute this information. A summary of the interview will be made and included with the committee's recommendation. This meeting is not a hearing, and none of the procedural rules for hearings will apply. The individual will not have the right to be represented by legal counsel at this meeting.

Section 6. Clinical Privileges

6.1 Exercise of privileges: A credentialed practitioner providing clinical services at Salem Hospital may exercise only those privileges granted to him/her by the Board of Trustees or emergency and disaster privileges as described herein.

6.2 Requests: Each application for appointment or reappointment to the medical staff must contain a request for clinical privileges desired by the applicant. Requests must also be submitted for temporary privileges and for modifications of privileges in the interim between reappointments.

6.3 Basis for privileges determination:

6.3.1 Requests for clinical privileges will be considered only when accompanied by evidence of education, training, experience, and demonstrated current competence as specified by the hospital in its Board approved criteria for clinical privileges.

6.3.2 Privileges for which no criteria have been established:

(a) In the event a request for privileges is submitted for which no criteria have been established, the request will be tabled. The Medical Executive Committee will, upon recommendation from the Credentials Committee

and appropriate subject matter experts, formulate the necessary criteria and recommend these to the Board of Trustees. Once objective criteria have been established, the original request will be processed as described herein.

(b) For the development of the privilege criteria and for granting the privilege, the Section for which the privilege will apply 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.

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

(d) If the privileges requested overlap two or more specialty disciplines, an ad hoc committee will be appointed by the Chair of the Credentials Committee 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 Credentials Committee who has no vested interest in the issue.

6.3.3 Valid requests for clinical privileges will be evaluated on the basis of prior and continuing education, training, experience, utilization practice patterns, current ability to perform the privileges requested, and demonstrated current competence, ability, and judgment. Additional factors that may be used in determining privileges are patient care needs for and the hospital's capability to support the type of privileges being requested and the availability of qualified coverage in the applicant's absence. The basis for privileges determination to be made in connection with periodic reappointment or a requested change in privileges must include documented clinical performance and results of the staff's performance improvement program activities. Privileges determinations will also be based on pertinent information from other sources, especially other institutions and health care settings where a professional exercises clinical privileges.

6.3.4 The procedure by which requests for clinical privileges are processed are as outlined in Section 3 of this manual.

6.4 Special conditions for dental privileges: Requests for clinical privileges for dentists are processed in the same manner as all other privilege requests. Privileges for surgical procedures performed by dentists and/or oral surgeons will require that all dental patients receive a basic medical evaluation (history and physical) by a physician member of the medical staff with privileges to perform such an evaluation, which will be recorded in the medical record. Oral surgeons may be granted the privilege of performing a history and physical on their own patients upon submission of documentation of completion of an accredited postgraduate residency in oral/maxillofacial surgery and demonstrated current competence.

6.5 Special conditions for practitioners not qualified for medical staff appointment and practicing pursuant to medical staff privileges per hospital policy: Requests for privileges from such individuals are processed in the same manner as requests for clinical privileges by practitioners eligible for medical staff membership, with the exception that such individuals are not eligible for membership on the Salem Hospital medical staff and do not have the rights and privileges of such membership. Only those categories of practitioners approved by the Board of Trustees for providing services pursuant to medical staff privileges at Salem Hospital are eligible to apply for privileges. Credentialed Practitioners in this category may, subject to any licensure requirements, requirements for collaborative relationships, any policies for such practitioners established by the Board of Trustees or other limitations, exercise independent judgment only within the areas of their professional competence and may then participate directly in the medical management of patients under the supervision of a physician who has been accorded privileges to provide such care.

6.6 Special conditions for podiatric privileges: Requests for clinical privileges for podiatrists are processed in the same manner as all other privilege requests. All podiatric patients will receive a basic medical evaluation (history and physical) by a physician member of the medical staff that will be recorded in the medical record. Podiatrists may be credentialed to perform histories and physicals on ASA 1, 2 and 3 outpatients.

6.7 Special conditions for residents or fellows in training: Residents or fellows in training in the hospital shall not hold membership on the medical staff and shall not be granted specific clinical privileges.

6.8 Telemedicine Privileges: Telemedicine privileges may be granted to remote practitioners who are not members of the Medical Staff, who prescribe, render a diagnosis or otherwise provide clinical treatment to a patient by means of telemedicine from a site outside the Hospital. Individuals granted telemedicine privileges shall meet in all ways the qualifications for Medical Staff membership unless otherwise approved by the Board of Trustees. Individuals providing telemedicine services shall complete the same credentialing and privileging process that is conducted for applicants to the Medical Staff unless otherwise approved by the Board of Trustees.

6.9 Temporary Privileges: Temporary privileges may be granted by the Chief Executive Officer acting on behalf of the Board of Trustees, upon written concurrence of the Chief Nursing Officer (if applicable), Section Chief (if applicable), Chair of the department in which the privileges will be exercised, and the President of the Medical Staff or designee, provided there is verification of current licensure and current competence. Temporary privileges may be granted in any of the following circumstances:

1. To fulfill an important patient care need,
2. When an initial applicant with a complete, Category 1 application is awaiting review and approval of the Board Professional Review Committee

6.9.1 Important Patient Care Need: Temporary privileges may be granted on a case-by-case basis when an important patient care need exists that mandates an immediate authorization to practice, for a limited period of time, while the full credentials information is verified and approved. For the purposes of granting temporary privileges, an important patient care need is defined as including the following:

(a) A circumstance in which one or more individual patients will experience care that does not adequately meet their clinical needs if the temporary privileges under consideration are not granted, i.e. a patient scheduled for urgent surgery who would not be able to undergo the surgery in a timely manner.

(b) A circumstance in which the institution will be placed at risk of not adequately meeting the needs of patients who seek care from the institution if the temporary privileges under consideration are not granted (i.e., the institution will not be able to provide adequate emergency room coverage in the practitioners specialty, or the Board of Trustees has granted privileges involving new technology to a physician on staff provided the physician is precepted for a specific number of initial cases and the precepting physician, who is not seeking medical staff membership, requires temporary privileges to serve as a preceptor).

6.9.2 Category 1 Application Awaiting Approval: Temporary privileges may be granted for up to 45 days when the new applicant for medical staff membership or privileges is waiting for approval by the Board of Trustees. Criteria for granting temporary privileges in these circumstances include a fully verified application meeting all criteria for Medical Staff membership that has been recommended by the Credentials Committee and/or Credentials Committee Chair and the Medical Executive Committee. Additionally, the application must meet the criteria for Category 1, expedited credentialing consideration as noted in Section 3 of this manual.

6.9.3 Special requirements of consultation and reporting may be imposed as part of the granting of temporary privileges. Except in unusual circumstances, temporary privileges will not be granted unless the practitioner has agreed in writing to abide

by the Bylaws, rules, and regulations and policies of the medical staff and Salem Hospital in all matters relating to his/her temporary privileges. Whether or not such written agreement is obtained, these Bylaws, rules, regulations, and policies control all matters relating to the exercise of clinical privileges.

6.9.4 Termination of temporary privileges, telemedicine privileges and/or residents and fellows: The Chief Executive Officer, acting on behalf of the Board of Trustees, and after consultation with the President of the Medical Staff, may terminate any or all of the practitioner's privileges based upon the discovery of any information or the occurrence of any event of a nature which raises questions about a practitioner's privileges. Where the life or well-being of a patient is determined to be endangered, any person entitled to impose summary suspension under the medical staff bylaws may affect the termination. In the event of any such termination, the practitioner's patients then will be assigned to another practitioner by the Chief Executive Officer, Chief Medical Officer, Vice President of Medical Affairs and President of the Medical Staff or his/her designee. The wishes of the patient shall be considered, when feasible, in choosing a substitute practitioner.

6.9.5 Rights of the practitioner with temporary privileges: A practitioner is not entitled to the procedural rights afforded by the Medical Staff Bylaws because his/her request for temporary privileges is refused or because all or any part of his/her temporary privileges are terminated or suspended.

6.9.6 Emergency Privileges: In the case of a medical emergency, any medical staff appointee is authorized to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by the appointee's license, but 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.

6.9.7 Disaster Privileges:

(a) The hospital assigns disaster responsibilities to volunteer licensed practitioners only when the Emergency Operations Plan has been activated in response to a disaster and the hospital is unable to meet immediate patient needs.

(b) The Incident Commander will make the determination of whether to use volunteer licensed practitioners.

(c) When the decision is made to use disaster volunteer licensed practitioners, personnel from the Medical Staff Office will communicate to potential volunteer licensed practitioners the disaster needs of the hospital.

(d) A licensed practitioner seeking disaster privileges must present his or her valid government issued photo identification (for example, a driver's license or passport) and at least one of the following:

1. A current picture identification card from a health care organization that clearly identifies professional designation
2. A current license to practice
3. Primary source verification of licensure
4. Identification that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corp (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or group
5. Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances
6. Confirmation by a licensed practitioner currently privileged by the hospital or by a staff member with personal knowledge of the volunteer practitioner's ability to act as a qualified practitioner during a disaster

(e) Credential verification:

1. Primary source verification of licensure by the Medical Staff Office occurs as soon as the disaster is under control or within 72 hours from the time the volunteer practitioner presents himself or herself to the hospital, whichever comes first.
2. If primary source verification of a volunteer licensed practitioner's licensure cannot be completed within 72 hours of the practitioner's arrival due to extraordinary circumstances, the hospital documents all of the following:

    i. Reason(s) it could not be performed within 72 hours of the practitioner's arrival
    ii. Evidence of the licensed practitioner's demonstrated ability to continue to provide adequate care, treatment, or services
    iii. Evidence of the hospital's attempt to perform primary source verification as soon as possible

3. If, due to extraordinary circumstances, primary source verification of licensure of the volunteer practitioner cannot be completed within 72 hours of the practitioner's arrival, it is performed as soon as possible.

(f) Privilege granting authority

1. The Chief Executive Officer, Chief Medical Officer, and Vice President of Medical Affairs, or their designee will make a decision within 72 hours whether to continue to extend disaster privileges to the volunteer licensed practitoner, based on information obtained regarding their professional practice.
2. When the disaster situation has passed, as determined in the hospital's emergency operations plan (EOP), the licensed practitioner's disaster privileges terminate immediately.
3. The Chief Executive Officer, Chief Medical Officer, and Vice President of Medical Affairs shall also have the authority to terminate disaster privileges. Such authority may be exercised at the sole discretion of the hospital and will not give rise to a right to a fair hearing or an appeal.

(g) Those individuals that have been authorized as volunteer licensed practitioners will be issued a temporary badge making their credentialed volunteer status clear and distinct from other licensed practitioners.

1. The identification badge will be worn by the volunteer licensed practitioner at all times they are assigned and are performing disaster duties and displayed in a manner to be easily seen.

(h) Qualified volunteer licensed practitioners will be assigned by Medical Staff Office personnel as needed.

(i) During a disaster, the medical staff oversees the performance of each volunteer licensed practitioner.

(j) Based upon its oversight of each volunteer licensed practitioner, the hospital determines within 72 hours after the practitioner's arrival if granted disaster privilege should continue.

(k) The Medical Staff Office will assign a hospital employee in charge of the area to which the volunteer licensed practitioner is assigned. The employee is responsible for overseeing the performance of each volunteer licensed practitioner. Examples of methods of oversight that may be used include:

1. Direct observation of the volunteer's performance
2. Mentoring
3. Medical record review

Section 7. Preceptorship

7.1 A practitioner who is a member of the medical staff and has not provided acute inpatient care within the past twelve (12) months who requests clinical privileges at the hospital

must upon recommendation of the Chief Executive Officer, Chief Medical Officer, Vice President of Medical Affairs, President of the Medical Staff or Medical Executive Committee arrange for a preceptorship either with a current Active member in good standing of the medical staff who practices in the same specialty or with a training program. The practitioner must assume responsibility for any financial costs required to fulfill the requirements of Sections 8.1 and 8.2.

7.2 A description of the preceptorship program, including details of monitoring and consultation must be written and submitted for approval to the Department Chair, Credentials Committee, Medical Executive Committee and Board of Trustees. At a minimum, the preceptorship program description must include the following:

7.2.1 The scope and intensity of required preceptorship activities; and

7.2.2 The requirement for submission of a written report from the preceptor prior to termination of the preceptorship period assessing, at a minimum, the applicant's demonstrated clinical competence related to the privileges requested, the quality and timeliness of medical records documentation, ability to perform the privileges requested, and professional ethics and conduct.

Section 8. Reapplication and Modifications of Membership Status or Privileges and Exhaustion of Remedies

8.1 Reapplication after adverse credentials decision: Except as otherwise determined by the Medical Executive Committee or Board of Trustees in light of exceptional circumstances, a practitioner who has received a final adverse decision or who has resigned or withdrawn an application for appointment or reappointment or clinical privileges while under investigation is not eligible to reapply to the medical staff for a period of two (2) years from the date of the notice of the final adverse decision or the effective date of the resignation of application withdrawal. Any such application is processed in accordance with the procedures then in force. As part of the reapplication, the practitioner must submit such additional information as the Medical Staff Office, Credentials Committee, Medical Executive Committee and/or Board of Trustees requires demonstrating that the basis of the earlier adverse action no longer exists. If such information is not provided, the reapplication will be considered incomplete and voluntarily withdrawn and will not be processed any further.

8.2 Reapplication after administrative revocation: A practitioner who has had his/her appointment or clinical privileges administratively revoked for, including but not limited to the following: failure to maintain current professional liability insurance in the specified amount or failure to maintain and complete medical records will be reinstated for appointment and appropriate privileges upon submission of documentation that he/she has resolved the reason for the revocation. Any period beyond ninety (90) days will be treated as a voluntary resignation of medical staff membership and/or privileges.

8.3 Request for modification of appointment status or privileges: A staff appointee, either in connection with reappointment or at any other time, may request modification of staff category, department assignment, or clinical privileges by submitting a written request to the Medical Staff Office. A modification request must be on the prescribed form and must contain all pertinent information supportive of the request. All requests for additional clinical privileges must be accompanied by information demonstrating appropriate education, training, and current clinical competence in the specific privileges requested. A modification application is processed in the same manner as an initial appointment, which is outlined in Section 6 of this manual. A practitioner who determines that he/she no longer exercises, or wishes to restrict or limit the exercise of, particular privileges that he/she has been granted shall send written notice, through Medical Staff Office, to the Credentials Committee, Medical Executive Committee and Board of Trustees. A copy of this notice shall be included in the practitioner's credentials file as allowed in Section 6.

8.4 Resignation of staff appointment: A practitioner may resign his/her staff appointment and/or clinical privileges by providing written notice to the appropriate Department Chair, President of the Medical Staff or Medical Staff Office. The resignation shall specify the reason for the resignation and the effective date. A practitioner who resigns his/her staff appointment and/or clinical privileges is obligated to fully and accurately complete all portions of all medical records for which he/she is responsible prior to the effective date of resignation. Failure to do so may result in an entry in the practitioner's credentials file acknowledging the resignation and indicating that it became effective under unfavorable circumstances and may be considered a matter of professional conduct that could adversely affect the health or welfare of a patient and so is reportable to the National Practitioner Data Bank, pursuant to the HCQIA (Health Care Quality Improvement Act) of 1986.

8.5 Exhaustion of administrative remedies: Every practitioner agrees that he/she will exhaust all the administrative remedies afforded in the various sections of this manual and the Bylaws before initiating legal action against the hospital or its agents.

8.6 Reporting requirements: The Chief Executive Officer or his/her designee shall be responsible for complying with the hospital's obligations under the Health Care Quality Improvement Act of 1986 and its successor statutes. Actions that must be reported include any professional review action involving a practitioner related to clinical competence or professional conduct adversely affecting clinical privileges for greater than thirty (30) days, or surrender of privileges, either during investigation or to avoid investigation in accordance with the NPDB requirements and any amendments there to.

Section 9. Leave of Absence

9.1 Initiation

(a) Members of the Medical Staff and credentialed practitioners other than u-status and locum practitioners must submit a request for a leave of absence when they cease to

practice for sixty (60) days or more. All members of the medical staff and credentialed practitioners must submit a request for a leave of absence when the reason for the leave is related to health issues or has the potential to materially affect their ability to practice. Maternity leave for less than one-year does not require a request for leave of absence unless fitness to practice arise. Should fitness to practice issues arise, the leave of absence process outlined in this section applies. Upon becoming aware of such circumstances, the Chief Medical Officer and/or Vice President of Medical Affairs, in consultation with the Medical Staff President, may trigger an automatic medical leave of absence at any point after becoming aware of that information. A leave of absence may not exceed one year, except for military service. The leave request must be submitted in writing to the President of the Medical Staff or his/her designee, stating the beginning and ending dates of the leave and the reason for the leave. Except in extraordinary circumstances, this request must be submitted at least thirty (30) days prior to the anticipated start of the leave. A voluntary educational Leave of Absence may also be developed as part of a Performance Improvement Plan through the peer review process.

(b) The Medical Executive Committee will determine whether a request for a leave of absence will be granted. The granting of a leave of absence or reinstatement may be conditioned upon the individual's completion of all medical records.

(c) Should it become apparent that a Medical Staff member or privileged practitioner has been absent for an extended period of time and has not requested a Leave of Absence under the required circumstances outlined in item 10.1 (a), the President of the Medical Staff or his/her designee may request a leave of absence on behalf of the practitioner.

(d) In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for an extension is not granted, or where reinstatement is not granted for reasons other than professional competence or conduct, the determination will be final, with no recourse to a hearing and appeal.

9.2 Duties of Members and Privileged Practitioners on Leave

(a) During the leave of absence, the individual will not exercise any clinical privileges, and will be excused from all Medical staff responsibilities (e.g., meeting attendance, committee service, emergency service call obligations). Access to the Salem Health electronic medical record, other than for the purpose of completing medical records, will be evaluated by the Medical Executive Committee and granted on a case-by-case basis. All medical records must be completed as soon as reasonably possible. The obligation to pay dues will continue during a Leave of Absence, except that a member granted a leave of absence for U.S. military service will be exempt from the obligation.

(b) Related to the reappointment process, if a Medical Staff member or privileged practitioner's two (2) year reappointment arises during the term of the leave, the practitioner must complete the reappointment packet in a timely fashion and have it processed before the membership and/or privileges expire. Failure to complete the

reappointment process prior to the two (2) year expiration will result in a lapse and termination of membership and/or privileges, requiring the individual to reapply.

(c) Failure by the practitioner to report a leave of absence within thirty (30) days of initiation of the leave shall be reported to the Credentials Committee, which shall review the failure to report and the circumstances involved, and shall have discretion to recommend sanctions up to and including loss of medical staff membership and privileges.

9.3 Reinstatement

(a) At least thirty (30) days prior to the termination of the leave, or at any time earlier, the individual requesting reinstatement must submit a written summary of their professional activities and any medical issues during the leave and any other information that may be requested by the Credentials Committee or Medical Executive Committee. Requests for reinstatement will then be reviewed by the relevant Department Chair, the Chair of the Credentials Committee, the President of the Medical Staff or his/her designee, and the Chief Medical Officer.

(b) The individual on a medical leave of absence may be required to provide a report from a treating physician or program stating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested.

(c) If a favorable recommendation on reinstatement is made, the individual may immediately resume clinical practice. However, if any of the committees or individuals reviewing the request have any questions or concerns about the ability to provide safe, competent patient care, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, Medical Executive Committee and the Board of Trustees. If any request for reinstatement is not granted for reasons related to clinical competence or professional conduct, and if a report to the National Practitioner Data Bank is determined to be required, the individual will be entitled to request a hearing and appeal.

Section 10. Practitioners Providing Contracted Services

10.1 When the hospital contracts for care services with licensed practitioners who provide official readings of images, tracings or specimens through a telemedicine mechanism, all licensed practitioners who will be providing services under this contract will be permitted to do so only after being granted privileges at the hospital through the mechanisms established in this manual.

10.2 Exclusivity policy: Whenever hospital policy specifies that certain hospital facilities or services may be provided on an exclusive basis in accordance with contracts or letters of agreement between Salem Hospital and qualified practitioners, then other staff appointees must, except in an emergency or life threatening situation, adhere to the exclusivity policy in arranging for or providing care. The contract or letter of agreement shall be

reviewed and approved by the Medical Executive Committee in accordance with hospital policy. Application for initial appointment or for clinical privileges related to Salem Hospital facilities or services covered by exclusive agreements will not be accepted or processed unless submitted in accordance with the existing contract or agreement with the hospital.

10.3 Qualifications: A practitioner who is or will be providing specified professional services pursuant to a contract or a letter of agreement with the hospital must meet the same qualifications, must be processed in the same manner, and must fulfill all the obligations of his/her appointment category as any other applicant or staff appointee.

10.4 Effect of disciplinary or corrective action recommended by the Medical Executive Committee: The terms of the Medical Staff Bylaws will govern disciplinary action taken or recommended by the Medical Executive Committee.

10.5 Effect of contract or employment expiration or termination: The effect of expiration or other termination of a contract upon a practitioner's staff appointment and clinical privileges will be governed solely by the terms of the practitioner's contract with Salem Hospital. If the contract or the employment agreement is silent on the matter, then contract expiration or other termination alone will not affect the practitioner's staff appointment status or clinical privileges.

Section 11. Medical Directors

11.1 A medical director is a practitioner engaged by the hospital either full or part time in an administratively responsible capacity, whose activities may also include clinical responsibilities such as direct patient care, teaching, or supervision of the patient care activities of other practitioners under the officer's direction.

11.2 Each medical director must achieve and maintain medical staff appointment and clinical privileges appropriate to his/her clinical responsibilities and discharge staff obligations appropriate to his/her staff category in the same manner applicable to all other staff members.

11.3 Effect of removal from office or adverse change in appointment status or clinical privileges:

(a) Where a contract exists between the medical director and the hospital, its terms govern the effect of removal from the medical administrative office on the medical director's staff appointment and privileges and the effect of an adverse change in the medical director's staff appointment or clinical privileges on his/her remaining in office as a medical director.

(b) In the absence of a contract or where the contract is silent on the matter, removal from office has no effect on appointment status or clinical privileges. The effect of an adverse change in appointment status or clinical privileges on continuance

in office will be as determined by the Board of Trustees after requesting and considering the recommendation of relevant components and officials of the staff.

(c) A medical director has the same procedural rights as all other staff members in the event of an adverse change in appointment status or clinical privileges unless the change is, by contract a consequence of removal from office.