MEDICAL STAFF

ORGANIZATIONAL MANUAL

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PAWNEE VALLEY COMMUNITY HOSPITAL

ADOPTION

This Medical Staff Organizational Manual is adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff bylaws and policies pertaining to the subject matter herein, and henceforth all department and committee activities of the Medical Staff and of each individual serving as a member of a department or staff committee shall be undertaken pursuant to the requirements of this manual.

Adopted by the Medical Staff of Pawnee Valley Community Hospital this 23rd day of June, 2010.

/s/

Matt Heyn

Hospital Chief Executive Officer

/s/

David W. Sanger, MD

Chief of Staff

Approved by the Board of Pawnee Valley Community Hospital this 28th day of June, 2010.

/s/

John H. Jeter, MD

Chairperson

Board of Directors

ARTICLE I

DEFINITIONS

A. The following definitions shall apply to terms used in this manual:

(1) “Administrator/Chief Executive Officer” means the individual, or designee, in charge of the operations of the hospital.

(2) "Appointee" means any physician and dentist who has been granted Medical Staff appointment and clinical privileges by the Board to practice at the hospital.

(3) "Board" means the Board of Directors of Pawnee Valley Community Hospital, which has the overall responsibility for the conduct of the hospital.

(4) "Chief Medical Officer" is the Chief Medical Officer of Hays Medical Center who shall serve as a member of the PVCH Board of Directors and Medical Staff committees, supporting the administrative and clinical functions of PVCH.

(5) "Clinical Privileges" or "privileges" means the authorization granted by the Board to an applicant, Medical Staff appointee, other independent practitioner or advanced dependent practitioner to render specific patient care services in the hospital within defined limits.

(6) "Dentist" shall be interpreted to include a doctor of dental surgery ("D.D.S.") and doctor of dental medicine ("D.M.D.").

(7) "Executive Committee" means the Executive Committee of the Medical Staff unless specifically written "Executive Committee of the Board."

(8) "Ex Officio" means service as an appointee of a body by virtue of an office or position held and, unless otherwise specified in these bylaws or the Medical Staff Organizational Manual, means without voting rights.

(9) "Good standing" means that Medical Staff appointee who is not under suspension or any restriction regarding staff appointment or admitting or clinical privileges at this hospital and/or at any other health care facility or organization.

(10) "Hospital" means Pawnee Valley Community Hospital.

(11) "Medical Staff" means all physicians, dentists and podiatrists who are given privileges to treat patients at the hospital.

(12) "Patient encounters" means the number of inpatient admissions, inpatient surgeries, inpatient visits as admitting or attending physician, outpatient surgeries, physician clinic visits, anesthetic cases, radiology interpretations, pathology interpretations, emergency department patients, observation admissions, consultations, which are defined as face-to-face contacts, telemedicine, or supervision of licensed master-level psychologists, licensed master-level social workers, licensed clinical psychologists, licensed clinical marriage and family therapists, and licensed clinical professional counselors.

(13) "Physicians" shall be interpreted to include both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s").

(14) "Professional review action" means an action or recommendation of a professional review body which is taken or made in the conduct of professional peer review activity, which is based on the competence or professional conduct of a staff appointee, and which affects or may affect adversely the clinical privileges or appointment of the staff appointee.

(15) "Professional review activity" means a peer review activity of the hospital with respect to an individual Medical Staff applicant or appointee (a) to determine whether the Medical Staff applicant or appointee may have clinical privileges with respect to his/her appointment; (b) to determine the scope or conditions of those clinical privileges and appointment; and (c) to change or modify such privileges and/or appointment.

(16) "Professional review body" means the Board of the hospital or any Board committee which conducts professional peer review activity, and includes any committee of the Medical Staff when assisting the Board in a professional peer review activity.

(17) "Unassigned patient" means any individual who comes to the hospital for care and treatment who does not have an attending physician; or whose attending physician or designated alternate is unavailable to attend the patient; or who does not want the prior attending physician to provide him/her care while a patient at the hospital.

(18) "Voluntary" or "automatic relinquishment" of Medical Staff appointment and/or clinical privileges means a lapse in appointment and/or clinical privileges deemed to automatically occur as a result of stated conditions.

B. Words used in this manual shall be read as the masculine or feminine gender, and as the singular or plural, as the content requires. The captions or headings are for convenience only and are not intended to limit or define the scope or effect of any provision of this manual.

ARTICLE II

MEDICAL STAFF ORGANIZATIONAL PLAN

ARTICLE II - PART A: DEVELOPMENT AND ANNUAL REVIEW OF PLAN

Each year, the Executive Committee shall review the structure of the Medical Staff as set forth in this manual with reference to appropriate legal guidelines and accrediting agency standards. This plan shall describe the organization of the Medical Staff and specify the duties of each Medical Staff standing committee. A special or ad hoc committee may be created by the Executive Committee from time to time to assist with the development of an organizational plan.

ARTICLE III

MEDICAL STAFF COMMITTEES

This article shall outline those Medical Staff committees responsible for the performance of quality assessment/evaluation or other review functions delegated to the Medical Staff by the Board.

ARTICLE III – PART A: COMMITTEES

Section 1. General Information:

(a) All committees of the medical staff shall reside within the Executive Committee.

(b) The medical staff committee meetings shall occur during the Executive Committee meetings.

(c) Separate minutes for each medical staff committee shall be maintained, even though the medical staff committee meetings are logistically occurring in the same forum, the Executive Committee.

ARTICLE III - PART A: APPOINTMENT

Section 2. Chairperson:

The Chairperson of all Medical Staff Committees shall be the Chief of Staff, who is the Chairperson of the Executive Committee. The chairperson shall be appointed based on the criteria set forth in Article III, Part A, Section 4 of the bylaws. Such appointments will be ratified by the Board at its last meeting prior to the end of the Medical Staff year every two years.

ARTICLE III - PART A:

Section 3. Members:

(a) Except as otherwise provided for in these bylaws or the Medical Staff Organizational Manual, members of each committee shall be appointed every two years by the Chief of Staff, in consultation with the Chief Executive Officer, not more than thirty (30) days after the annual meeting of the Medical Staff, and there shall be no limitation in the

number of terms they may serve. All appointed members may be removed and vacancies filled at the discretion of the Chief of Staff.

(b) The Chief Executive Officer or their respective designees shall be a member, *ex officio*, without vote, on all committees.

ARTICLE III - PART A:

Section 4. Quorum for Committee Meetings:

No quorum shall be required to convene a regular or special meeting of a committee, but in no event shall a meeting be convened with less than two (2) members, including the chairperson in attendance.

ARTICLE III - PART A:

Section 5. Attendance by Medical Staff Appointees:

Active or Consulting Staff appointees may attend any staff committee meetings, except for portions of such meetings during which confidential credentialing and/or peer review matters are discussed.

ARTICLE III - PART A:

Section 6. Designation and Substitution:

(a) There shall be an Executive Committee and such other standing and special committees of the Medical Staff responsible to the Executive Committee as may from time to time be necessary and desirable to perform the staff functions set forth in this manual and the Medical Staff Bylaws.

(b) The Chief of Staff shall appoint Medical Staff appointees to participate in interdisciplinary hospital committees.

ARTICLE III - PART B: EXECUTIVE COMMITTEE

Section l. Composition:

(a) The Executive Committee shall consist of the Chief of Staff and no more than six (6) members elected at large from the Active Medical Staff.

(b) The Executive Committee members at large shall be elected at the annual Medical Staff meeting every two years. Members at-large shall be eligible for re-election.

(c) The Chief of Staff shall be Chairperson of the Executive Committee.

(d) The Chairperson of the hospital Governing Board and the hospital's Chief Executive Officer, Chief Medical Officer, an Allied Health Professional to be appointed by the Allied Health Professional Review Committee at the annual Medical Staff meeting, and Chief Nursing Officer may attend meetings of the Executive Committee and participate in its discussions, but without vote.

ARTICLE III - PART B:

Section 2. Duties:

The duties of the Executive Committee shall be:

(a) to represent and act on behalf of the Medical Staff in all matters, without requirement of subsequent approval by the staff, subject only to any limitations imposed by these bylaws and/or the Medical Staff Organizational Manual;

(b) to coordinate the activities and general policies of the hospital;

(c) to serve as the residing body of all medical staff committees.

(d) to receive and act upon those committee, and other assigned activity group reports as specified in these bylaws and the Medical Staff Organizational Manual, and make recommendations concerning such reports to the Chief Executive Officer and the Board;

(e) to implement policies of the hospital that affect the Medical Staff;

(f) to provide liaison among the Medical Staff, the Chief Executive Officer and the Board;

(g) to keep the Medical Staff abreast of applicable accreditation and regulatory requirements affecting the hospital;

(h) to enforce hospital and Medical Staff rules in the best interest of patient care and of the hospital, with regard to all persons who hold appointment to the Medical Staff;

(i) to be responsible for situations involving questions of the clinical competence, patient care and treatment, case management, or inappropriate behavior of any Medical Staff appointee.

(j) to be responsible to the Board for the implementation of the hospital's quality/performance improvement plan as it affects the Medical Staff;

(k) to review every two (2) years the bylaws, policies, rules and regulations, and associated documents of the Medical Staff, including, but not limited, to the mechanisms designed to evaluate the credentials and to delineate the clinical privileges of Medical Staff applicants and appointees, to terminate Medical Staff appointment and clinical privileges, to provide a fair hearing, and to recommend such changes as may be necessary or desirable to the Board;

(l) to determine minimum continuing education requirements for appointees to the staff;

(m) to review all reports regarding situations involving questions of clinical competence, patient care and treatment, case management, or inappropriate behavior of any Medical Staff appointee and, as a result of such reviews, take appropriate action as warranted;

(n) to review all reports regarding appointments to the Medical Staff and delineation of clinical privileges and as a result of such reviews make recommendations for appointment and clinical privileges to the Board;

(o) to review all reports regarding the performance and clinical competence of persons who hold appointments to the Medical Staff and as a result of such review make recommendations for reappointments, clinical privileges and/or changes in clinical privileges to the Board; and

(p) to organize and monitor the Medical Staff's performance improvement activities and establish a mechanism to conduct, evaluate, and revise such activities.

ARTICLE III - PART B:

Section 3. Meetings, Reports and Recommendations:

(a) The Executive Committee shall meet quarterly or more or less often, if necessary, to transact pending business. The Chief of Staff will maintain reports of all meetings, which reports shall include the minutes of the various committees. Copies of all minutes and reports of the Executive Committee shall be forwarded to the Chief Executive Officer routinely as prepared. Recommendations of the Executive Committee shall be forwarded to the Board with a copy to the Chief Executive Officer. The Chief of Staff shall be available to meet with the Board or its applicable committee on all recommendations that the Executive Committee may make.

(b) Between meetings of the Executive Committee, an ad hoc committee composed of the Chief of Staff, the Chief Executive Officer and the Chief Medical Officer shall be empowered to act in situations of urgent or confidential concern where not prohibited by these bylaws.

ARTICLE III - PART D: UTILIZATION MANAGEMENT COMMITTEE

Section 1. Composition:

(a) The Utilization Management Committee shall consist of no more than (3) appointees from the Active Medical Staff, Chief Nursing Officer, Social Services Supervisor, Chief of Staff, and the Chief Executive Officer. The Chief Executive Officer may also assign representatives from Health Information Management and Continuing Care. Such representatives shall serve as advisors to, and not members of, the Executive Committee.

(b) The Utilization Review Committee shall meet monthly and report quarterly to the Executive Committee.

ARTICLE III - PART D:

Section 2. Duties:

(a) Utilization Review Functions:

(1) monitor utilization to evaluate the appropriateness of hospital admissions, length of stays, discharge practices, use of medical and hospital services and resources, and other factors related to utilization of hospital and physician services;

(2) formulate a written utilization review plan for the hospital to be approved by the Chief Executive Officer and the Board. Such plan shall at least be in accordance with all applicable accreditation, regulatory and third-party payor requirements; and

(3) evaluate the medical necessity for continued hospital services for particular patients, where appropriate, and make recommendations on the same to the attending physician and the Chief Executive Officer. No physician or other staff appointee shall have review responsibility for any extended stay cases in which that individual has been professionally involved.

(b) Medical Records Functions:

(1) review and determine that each medical record, or a representative sample of records, is complete and consistent and reflects the diagnosis, results of diagnostic tests, therapy rendered, condition and in-hospital progress of the patient, and condition of the patient at discharge;

(2) conduct periodic reviews of summary information regarding the timely completion of all medical records and make recommendations concerning the same as appropriate;

(3) review Medical Staff and departmental policies and/or rules pertaining to medical records, including medical record completion, filing, indexing, storage, destruction and availability, and recommend changes as appropriate and/or necessary;

(4) review annually the policies and procedures of the medical records department and make recommendations as appropriate and/or necessary; and

(5) recommend a medical record abbreviation list.

ARTICLE III - PART D:

Section 3. Meetings, Reports and Recommendations:

(a) The Utilization Review Committee shall maintain a permanent record of its findings, proceedings and actions, and shall make a written report after each meeting to the Performance Improvement Committee and the Chief Executive Officer.

(b) The Utilization Review Committee shall also report to the Chief Executive Officer and Chief of Staff any situation involving questions of clinical competency, patient care and treatment, professional ethics, infraction of hospital or Medical Staff bylaws, policies or rules, or unacceptable conduct on the part of any individual appointed to the Medical Staff.

(c) Pending medical necessity appeals will be reported to the Utilization Review Committee and final determination appeals will be reported to the Executive Committee.

ARTICLE III - PART E: PHARMACY AND THERAPEUTICS COMMITTEE

Section l. Composition:

The Executive Committee shall assume the duties of the Pharmacy and Therapeutics Committee and shall consist of no more than (3) appointees from the Active Medical Staff, Chief of Staff, Chief Executive Officer, Chief Medical Officer, Director Patient Quality Services, Chief Nursing Officer, Infection Prevention Supervisor, and the Pharmacist in Charge. The Pharmacist in Charge shall serve as chairperson of the committee.

ARTICLE III - PART E:

Section 2. Duties:

The Pharmacy and Therapeutics Committee shall:

(a) review the appropriateness of the prophylactic, empiric and therapeutic use of drugs through the review and analysis of individual or aggregate patterns or variations of drug practice;

(b) develop and recommend to the Executive Committee and the Board policies relating to the selection, distribution, handling, use and administration of drugs and diagnostic testing materials;

(c) define and review all significant untoward drug reactions;

(d) maintain and periodically review the hospital formulary or drug list;

(e) review the appropriateness, safety, and effectiveness of the prophylactic, empiric and therapeutic use of antibiotics in the hospital;

(f) recommend drugs to be stocked on the nursing unit floors and by other services;

(g) recommend policies concerning the safe use of drugs in the hospital, including new drugs, drug preparations requested for use in the hospital, hazardous drugs and investigational drugs; and

(h) monitor guidelines for automatic stop orders for drugs as specified in the Medical Staff Rules and Regulations or other relevant hospital policies as herein incorporated by reference.

ARTICLE III - PART E:

Section 3. Meetings, Reports and Recommendations:

(a) The Pharmacy and Therapeutics Committee shall meet as often as necessary to transact its business, but at least quarterly, shall maintain a permanent record of its findings, proceedings and actions, and shall make a written report after each meeting to the Executive Committee and Chief Executive Officer.

(b) The Pharmacy and Therapeutics Committee shall also report (with or without recommendation) to the Executive Committee for its consideration and appropriate action any situation involving questions of clinical competency, patient care and treatment, professional ethics, infraction of hospital or Medical Staff bylaws, policies or rules, or unacceptable conduct on the part of any individual appointed to the Medical Staff.

ARTICLE III - PART F: INFECTION PREVENTION COMMITTEE

Section 1. Composition:

The Executive Committee shall assume the duties of the Infection Prevention Committee and shall consist of the Infection Prevention Supervisor, no more than (3) appointees from the Active Medical Staff, Chief of Staff, Chief Executive Officer, Chief Medical Officer, Chief Nursing Officer, Director of Patient Quality Services, Pharmacist in Charge, Dietary representative, Environmental Services representative, and a Laboratory representative. The Chief of Staff shall serve as chairperson of the committee.

ARTICLE III - PART F:

Section 2. Duties:

The Infection Control Committee shall:

(a) be responsible for the surveillance of inadvertent hospital infection potentials, the review and analysis of actual infections, the promotion of a preventive and corrective program designed to minimize infection hazards, and the supervision of infection control in all phases of the hospital's activities;

(b) establish a system for documenting all hospital infections, including infections among patients and hospital personnel, to provide a basis for studying infection sources;

(c) monitor the standards and the bacteriological services available to the hospital;

(d) recommend specific immunization programs;

(e) review and recommend proper isolation techniques; and

(f) recommend an infection control prevention program and a continuing education program for Medical Staff appointees and hospital personnel on infectious disease control.

ARTICLE III - PART F:

Section 3. Meetings, Reports and Recommendations:

The Infection Control Committee shall meet quarterly, shall maintain a permanent record of its findings, proceedings and actions, and shall make a written report after each meeting to the Executive Committee and Chief Executive Officer.

ARTICLE III - PART G: PERFORMANCE IMPROVEMENT COMMITTEE

Section 1. Composition:

The Performance Improvement Committee shall consist of the Chief of Staff, Chief Executive Officer, Infection Prevention Supervisor, and Chief Nursing Officer. The Chief of Staff shall serve as chairperson. Additional members may include Department Supervisors to serve *ex-officio*, without vote.

ARTICLE III - PART G:

Section 2. Duties:

The Performance Improvement Committee shall assume the responsibility for directing the ongoing development and maintenance of the hospital's Quality/Performance Improvement Program as it affects the Medical Staff. Specifically, the committee shall:

(a) provide medical staff leadership for quality initiatives involving patient care and patient safety;

(b) review patient care evaluation studies and efforts by medical review committees to comply with the hospital's Quality/Performance Improvement Program and make appropriate recommendations for corrective action;

(c) receive and review reports of other medical care evaluation and patient care committees to ensure that prospective and retrospective studies are appropriately integrated into the hospital's Quality/Performance Improvement Program;

(d) identify those tasks and responsibilities of committees, multi-disciplinary subcommittees, ad hoc committees, and/or individuals that impact quality

improvement projects, resolve patient care problems and problems of institutional waste and duplication;

(e) receive reports of specific quality improvement activities involving the medical staff;

(f) in conjunction with CME providers, develop and plan programs of graduate and continuing medical education designed to keep the Medical Staff informed of significant developments and skills in medicine and plan CME responsive to outcome findings;

(g) review transfusion services, which include procedures for distribution, handling, use, administration of whole blood and blood components; adequacy of transfusion services for patient needs; actual or suspected transfusion reactions; and evaluate blood usage, including the review of the amount of blood requested, the amount of blood used, and the amount of blood wasted; and

(h) receive reports of all Medicare Conditions of Participation (COP) mandatory reporting requirements as they pertain to the Medical Staff.

ARTICLE III - PART G:

Section 3. Meetings, Reports and Recommendations:

(a) The Performance Improvement Committee shall meet monthly and report quarterly to the Executive Committee, shall maintain a permanent record of its proceedings and recommendations, and shall make a written report after each meeting to the Executive Committee, Chief Executive Officer, and the Board of Directors. The committee shall report to the Medical Staff on the activities of the committee and the status of patient care at the hospital.

(b) The Performance Improvement Committee shall also report (with or without recommendation) to the Executive Committee for its consideration and appropriate action any situation involving questions of clinical competency, patient care and treatment, professional ethics, infraction of hospital or Medical Staff bylaws, policies, rules or regulations, or unacceptable conduct on the part of any individual appointed to the Medical Staff.

ARTICLE III - PART H: BYLAWS COMMITTEE

Section 1. Composition:

The Executive Committee shall assume the duties of the Bylaws Committee and shall consist of no more than (3) appointees from the Active Medical Staff. The Chief of Staff shall serve as the Chairperson. A representative from hospital management shall serve on the committee, ex officio, without vote.

ARTICLE III - PART H:

Section 2. Duties:

The Bylaws Committee shall:

(a) review the bylaws of the Medical Staff, the Policy on Appointment, Reappointment and Clinical Privileges, and other associated documents at least annually and recommend amendments as appropriate to the Executive Committee. This review shall include, but not be limited to, the Medical Staff Rules and Regulations, and appointment and reappointment application forms; and

(b) receive and consider all recommendations for changes in these documents made by the Board, any committee of the Medical Staff, any individual appointed to the Medical Staff, and the Chief Executive Officer.

ARTICLE III - PART H:

Section 3. Meetings, Reports and Recommendations:

The Bylaws Committee shall meet as often as necessary to fulfill its duties, but at least annually, shall maintain a permanent record of its findings, proceedings and actions, and shall make a written report of its recommendations after each meeting to the Executive Committee and the Chief Executive Officer.

ARTICLE III - PART I: ONCOLOGY COMMITTEE

Section 1. Composition:

The Executive Committee shall assume the duties of the Oncology Committee and shall consist of no more than (3) appointees from the Active Medical Staff who are actively interested in the diagnosis and treatment of cancer, a cancer liaison physician who may be one of the three (3) Medical Staff appointees, as well as the hospital pharmacist, a representative each from hospital management and nursing service appointed by the Chief Executive Officer to serve, *ex officio*, without vote. The Tumor Registrar shall serve as secretary of the committee and one member of the committee shall be appointed to assume direct supervision of, and to maintain liaison between, the Tumor Registry, the Medical Staff and other hospital departments.

ARTICLE III - PART I:

Section 2. Duties:

The Oncology Committee shall:

(a) develop and evaluate the annual goals and objectives for the clinical, educational, and programmatic activities related to cancer;

(b) promote a coordinated, multidisciplinary approach to patient management;

(c) ensure that educational and consultative cancer conferences cover all major sites and related issues;

(d) ensure that an active supportive care system is in place for patients, families and staff;

(e) monitor quality management and performance improvement through completion of quality management studies that focus on quality, access to care, and outcomes;

(f) promote clinical research;

(g) supervise the cancer registry and ensure accurate and timely abstracting, staging and follow-up reporting;

(h) perform quality control of registry data;

(i) encourage data usage and regular reporting;

(j) ensure that the content of the annual report meets requirements;

(k) publish the annual report by November 1 of the following year; and

(l) uphold medical ethical standards.

ARTICLE III - PART I:

Section 3. Meetings, Reports and Recommendations:

The Oncology Committee shall meet as often as necessary to transact its business, but at least quarterly, shall maintain a permanent record of its findings, proceedings and actions, and shall make a written report after each meeting to the Executive Committee, and the Chief Executive Officer.

ARTICLE III - PART J: RADIATION SAFETY COMMITTEE

For purposes of this Article, the term "radiation" applies specifically to ionizing radiation.

Section 1. Composition:

The Executive Committee shall assume the duties of the Radiation Safety Committee and shall consist of at least one (1) authorized physician user of each type of use permitted by the license, and the Radiation Safety Officer. One (1) representative each from nursing service and hospital management, who is neither an authorized user nor a radiation safety officer, shall be appointed by the Chief Executive Officer to serve, *ex officio*, without vote. The chairperson of the committee shall be an individual listed as an authorized user on the Kansas Radioactive Materials License.

ARTICLE III - PART J:

Section 2. Duties:

The Radiation Safety Committee shall:

(a) monitor and make recommendations concerning the safe handling of radioactive isotopes utilized within the hospital pursuant to the standards set forth in the applicable policy and regulatory manual;

(b) maintain a policy manual in keeping with guidelines and recommendations of appropriate state and federal governmental agencies and accreditation standards;

(c) review all proposals for research, diagnostic, and therapeutic uses of radioisotopes and unsealed radionuclides;

(d) develop a policy and procedures for the use, transport, storage and disposal of radioactive materials;

(e) develop quality control procedures to guide personnel in the standardized performance of diagnostic studies and therapeutic processes in order to maintain the identity, strength and integrity of radiopharmaceutical agents;

(f) establish policies to guide nursing and other health care practitioners who are in contact with patients receiving therapeutic amounts of unsealed radionuclides;

(g) maintain a file of special rules and regulations wherever radioactive materials are used or dispensed;

(h) review the training and experience of proposed authorized users, the Radiation Safety Officer, and teletherapy physicists to determine that their qualifications are sufficient to enable the individuals to perform their duties safely;

(i) prescribe special conditions that will be required during the use of radioactive materials and radiation producing devices, such as requirements for bioassays, physical examinations of users, and special monitoring procedures;

(j) establish an ongoing educational and safety program for all persons whose duties may require them to work in or to frequent areas where radioactive materials or radiation producing equipment are used;

(k) review summary reports prepared by the Radiation Safety Officer concerning the occupational radiation exposure records of all personnel, with particular attention to those individuals or groups whose occupational exposure appears excessive;

(l) review, at least annually, summary reports of the entire Radiation Safety Program to determine that all activities are being conducted safely, in accordance with state regulations, and the conditions of license;

(m) recommend remedial action to correct any deficiencies identified in the Radiation Safety Program;

(n) establish a table of investigational levels for individual occupational radiation exposures based upon state regulations;

(o) provide technical advice to the Radiation Safety Officer on matters pertaining to radiation safety; and

(p) make recommendations concerning safe use of non-ionizing radiation.

ARTICLE III - PART J:

Section 3. Meetings, Reports and Recommendations:

(a) The Radiation Safety Committee shall meet as often as necessary to conduct its business, but at least quarterly, shall maintain a permanent record of its findings, proceedings and actions, and shall make a written report after each meeting to the Executive Committee and the Chief Executive Officer.

(b) At least one-half of the committee's membership, including the Radiation Safety Officer and the representative from hospital management, must be present at any meeting of the Radiation Safety Committee to establish a quorum and to conduct business.

(c) The Radiation Safety Committee shall also report (with or without recommendation) to the Executive Committee for its consideration and appropriate action any situation involving questions of clinical competency, patient care and treatment, professional ethics, infraction of hospital or Medical Staff bylaws, policies, rules or regulations, or unacceptable conduct on the part of any individual appointed to the Medical Staff.

ARTICLE III - PART K: CREATION OF STANDING COMMITTEES

The Executive Committee of the Medical Staff may, by resolution and upon approval of the Board, without amendment of the bylaws, establish additional committees to perform one or

more staff functions. In the same manner, the Executive Committee may, by resolution and upon approval of the Board, dissolve or rearrange committee structure, duties or composition as needed to better accomplish Medical Staff functions. Any function required to be performed by the bylaws, which is not assigned to a standing or special committee shall be performed by the Executive Committee.

ARTICLE III - PART L: SPECIAL COMMITTEES

Special committees shall be created, and their members and chairpersons shall be appointed, by the Chief of Staff with the approval of the Board as required. Such committees shall confine their activities to the purpose for which they were appointed, and shall report to the Executive Committee.

ARTICLE IV

BOARD APPROVAL AND INDEMNIFICATION

Any Medical Staff officer, department chairperson, committee chairperson, committee member, and individual staff appointee who acts for and on behalf of the hospital in discharging duties, functions or responsibilities stated in this manual, the Medical Staff Bylaws and/or the Policy on Medical Staff Appointment, Reappointment and Clinical Privileges and/or the Policy on Allied Health Professionals, shall be indemnified, to the fullest extent permitted by law, when the appointment and/or election of the individual has been approved by the Board.

ARTICLE V

AMENDMENTS

This Medical Staff Organizational Manual may be amended or repealed by vote of the Executive Committee at any regular or special meeting, provided that copies of the proposed amendments, additions or repeals are posted on the Medical Staff bulletin board and/or electronic information system, and/or delivered, either in person or by mail, to each Medical Staff appointee and made available to all members of the Executive Committee at least fourteen (14) days before being voted upon, and further provided that all written comments on the proposed changes by persons holding current appointments to the Medical Staff are brought to the attention of the Executive Committee before the change is voted upon. When notice of proposed amendments, additions or repeals are mailed, they shall be deemed delivered when deposited, postage prepaid, in the United States mail addressed to committee members at their addresses as they appear on the records of the hospital. Such posting and mailing shall be deemed to constitute actual notice to the persons concerned. Adoption of and changes to this Medical Staff Organizational Manual shall become effective when approved by the Board.

Executive Committee Approval: 6/23/10; 1/18/11; 3/15/11; 5/17/11; 7/19/11; 3/12; 10/14/14; 7/21/15

Board Approval: 6/28/2010; 1/31/11; 3/28/11; 5/23/11; 7/25/11; 3/12; 10/27/14; 4/27/15; 7/27/15