BYLAWS

MEDICAL STAFF

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CONFIDENTIAL

BYLAWS

OF THE

MEDICAL STAFF

OF

BEAVER DAM COMMUNITY HOSPITALS, INC.
I. Introduction.

The physicians, podiatrists, dentists and allied health professionals practicing at Beaver Dam Community Hospitals, Inc. ("Hospital") hereby organize themselves in conformity with these Medical Staff bylaws ("Bylaws"). Collectively, these health professionals are referred to as "Practitioners" throughout these Bylaws.

For the purpose of these Bylaws, the words "Medical Staff" are defined to include only the physicians, podiatrists and dentists who have been granted Medical Staff membership and/or clinical privileges with the Hospital. An individual member of the Medical Staff may be referred to as "Member." Similarly, the words "Allied Staff" are defined to include the allied health professionals who are not members of the Medical Staff, but are privileged to serve patients at the Hospital.

The term "Board" and the "Governing Body" refers to the Hospital Board of Directors. The Hospital's Chief Executive Officer, and his/her designee, is identified as "CEO". The Medical Staff's Chief of Staff, and his/her designee, is identified as "Chief of Staff". The Medical Staff's Medical Executive Committee is referred to as the "MEC" throughout these Bylaws.

The Medical Staff of the Hospital is non-departmentalized. The MEC and CEO will periodically examine the structure and recommend to the Board what action is desirable or necessary for organizational efficiency and improved patient care. The roles and responsibilities traditionally attributed to departments are assumed by the Medical Staff as a whole but may be delegated to committees or individual Members of the Medical Staff as appropriate.

It is recognized that Members of the Medical Staff are responsible for the medical care at the Hospital and for advising the Board on medical matters, including the quality of care provided within the Hospital and the credentialing, delineation of privileges and ongoing evaluation of the competency of all Practitioners within the Hospital. The Medical Staff must accept and discharge this responsibility subject to the ultimate authority of the Board. Members of the Medical Staff assume this responsibility and, in cooperation with Hospital administration, strive to fulfill the Hospital's obligations to its patients and the community.

II. Nature of Appointment.

No Practitioner will be permitted to admit or provide medical or health-related services to patients in the Hospital unless he/she has been appointed to the Medical or Allied Staff and has been granted privileges to do so pursuant to the policies and procedures of the Medical Staff and its Credentials Committee ("Credentials Procedures"). Appointment to the Medical or Allied Staff confers upon the Practitioner a privilege in the nature of a license to exercise only such clinical privileges within the Hospital as are specifically granted by the Board in accordance with these Bylaws and Credentials Procedures. The requirements and procedures for appointment and reappointment to the Medical and Allied Staffs, and the granting of clinical privileges, are set forth in these Bylaws, the Credentials Procedures and/or the Medical Staff policies and procedures.
A Practitioner is neither an employee nor an independent contractor of the Hospital, unless such a relationship is separately established between the Hospital and such Practitioner. In the event of any conflict between the language of Medical Staff or Hospital bylaws, policies or procedures and a specific contract between the Hospital and a Practitioner, the language of the contract controls.

III. Qualifications for Appointment to the Medical Staff.

Applications for appointment to the Medical Staff will only be accepted from physicians, podiatrists and dentists: who (1) have unrestricted legal licenses to practice their respective profession in the State of Wisconsin which permits them to practice independently in the Hospital setting and authorizes them to receive and examine patients, diagnose conditions, prescribe and implement a treatment plan and to prescribe all medications necessary for the treatment of conditions and diagnoses within their area of practice, independent of review, supervision or prescription by another practitioner; (2) have offices and residences located in sufficient proximity to the Hospital to be able to provide quality care to their patients at the Hospital; (3) can document (i) their background, experience, training, good judgment, and current competence, as demonstrated by peer data, references and otherwise, (ii) adherence to the ethics of their profession, (iii) their good reputation and character, including mental and emotional stability and physical health status, according to the law, and (iv) their ability to work harmoniously with others so that the Hospital is sure that all patients treated by them at the Hospital will receive quality care and that the Hospital and its Medical and Allied Staffs will be able to operate in an orderly manner; and (4) maintain at least the minimum professional liability insurance coverage set forth by the Hospital. All applicants for membership to the Medical Staff ("Prospective Member") have the burden of adequately documenting and demonstrating that their credentials meet the standards necessary to assure the Medical Staff and the Board that patients treated by them in the Hospital will be given a high quality of medical care. No Prospective Member is entitled to appointment to the Medical Staff or to the exercise of particular clinical privileges in the Hospital solely by virtue of the fact that he/she is duly licensed to practice medicine, osteopathy, podiatry or dentistry in Wisconsin, or any other state, or that he/she meets any written minimum criteria which may from time to time be adopted by the Board, or that he/she maintains a certification, fellow status or is a member of any professional organization specialty body or society, or that he/she had in the past or presently has, such privileges at another healthcare entity. The Hospital does not and will not discriminate on the basis of sex, race, creed, national origin, religion, disability, ancestry, sexual orientation or any other status protected by law.

All Prospective Member physicians must be either board certified or board admissible doctors of medicine or osteopathy at the time of appointment to the Medical Staff. Acceptable Board Certification/Admissibility includes: the American Board of Medical Specialties and the American Osteopathic Association. All Prospective Member podiatrists must be either board certified or board admissible with the American Board of Podiatric Surgery at the time of appointment to the Medical Staff.

If the applicable board admissibility requirements include the successful completion of a residency program, this residency program must be completed through an approved postgraduate training program. In the event that the board admissibility requirement includes a post-residency practice requirement, this requirement may be met at the Hospital provided that all other requirements for Medical Staff membership are met.
All Prospective Member dentists must have graduated from an education program accredited by the American Dental Association, and have completed an approved post-graduate training program or be pursuing board certification as may be required by the Credentials Committee and the Board.

Continued Medical Staff membership/privileges will require a physician who is board admissible at the time of appointment to the Medical Staff to obtain board certification in the proposed area of practice within five (5) years of initially having become board admissible and to maintain such certification throughout his/her membership/privileges. The Credentials Committee, MEC or the Board may impose different board certification requirements in the event an applicant has lost board certification prior to appointment or in other circumstances not contemplated hereunder. Notwithstanding the foregoing, the Board has the power to waive the board certification requirement, upon recommendation of the Credentials Committee and approval of the MEC, when the Prospective Member has demonstrated that he/she has obtained the training requisite to board certification in the area of proposed practice and there is documentation both of the need for the talents of the Prospective Member (prepared by the MEC for review and recommendation by the Credentials Committee and for review and action by the Board) and where either (i) the Prospective Member has been licensed to practice medicine in the United States for at least three (3) years or (ii) the Prospective Member has achieved extraordinary recognition in the field of medicine as evidenced by nationally or internationally recognized awards or appointments.

For purposes of this Section, an "approved" post-graduate training program for physicians is a residency program fully accredited throughout the time of the Prospective Member's training by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association. An approved post-graduate training program for podiatrists is one fully accredited throughout the time of the Prospective Member's training by the Council on Podiatric Medical Education of the American Podiatric Medical Association. An approved post-graduate training program for dentists is one fully accredited throughout the time of the Prospective Member's training by the Commission on Dental Accreditation.

The requirements outlined in these Bylaws for satisfactory completion of approved postgraduate training, and the general board certification or eligibility requirements, will be waived for any Member who was a member in good standing of the Medical Staff for three (3) continuous years immediately prior to July 26, 2004. The requirements outlined for specific board certification/eligibility requirements (from the American Board of Medical Specialties or the American Osteopathic Association) will be waived for any Member who was a member in good standing of the Medical Staff for three (3) continuous years immediately prior to December 1, 2009.

IV. Qualifications for Appointment to the Allied Staff.

Applications for appointment to the Allied Staff ("Prospective Allied Staff Member") will only be accepted from allied health professionals: who (1) have unrestricted legal licenses, certifications and/or registrations, as applicable, to practice their respective profession in the State of Wisconsin which permits them to practice in the Hospital setting; (2) work and live in sufficient proximity to the Hospital to be able to provide quality care to their patients at the Hospital; (3) can document (i) their background, experience, training, good judgment, and current competence, as demonstrated by peer data, references and otherwise, (ii) adherence to the ethics of their profession, (iii) their good reputation and character, including mental and...
emotional stability and physical health status, according to the law; (iv) their ability to work harmoniously with others so that the Hospital is sure that all patients treated by them at the Hospital will receive quality care and that the Hospital and its Medical and Allied Staffs will be able to operate in an orderly manner; and (4) maintain at least the minimum professional liability insurance coverage set forth by the Hospital. All Prospective Allied Staff Members have the burden of adequately documenting and demonstrating that their credentials meet the standards necessary to assure the Medical Staff and the Board that patients treated by them in the Hospital will be given a high quality of care. No Prospective Allied Staff Member is entitled to appointment to the Allied Staff or to the exercise of particular clinical privileges in the Hospital solely by virtue of the fact that he/she is duly licensed, certified, and/or registered, as applicable, to practice in Wisconsin, or any other state, or that he/she meets any written minimum criteria which may from time to time be adopted by the Board, or that he/she maintains a certification, fellowship or is a member of any professional organization specialty body or society, or that he/she had in the past or presently has, such privileges at another healthcare entity. The Hospital does not and will not discriminate on the basis of sex, race, creed, national origin, disability, ancestry, sexual orientation or any other status protected by law.

V. Processing Applications for Initial Appointment.

Any initial applicant for Medical or Allied Staff membership will be provided the appropriate application form, a supplemental application form (for information on physical and mental health, in the manner and to the extent permitted by applicable laws and regulations, which will be returned in a separately sealed envelope), and instructions for accessing the Medical Staff Bylaws and Rules and Regulations.

The application form includes, but is not limited to, the following:

1. **Qualifications.** Detailed information concerning the applicant's Credentials.

2. **Location of Practice.** The geographic location of the applicant's current practice.

3. **Requests.** Specific requests stating the appointment category and clinical privileges for which the applicant wishes to be considered.

4. **References.** The names and current addresses of at least three (3) active practitioners and one (1) administrator or similar individual who have had significant work experience with the applicant and observed his/her professional performance in the recent past and who can provide reliable, nonconfidential information as to the applicant's training, clinical experience and ability, ethical character, ability to work with others and other qualifications for appointment.

5. **Institutional Affiliations.** The names and complete addresses of the chairpersons of each department of any and all hospitals or other institutions at which the applicant has worked or trained (i.e., the individuals who served as chairpersons at the time the applicant worked in the particular department) for the most recent five (5) years. If the entity was not departmentalized, the applicant shall submit the names and complete addresses of any appropriate supervising physicians.

6. **Revocation of Privileges.** Information as to whether the applicant's staff appointment and/or clinical privileges have ever been terminated (whether voluntarily or involuntarily), denied, revoked, suspended, limited, reduced or not renewed at a
hospital or at any other healthcare entity, and whether any proceeding is pending or has been instituted which, if decided adversely to the applicant, would result in any of the foregoing.

7. **Withdrawal of Application.** Information as to whether the applicant has ever withdrawn his/her application for appointment, reappointment or clinical privileges, or resigned their privileges before final decision by a hospital's, or any healthcare entity's, MEC or governing body.

8. **Professional Sanctions.** Information as to whether any of the following has ever been suspended, revoked, denied, restricted, limited or terminated (whether voluntary or involuntary) and whether any proceeding is pending or has been instituted which, if decided adversely to the applicant, would result in any of the following being suspended, revoked, denied, restricted, limited or terminated: (i) licensure, certification or registration with any local, state or federal agency or body to practice his/her profession; (ii) appointment or fellowship in a local, state or national professional organization; (iii) any specialty board certification; or (iv) the applicant's DEA registration.

9. **Professional Liability Insurance.** Information documenting that the applicant carries professional liability insurance coverage in an amount at least equal to the minimum amount of coverage established from time to time by the Hospital for the privileges requested and information as to the applicant's malpractice claims history and experience and the applicant's involvement in any professional liability actions (including out-of-court settlements) during the past five (5) years, including a consent to the release of information by his/her present and any past insurance carriers and a waiver of any privilege relating thereto.

10. **Criminal Charges.** Information as to whether the applicant has ever been named as a defendant and/or convicted in a criminal action and details about any such instances, in the manner and to the extent permitted by applicable laws and regulations.

11. **Ability to Work in the United States.** Information on the permitted work/visa status of the applicant.

12. **Participation in Reimbursement Programs.** Information regarding whether the applicant has ever been denied, sanctioned by, restricted, excluded, limited, or suspended from participation in Medicare, Medicaid or any other governmental reimbursement program.

13. **Other Information.** Such other information as the Board may require.

14. **Identification.** A photo identification document, current within past 12 months (i.e., copy of government-issued ID or current Hospital identification card).

15. **Acknowledgment.** A statement that the applicant has received and read the Medical Staff Bylaws and the Rules and Regulations of the Medical Staff and (i) if granted appointment and/or clinical privileges, agrees to be bound by the terms of such documents, and (ii) without regard to whether or not the application is granted, agrees to be bound by the terms thereof in all matters relating to consideration of the application.

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Applicants for appointment to the Medical or Allied Staff have the burden of promptly providing the information required in the application form and any additional information reasonably required to document or verify the applicant’s qualification and suitability for appointment to the staff, including, but not limited to, personal health information and/or results of a medical examination. The Executive Assistant to the Medical Staff ("Executive Assistant") will notify an applicant if any information is incomplete or missing from his/her application, and the applicant then has the obligation of obtaining and providing the requested information promptly.

Following receipt of all information requested or required, the Executive Assistant will confirm that all information has been received and will verify provided information in accordance with established policies and procedures. If the applicant fails to provide any or all information requested or required within the time period set forth by the Medical Staff, the application is considered withdrawn. Such an action is considered an administrative denial and not a professional review action, as defined in these Bylaws, such that no hearing or appeal rights are associated with this action.

The application is considered complete when: (1) all blanks of the forms are filled in, necessary additional explanation provided, and all information requested by the Hospital has been provided; (2) verification of the information is complete; and (3) responsive letters of reference and information from past hospitals and other affiliations have been received. Fully completed applications for appointment and all supportive documentation and other credentialing information gathered by the Executive Assistant are forwarded by the Executive Assistant to the Credentials Committee for review and will be processed in accordance with the Credentials Procedures and these Bylaws.

VI. Time Periods for Processing Applications for Appointment.

Applications for appointment or reappointment shall be considered in a timely and good faith manner and, except for good cause, shall be processed within the time periods specified in the applicable Credentials Procedure, generally within 120 days after receipt of the fully-completed application, all information requested by the Hospital, all supporting materials, and all required verifications. However, the time periods specified are to assist those responsible for accomplishing these tasks and shall not be deemed to create any right for the applicant to have his/her application processed within those periods nor to create a right for a Medical or Allied Staff member to be automatically reappointed for the coming term.

VII. Effect of Applications for Appointment.

By applying for appointment or reappointment to the Medical or Allied Staff, advancement in a Medical Staff category, or for particular clinical privileges or changes in clinical privileges, the applicant/Practitioner:

1. Authorizes the Hospital to solicit and act upon information, including otherwise privileged or confidential information, provided by third parties bearing on his/her credentials and agrees that any information so provided will not be required to be
disclosed to him or her if the third party providing such information does so on the condition that it be kept confidential.

2. Authorizes third parties to release information, including otherwise privileged or confidential information, as well as reports, records, statements, recommendations and other documents in their possession, bearing on his/her credentials to the Hospital, and consents to the inspection and procurement by the Hospital of such information, records and other documents.

3. Authorizes the Hospital to release such information, when requested by the applicant/Practitioner, to other healthcare entities and their agents, who solicit such information for the purpose of evaluating the individual's professional qualifications pursuant to the individual's request for appointment, reappointment or clinical privileges.

4. Authorizes the Hospital to maintain information concerning the Practitioner's age, training, board certification, licensure/certification/registration and other confidential information in a centralized database for the purpose of making aggregate information available for use by the Hospital.

5. Authorizes the Hospital to release confidential information, including peer review and/or quality assurance information, obtained from or about the Practitioner to peer review committees of the Hospital and external reviewers engaged by or for the Hospital, for purposes of accessing and improving patient care.

6. Consents to the reporting by the Hospital of information to the National Practitioner Data Bank, established pursuant to the Health Care Quality Improvement Act of 1986, and to any other state or federal authority which the Hospital believes in good faith is required or permitted by law to be reported.

7. Releases from any liability: (1) the Hospital and all Hospital employees, agents and representatives for their acts performed in connection with evaluating his/her credentials or releasing information to other institutions for the purpose of evaluating his/her credentials; (2) all Medical and Allied Staff members for their acts performed in connection with evaluating his/her credentials or releasing information to other institutions for the purpose of evaluating his/her credentials; and (3) all third parties who provide information, including otherwise privileged or confidential information, to the Hospital or its representative concerning his/her credentials, unless such information is false and the third party providing it knew it to be false.

8. Agrees that, if any adverse decision is made with respect to him or her, (1) he/she will follow and exhaust the administrative remedies afforded by the Medical Staff Bylaws, as applicable, as a prerequisite to any other action, and (2) he/she will have the burden of demonstrating that he/she meets the standards for appointment or continued appointment to the Medical or Allied Staff or for the clinical privileges requested.

9. Agrees that the foregoing provisions are in addition to any agreements, understanding, covenants, waivers, authorizations or releases provided by law or contained in any application or other forms.
VIII. Responsibilities of Appointment.

By accepting appointment or reappointment to the Medical or Allied Staff, the applicant/Practitioner agrees:

1. To appear for a personal interview at any reasonable time requested by the MEC, a Medical Staff committee, a member of Hospital administration or the Board.

2. To provide data, written information or other documents (such as, but not limited to, physical or mental health information) when requested by the CEO, Chief of Staff, MEC or the Board, in the manner and to the extent permitted by applicable laws and regulations.¹

3. To provide written notification to the Chief of Staff and CEO if, at any time following his/her initial application for membership/privileges, the Practitioner fails to maintain any of the Qualifications for Appointment, including but not limited to his/her being convicted of any crime, has been/is being investigated by any governmental agency for any act or offense, fails his/her board certification examination or loses board certification or admissibility, has had his/her clinical privileges restricted or terminated by any other health care organization, or is excluded, restricted, limited, sanctioned or denied eligibility for or by Medicare, Medicaid, DEA, Wisconsin Department of Health Services, Wisconsin Department of Regulation and Licensing, or any other federal or state agency, bureau or regulatory body. Such notice must be received by the Chief of Staff and CEO no later than twenty-four (24) hours following Practitioner's knowledge of same.

4. If granted privileges to do so, to complete and document a medical history and appropriate physical examination in the patient's medical record no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination shall be completed on each of the following categories of patients: inpatients; observation patients; outpatients undergoing any kind of surgery; outpatients undergoing an invasive procedure; and outpatients who will receive conscious sedation. The medical history and physical examination must be completed and documented by a physician (as defined in section 1861(r) of the Act), a dentist or podiatrist (consistent with state law and Hospital policy) or other qualified licensed individual in accordance with state law and Hospital policy. The attending physician shall countersign the medical history and physical examination when they have been recorded by any person other than the attending or admitting Practitioner (this requirement is fulfilled when doing an "update" see paragraph 5 below).

5. To perform or ensure that an updated examination of the patient, including any changes in the patient's condition, is completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are

¹ This includes documentation of the health assessment required or permitted under state or federal law or regulations, or accreditation standards for persons providing direct patient services in the Hospital. The health assessment does not apply to care provided through telemedicine when the physicians is not in "direct contact" with the patient when providing care.

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completed within 30 days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician (as defined in section 1861(r) of the Act), a dentist or podiatrist (consistent with state law and Hospital policy), or other qualified licensed individual in accordance with State law and Hospital policy. The attending physician shall countersign the update when it has been recorded by any person other than the attending or admitting Practitioner.

6. Practitioners should attempt to secure autopsies in all cases of unusual deaths and/or medical-legal and educational interest as further set forth in the Rules and Regulations.

7. To always report to the Hospital fit for duty.

8. To submit to and cooperate with focused, ongoing and any other professional practice evaluations or other review requested or directed by the MEC.

9. To complete medical records accurately and in a timely fashion during his/her membership, in anticipation of a leave of absence and when his/her Hospital practice is ending or has ended.

10. To refrain from fee splitting or other inducements relating to patient referral.

11. To practice within the scope of his/her license/certification/registration, experience and abilities and to seek consultation whenever necessary.

12. To obtain proper informed consent as a prerequisite to any procedure requiring informed consent.

13. Practitioners will refrain from delegating the responsibility for diagnosis or care of hospitalized patients to any practitioner who is not qualified to undertake this responsibility or who is not adequately supervised.

14. Practitioners are responsible for providing for continuous care for their patients. This responsibility may be carried out by providing appropriately credentialed professional coverage when the responsible Practitioner is unavailable.

15. Physicians are responsible for helping the Hospital meet its mission to provide emergency services by taking call in accordance with policies established and approved by the MEC and Board. A physician's responsibility to participate in the Hospital's emergency call coverage schedule is determined by his/her specialty, clinical privileges, the number of medical staff members in the specialty, the Hospital's competency and capacity, and other factors determined by the MEC and the Board including those set forth in Hospital policy. Accordingly, some Members of the Active Staff may, and others may not have unassigned patient/emergency call obligations. Those physicians subject to unassigned patient/emergency call obligations must comply with the Hospital's EMTALA and other policies including, but not limited to, the response times designated therein.

16. To attend, without compensation or remuneration, an orientation program for new members, training regarding compliance issues, such as, but not limited to, HIPAA, OSHA, etc., and other meetings as directed by the MEC.
17. To assist the Hospital in its mission to provide quality care to all patients by acting as a mentor or proctor for training or evaluation purposes as requested by the Chief of Staff, Credentials or Medical Executive Committee.

18. To promote and participate in continuing education opportunities based, at least in part, on the needs demonstrated through patient care audits and other quality assessment and improvement programs.

19. To notify the Executive Assistant immediately upon a change of home or office address, telephone, email or other contact information.

20. To follow all bylaws, rules, regulations, policies and procedures of the Hospital and of the Medical Staff and to maintain all of the qualifications of appointment throughout his/her membership.

IX. Immunity from Liability.

1. **Persons Protected.** By applying for and/or accepting appointment or reappointment to the Medical or Allied Staff and by applying for, accepting and/or exercising clinical privileges within the Hospital, each applicant and Practitioner extends absolute immunity to, and releases from all claims, damages and liability whatsoever to:

   a. The Hospital and any Hospital employee, agent or representative for any action taken or statement or recommendation made within the scope of his/her duties in compliance with Hospital or Medical Staff bylaws, policy or procedure, including disclosures made to other healthcare entities pursuant to these Bylaws.

   b. Any member of the Medical or Allied Staff for any action taken or statement or recommendation made within the scope of his/her role as a member of the staff in compliance with Hospital or Medical Staff bylaws, policy or procedure, including disclosures made to other healthcare entities pursuant to these Bylaws.

   c. Any third party for releasing or disclosing information including otherwise privileged or confidential information, to the Hospital concerning any former or current applicant or Practitioner unless such information is false and the third party providing it knew it to be false.

2. **Acts Covered.** The immunity provided by these Bylaws shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with the Hospital's activities, including, but not limited to:

   a. Applications for appointment/re-appointment and/or clinical privileges;

   b. Periodic reappraisals undertaken for reappointment or for changes in clinical privileges;

   c. Focused and ongoing professional practice evaluations and other peer review;

   d. Corrective action;

   e. Hearings and appellate reviews;
f. Patient care audits;
g. Medical care evaluations;
h. Utilization reviews;
i. Other healthcare entity or Hospital staff, department, service, committee and subcommittee activities related to monitoring and maintaining quality patient care and appropriate professional conduct;
j. Matters or inquiries concerning the credentials of any applicant or Practitioner;
k. Matters directly or indirectly affecting patient care or the efficient operation of the Hospital; and
l. Reports to The Joint Commission, Department of Regulation and Licensing, Department of Quality Assurance, National Practitioner Data Bank or other report pursuant to the law.

X. Reappointment.

The requirements and procedures outlined herein for a Practitioner's initial appointment to the Medical or Allied Staff will also govern reappointment, except that peer recommendations will be used only when there is insufficient peer review data. Additional considerations for reappointment will include, but are not limited to, the Practitioner's:

1. Compliance with the responsibilities of membership (including, for example, satisfactory completion of medical records);

2. Ethics, behavior in the facility, cooperation with medical and other personnel and general attitude towards patients, the Hospital and its personnel;

3. Appraisals of the Practitioner's current professional competence and conduct, and his/her clinical performance, including, patterns of practice, based at least in part on the findings of quality assurance measures such as: medical audits; utilization review; medical record review; peer review; infection control activities; tissue review; Practitioner-specific data as compared to aggregate data; morbidity and mortality data; and pharmacy and therapeutics activities. Consideration also includes: current privileges and the basis for any requested modifications; core privilege or special privilege ongoing requirements; current health status; current liability insurance coverage and any filed, settled or pending professional liability claims or actions; current and past professional sanctions, participation in relevant continuing educational programs; participation in medical staff affairs; compliance with the Medical Staff Bylaws, Rules & Regulations and policies; and any other information the Credentials Committee, MEC or Board deems necessary and appropriate for a proper evaluation of a Practitioner's continued status and clinical privileges;

4. Use of the Hospital's facilities for patient care;

5. Satisfactory re-credentialing; and
6. Payment of dues and participation in Medical Staff meetings and committee assignments.

Reappointment will take place at least every two years, based on a recredentialing cycle. Efforts will be made such that all members of each specialty will be recredentialied at generally the same time and the specialties will be staggered throughout the course of the year. For example, all ER physicians may be recredentialied in July of the odd years while the OB physicians may be recredentialied in March of even years. New Practitioners will be credentialied and appointed to the Medical Staff when they begin with the Hospital and will be eligible for recredentialing and reappointment during the next cycle in which their specialty is reappointed. New Practitioners may be subject to short cycles of reappointment, in which they will be reappointed more than once in two years, in order to align their reappointment with their specialty.

XI. Action of the Credentials Committee, MEC and the Board.

The Credentials Committee shall consider the credentials and qualifications of all Medical and Allied Staff applicants for whom a fully completed application was received from the Executive Assistant.2

The Credentials Committee, MEC or the Board may, at any time, request additional information in connection with a completed application, and the processing of the application shall be suspended for 60 days or until the applicant has provided the information requested or satisfactorily explains his/her failure to do so, whichever occurs first. If the applicant fails to respond in any manner, the application will be deemed withdrawn.

The Credentials Committee shall confirm the validity of the current medical license (or other license as applicable), registration, certification, residency training or other post graduate education of the applicant, particularly as they apply to the privileges requested. The committee shall also verify, through references and other sources, that the applicant meets and has established all basic qualifications and criteria set forth by the Hospital. The Credentials Committee may require that the applicant appear for an interview.

While the Credentials Committee’s recommendation shall be based primarily on professional competence and conduct of applicants, the Hospital’s ability to provide adequate facilities and supportive services to the applicant and his/her patients, the need for additional staff members with the applicant’s skill and training, composition of the Medical Staff, present and future, the Hospital’s needs, and other factors shall also be considered.

The recommendations of the Credentials Committee are advisory to the MEC and do not of themselves constitute professional review action such that an applicant does not have the right to hearing or appeal based upon the Credentials Committee’s recommendation.

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2 The Credentials Committee shall also consider the credentials and qualifications of all individuals that perform surgical tasks, including, for example, surgical technicians, so that all surgical tasks are performed by an individual who meets the medical staff criteria and who has been granted specific surgical privileges, consistent with 42 C.F.R. 482.51(a)(4).
After reviewing the applicant's credentials, qualifications and the written criteria for the clinical privileges requested (if any), the Credentials Committee shall then formulate a recommendation regarding appointment and, if applicable, clinical privileges.

If the recommendation of the Credentials Committee is favorable to an applicant's request, one of the processes below will be followed:

1. **Unlimited Membership.** If the applicant has applied for participation in a clinical service line, subspecialty or staff category of the Hospital for which no numerical limitation has been established, the Credentials Committee shall forward a report to the MEC containing a recommendation for appointment and/or clinical privileges. The MEC assesses the applicant's credentials and qualifications, as well as the recommendation of the Credentials Committee, and if it concurs with the Credentials Committees' recommendation, shall then unseal and review the supplemental application and proceed in accordance with applicable laws and regulations. If the MEC determines that information within the supplemental application may be directly related to the applicant's ability to safely and effectively perform the privileges requested, the application is returned to the Credentials Committee for further consideration consistent with these Bylaws. Otherwise, the MEC formulates its recommendation regarding appointment and clinical privileges and forwards such recommendation to the Board. The Board will review the applicant's credentials, qualifications and the recommendations of the Credentials Committee and the MEC. The Board makes the final determination as to whether the applicant is granted appointment or clinical privileges. If the Board's final action is an approval of the application, the CEO shall notify the applicant in writing. Additional duties and responsibilities of the Credentials Committee, the MEC and the Board, with regard to credentialing and processing applications for appointment and reappointment, are set forth in the Credentials Procedures.

2. **Limited Membership.** If the applicant has applied for participation in a clinical service line, subspecialty or staff category of the Hospital for which a numerical limitation has been established, the Credentials Committee will notify the applicant and hold the application in abeyance. This action is considered to be an administrative denial by the Credentials Committee and does not entitle the applicant to a hearing or, if applicable, appeal, under these Bylaws and is not reportable to the National Practitioner Data Bank. As openings subsequently arise, the Credentials Committee may make recommendation to the MEC for filling such positions by selecting from the available list of deferred and current applicants. The applicants found to be best qualified for staff appointment will be recommended regardless of the date of application. If an application has been held by the Credentials Committee for six (6) months under this Section, the application will expire and the applicant must file a new application if he/she desires to be continued for consideration.

If the recommendation of the MEC is unfavorable to an applicant's request, the proposed recommendation will be forwarded to the CEO who will notify the applicant in writing of the proposed adverse recommendation, the reason for the denial and, if applicable, of the applicant's right to a hearing and appeal in accordance with these Bylaws. Administrative denials, such as denials based upon an applicant's lack of required credentials or failure to provide required information in a timely manner, do not entitle the applicant to a hearing or, if applicable, appeal, under these Bylaws.

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If no hearing is timely requested, the MEC’s recommendation is forwarded to the Board and processes as described above. If the determination by the Board is ultimately unfavorable, the applicant will be informed in writing of the denial, the basis of the denial, and, if applicable, any due process rights.

If a hearing is timely requested, the hearing and appeal process, as set forth in these Bylaws, will be followed.

Privileging determinations will be made available to appropriate persons consistent with Credentials Procedures.

XII. Categories of the Medical Staff.

It is the responsibility of the Medical Staff Credentials Committee to recommend to the MEC, based upon the guidance which follows, the appropriate category of membership for each individual Practitioner so that the interests of the Hospital, and its patients, are best served. Ultimately the Board of Directors will determine the appropriate category of membership based upon the following category descriptions and considering the recommendations of the Credentials Committee and the MEC.

All categories of membership, other than Honorary, are required to pay full dues as established from time to time by the MEC.

A. Limiting Membership.

The CEO will have the authority, after having conferred with and received agreement from the Chief of Staff and the MEC, to limit the number of Practitioners within particular clinical service lines or subspecialties of the Hospital by establishing numerical limitations on the admission of particular categories to the Medical Staff. The decision to limit the admission of new Practitioners in a particular clinical service line or subspecialty will be based upon (i) written criteria developed by the CEO, the Chief of Staff and the MEC and (ii) a finding by the CEO that such action would be in the best interest of the total patient care function of the Medical Staff and the Hospital. The written criteria will take into account the utilization of the Hospital and each service, the average years of experience of the Practitioners, the average waiting time for scheduling elective procedures, the ability to and financial benefit of entering into an exclusive contract for the provision of services and/or any other factors deemed appropriate in evaluating the desirability or necessity of limiting the number of Practitioners in a particular clinical service line or subspecialty. Notwithstanding the foregoing, any request or recommendation to limit the number of Practitioners must be approved by the Board. Any numerical limitation (a) will be reviewed on a periodic basis, but at least every two (2) years, by the CEO and the Chief of Staff, and (b) may be raised, lowered or rescinded by the CEO, after consultation with the Chief of Staff, having received agreement of the MEC and with approval by the Board.

B. The Active Medical Staff.

The Active Medical Staff shall consist of physicians, podiatrists and dentists who are regularly involved in Hospital patient care, or who are actively involved with Hospital activities and who assume all of the functions and responsibilities of membership on the Active Medical Staff.
Accordingly, Members of the Active Medical Staff must generally maintain an active practice within the Hospital's service area (as defined by the Board from time to time).

Members of the Active Medical Staff may be permitted to admit patients, unless otherwise provided herein, consistent with the privileges granted by the Board. However, dentists and podiatrists who are members of the Active Staff may admit patients only with the concurrence of a physician member of the Active Staff, and that physician must assume responsibility at the time of patient admission for the basic medical appraisal of the patient and for the care of any medical problem that may be present or that may arise during hospitalization.

Subject to Article XVII, Section 5(a) below, Members of the Active Medical Staff shall be eligible to vote, hold office, chair committees, and participate on Medical Staff and Hospital committees. Such Members are strongly encouraged to attend Medical Staff meetings.

C. The Telemedicine Medical Staff.

The Telemedicine Medical Staff shall consist of physicians who meet the qualifications for Medical Staff membership but provide services to Hospital patients exclusively via telemedicine. For the purposes of these Bylaws, telemedicine shall mean the use of medical information exchanged from one site to another via electronic communications for the health and education of the patient or health care provider and for the purpose of improving patient care, treatment, and services. The Medical Staff shall recommend to the Board which clinical services may be delivered appropriately via telemedicine. Telemedicine Medical Staff members shall not be entitled to hold office, vote, admit patients, or have any other assigned duties or responsibilities unless deemed necessary by the MEC.

D. The Honorary Medical Staff.

The Honorary Medical Staff shall consist of physicians, podiatrists and dentists who are not active in the Hospital but who are honored by emeritus positions. Honorary Members may be physicians, podiatrists or dentists who have retired from active practice or who are of outstanding reputation, not necessarily residing in the community. Honorary Medical Staff members are not required to maintain active licensure, board certification, or malpractice insurance so long as they are not providing patient care. These Members shall not be eligible to admit patients, maintain privileges or to vote or hold office but may serve on Medical Staff committees as a non-voting member at the discretion of the Chief of Staff. Honorary Medical Staff members are not required to pay dues. The Honorary Medical Staff shall be appointed by the Board upon the recommendation of the MEC. Honorary Medical Staff need not be reappointed.

Physicians providing care through telemedicine who are not in "direct contract" with the patient may be exempt from certain of the qualification criteria (i.e. health assessment).
XIII. Determination of Clinical Privileges.

A. Establishment of Written Criteria.

The Credentials Committee shall be responsible for establishing written criteria for the granting of clinical privileges at the Hospital. From time to time the Credentials Committee will solicit recommendations from the clinical interest and other committees of the Medical Staff and the Hospital to establish certain written criteria for each position ("Core Criteria") recommended by the Credentials Committee and provided to the MEC and the Board for approval.

B. Initial Requests for Clinical Privileges.

Each application for appointment to the Medical or Allied Staff must contain a request for specific clinical privileges. Evaluation of initial requests for clinical privileges shall be conducted by the Credentials Committee by first comparing such request against the Core Criteria established by the Credentials Committee and approved by the MEC and the Board. An initial request for privileges shall also include evaluation of the applicant's licensure, training, experience, character, judgement, evidence of current competence, references, and ability to perform the privileges requested. Applicants shall have the burden of establishing qualifications and competencies in the clinical privileges requested. Specific policies and procedures for evaluating applicants requesting clinical privileges are set forth in the Credentials Procedures. Evaluation of initial requests for privileges will follow the process set forth herein for initial appointment, and, when applicable, run concurrently with the review for appointment, such that an individual's request for appointment and privileges is first reviewed by the Credentials Committee whose recommendation is reviewed by the MEC. Final determination of all requests for privileges rests with the Board.

C. Procedure for Requesting Modification of Clinical Privileges.

At any time, a Medical Staff member may request modification of his/her Medical Staff category or clinical privileges and an Allied Staff member may request modification of his/her clinical privileges. The Practitioner shall forward any such request, in writing, to the Chief of Staff. All requests for additional clinical privileges will be based upon observation of care provided, peer review and professional practice evaluations, among other things. Requests for additional privileges will be processed in the same manner as initial requests for clinical privileges and/or appointment to the Medical or Allied Staff, in accordance with the Credentials Procedures.

D. Focused and Ongoing Professional Practice Evaluation.

Focused Professional Practice Evaluations will be initiated for any new Practitioners initially being privileged at the Hospital, existing Practitioners requesting new privileges, existing Practitioners who have been clinically inactive, or when any questions arise regarding a currently privileged Practitioner's ability to provide safe, high-quality patient care consistent with the standards of the Hospital. Practitioners involved in the Focused Professional Practice Evaluation Process will comply with the requirements as provided by Credentials Procedures.

Ongoing Professional Practice Evaluation (OPPE) will be conducted for every Practitioner with medical staff privileges every six (6) months to monitor and evaluate the professional performance of all Practitioners through an objective, evidenced based process. Information gathered during the OPPE process will be utilized during the recredentialing process and
concerns raised through OPPE may result in a period of FPPE to ensure quality care is being provided. In the event that a Practitioner's practice at the Hospital does not provide the volume necessary to evaluate his/her privileges at the Hospital for FPPE/OPPE/recredentialing purposes, the Practitioner will consent to the Hospital's receipt of evaluation data from another facility at which the Practitioner has the privileges and will assist the Hospital in securing that data if necessary.

New Members of the Active staff subject to the Focused Professional Practice Evaluation process shall be eligible to serve on Hospital and Medical Staff committees. They shall be ineligible to hold a Medical Staff office, but shall have voting rights on Medical Staff matters so long as they are participating in the Focused Professional Practice Evaluation process. They shall be required to pay dues and are strongly encouraged to attend Medical Staff meetings. New Members of the Active staff subject to the Focused Professional Practice Evaluation process shall be responsible for attendance of patients pursuant to the emergency patient call schedule approved by the Hospital.

All Practitioners shall be subject to Ongoing Professional Practice Evaluation consistent with PIC policy and procedures.

E. Emergency Privileges.

In an emergency, any Medical or Allied Staff member with clinical privileges is permitted to provide any type of patient care, treatment, and/or services necessary as a life-saving measure or to prevent serious harm, regardless of his/her membership status or clinical privileges, so long as the care, treatment, and/or services provided are within the scope of the Practitioner's license, certification and/or registration. When the emergency no longer exists, the Practitioner must request the clinical privileges necessary to continue treating the patient or the patient will be reassigned to an alternative Practitioner.

F. Temporary Privileges.

Temporary Privileges may be granted only to fulfill an important patient care need and only for a specific period of time and is intended to be utilized in extenuating circumstances such as the unexpected, emergent illness of a Practitioner. Temporary privileges shall automatically expire at the end of the specified period, without recourse to hearing or appeal. Temporary Privileges may be granted to Practitioners who will provide locum tenens or other temporary coverage for a Medical or Allied Staff member for a period not to exceed sixty (60) days per calendar year. Such privileges may be granted on the recommendation of the Chief of Staff with approval of the CEO.

An applicant for Temporary Privileges must satisfy the qualifications and requirements for membership set forth in these Bylaws and will have his/her application processed as set forth here and in the Credentials Procedures. A Temporary Member will pay a pro-rated amount of dues.

G. Disaster Privileges and Disaster Responsibilities.

During any disaster in which the Hospital's Emergency Operations Plan has been activated and the Hospital is unable to meet immediate patient needs, the Hospital may grant Disaster Privileges and/or Disaster Responsibilities. The CEO, with the concurrence of the Chief of Staff,
may grant Disaster Privileges and/or Responsibilities in accordance with the policies and procedures set forth in the Credentials Procedures.

XIV. Grant of Clinical Privileges.

Clinical privileges granted to Practitioners are determined by the Board. The determination of the Board is based upon the recommendation of the Credentials Committee and the MEC and upon the written criteria established by the Board for the granting of specific clinical privileges for a Practitioner within the Hospital. Every Practitioner shall be entitled to exercise only those clinical privileges specifically granted to him/her by the Board for a period not to exceed two (2) years. The MEC, in consultation with the Credentials Committee, and upon approval of the Board, reserves the right to modify requirements for certain treatments or procedures at any time, based on changing standards of practice and new information in medical literature. Re-privileging will follow the same process set forth for re-appointment.

XV. Allied Health Professionals.

The Board, upon recommendation of the MEC, may appoint Allied Health Professionals ("AHPs") as members of the Allied Staff. AHPs desiring to become appointed or reappointed to the Allied Staff shall submit a comparable application form containing information pertinent to the profession and the qualifications and functions of the applicant as set forth otherwise in these Bylaws. Nevertheless, AHPs are not members of the Medical Staff and do not have the same rights and responsibilities provided to or required of Medical Staff members.

AHPs are health care providers who are not physicians, podiatrists or dentists, but by virtue of their special training, are able to provide services to the Hospital or its Medical Staff. AHPs perform specified patient care services, often under Medical Staff supervision (Physician Assistants) or collaboration (Advanced Practice Nurse Prescribers) and pursuant to written guidelines. Scope of practice is determined for each individual by his/her sponsoring physician with approval of the Credentials Committee, the MEC and the Board and consistent with state law. Candidates for this category would include, but are not necessarily limited to, chiropractors, nurse anesthetists, physician assistants, nurse practitioners and certified nurse midwives who are licensed, registered or certified, as appropriate, in the State of Wisconsin.

AHPs may be employed by the Hospital, a Medical Staff member or a contracted service provider or, except in the case of Physician Assistants, may be independent practitioners. Physician Assistants may not be self-employed. All AHPs must have a sponsoring Member of the Active Medical Staff. The sponsoring physicians of certain AHPs are required to work with the AHP in a supervisory (Physician Assistants) or collaborative (Advanced Practice Nurse Prescribers) relationship, as set forth in state law. All newly appointed AHPs will participate in the Focused Professional Practice Evaluation process.

AHPs must, at all times, comply with the scope of practice limitations set forth by State law, the Credentials Committee, the supervisory or collaborative written guidelines in place for that individual (if applicable), and applicable Hospital and Medical Staff bylaws, policy, procedures, rules and regulations. AHPs may be expected to participate in the care of patients pursuant to the emergency patient call schedule approved by the Hospital, as directed by the AHP's
supervising/collaborating physician, pursuant to Hospital and Medical Staff policies and procedures and consistent with the AHP's scope of practice and granted clinical privileges.

A. Sponsoring Member Acknowledgements.

In requesting that an AHP be authorized to practice in the Hospital, the sponsoring Medical Staff Member agrees:

1. To accept full legal and ethical responsibility for the AHP's performance in the Hospital with respect to patients under his/her supervision/collaboration;

2. To accept responsibility for the proper conduct of the AHP within the Hospital, and for the AHP's observation of all Bylaws, policies and rules and regulations of the Hospital and Medical Staff;

3. To abide by all Bylaws, policies, rules, regulations and laws governing the use of AHPs in the Hospital including refraining from requesting that the AHP provide services beyond, or what might reasonably be construed as being beyond his/her authorized scope of practice in the Hospital;

4. To immediately notify the MEC in the event any one of the following occurs:
   
a. The Member modifies or terminates his/her supervisory or collaborative agreement with the AHP;

b. Notification is given of the investigation of either the supervisory or collaborative Member or the AHP by any state or federal agency or authority;

c. The employment status or the authorized scope of practice of the AHP or the supervising or collaborating Member changes;

d. Professional liability insurance coverage is changed insofar as coverage of the acts of the AHP or supervision/collaboration by the Member is concerned.

AHPs may, serve on Hospital and Medical Staff committees (other than the MEC) and may vote as a Medical Staff committee member. AHPs may not chair a Medical Staff committee. AHPs are encouraged to attend the Medical Staff meetings, however, they do not have a vote on any Medical Staff matter and may not serve as Medical Staff officers. AHPs must pay dues.

B. Corrective Action for Allied Health Professionals.

Corrective or administrative actions may be instituted for AHPs for any grounds specified in the Bylaws or in Hospital or Medical Staff rules, regulations, policies or procedures. Although AHPs do not have access or right to the Corrective Action or Hearing and Appellate Review procedures set forth in these Bylaws for Members of the Medical Staff, their privileges may be terminated automatically for circumstances described below or in the Section entitled "Automatic Relinquishment."

1. Corrective action for Hospital-employed AHPs.
a. Any individual who believes that an AHP employed by the Hospital does not meet the requirements of the Bylaws or has violated a Hospital or Medical Staff bylaw, policy, procedure, rule, regulation or directive, shall report the belief to the AHP's sponsoring physician, the Chief Medical Officer ("CMO") and the Hospital's Chief Talent Officer.

b. Any action on a matter shall be taken in a manner consistent with established Hospital employment policies, procedures and/or practice. Employment action in accordance with such policies shall be final. Notice of such action will be provided to the sponsoring physician and to the Credentials Committee.

2. Corrective action for AHPs not employed by the Hospital.

a. Any individual who believes that an AHP not employed by the Hospital does not meet the requirements of the Bylaws or has violated a Hospital or Medical Staff bylaw, policy, procedure, rule, regulation or directive, shall report the belief to the AHP's sponsoring physician and to the Chief Medical Officer.

b. As they deem appropriate, the sponsoring physician and/or CMO will recommend to the MEC that the privileges of an AHP be terminated, suspended or limited.

c. If the sponsoring physician and CMO do not agree on the appropriate action to be taken, the matter will be referred to the Chief of Staff and CEO for resolution.

d. The AHP will receive notice of the decision and shall, for ten (10) days following his/her receipt of the notice, have an opportunity to request an appearance before the MEC or some other ad hoc committee of the Medical Staff, appointed by the Chief of Staff and CEO, at their discretion.

e. If the request is not received within ten (10) days as described above, the determination becomes final.

f. The reviewing committee will communicate their decision to the Chief of Staff, CMO and CEO and to the AHP and his/her sponsoring physician.

g. The committee's decision is final.

3. Other. If the employment or clinical privileges of the sponsoring physician are terminated or suspended, the AHP shall contemporaneously be terminated or suspended from his/her duties unless and until the AHP sponsor's member status is restored or the supervision or collaboration responsibility is transferred to another member of the Medical Staff and an executed supervisory or collaborative practice agreement is provided to the Credentials Committee.

Notwithstanding any other provision of the Bylaws, the Hospital may provide by agreement that a Practitioner’s membership on the Allied Staff and clinical privileges are contingent on and shall expire simultaneously with such agreement or understanding. In the event that an agreement has such a provision or there is such an understanding, the provisions of these Bylaws with respect to corrective action for AHPs shall not apply.
XVI. Officers of the Medical Staff.

1. Officers of the Medical Staff. The officers of the Medical Staff shall be:
   a. Chief of Staff;
   b. Past Chief of Staff;
   c. Chief of Staff-Elect; and
   d. Secretary-Treasurer.

2. Qualifications of Officers. Except for the position of Secretary-Treasurer (who may be board admissible), officers of the Medical Staff must be board certified and members of the Active Medical Staff in good standing at the time of nomination and election and throughout their term of office. "Good standing" for purposes of this Section means that the Member is licensed to practice medicine in the state of Wisconsin, has no license or DEA limitation, restriction or sanction, and has no limitation or restriction on his/her Hospital privileges. Failure to maintain good standing shall immediately create a vacancy in the office held by the Member. The officers shall be Members with demonstrated competence in their fields of practice, demonstrated qualifications on the basis of experience and have the ability to direct the medico-administrative aspects of the Hospital and Medical Staff activities. The Chief of Staff must be a doctor of medicine, osteopathy, dental surgery or dental medicine.

3. Election of Officers. The procedure for nomination and election of officers of the Medical Staff shall be as follows:
   a. The Chief of Staff-Elect will automatically become the Chief of Staff at the election following completion of his/her term as Chief of Staff-Elect, without further nomination or vote, unless he/she has achieved office by appointment of the MEC due to vacancy of office, in which case he/she will have to be elected to the office of Chief of Staff according to these Bylaws.
   b. The Chief of Staff will automatically become the Past Chief of Staff at the election following completion of his/her term as Chief of Staff, without further nomination or vote.
   c. Subject to Section 3(k) below, at or around the September meeting of the Medical Staff, the MEC shall issue a notice to the full Medical Staff membership to invite nominees for election to those positions to be filled at that time. The MEC will then prepare a slate of nominees for, if applicable, the offices of Chief of Staff-Elect (every 2 years or in the event of a vacancy) Secretary/Treasurer (every 2 years or in the event of a vacancy) and, as applicable, At Large Members of the MEC. Each nominee must be eligible for office according to these Bylaws. The MEC will strive to present at least two (2) nominees for each office.
   d. If there is no candidate for an officer position, the MEC may recommend that additional At Large Member(s) be elected to the MEC.
e. The MEC will contact each nominee and confirm whether they are interested in remaining a nominee. Only those nominees that affirmatively accept nomination will be included on the ballot.

f. The initial slate of candidates who have accepted nomination will be presented to the membership at a regular meeting of the Medical Staff. If nominations are made from the floor, the MEC will privately contact each additional nominee and confirm they are interested in remaining a nominee. Only those nominees that affirmatively accept nomination will be included on the ballot. Nominations will be accepted from the floor only during the meeting at which the initial slate of candidates is presented.

g. The MEC will prepare a ballot and distribute such ballot electronically to all Members eligible to vote, and in paper form to attendees at the following regular meeting of the Medical Staff.

h. Voting may be conducted by electronic and written ballot. Electronic ballots will be returned and confirmed by the Executive Assistant prior to the close of business on the day the election is conducted. The Chief of Staff will appoint two (2) Active Members of the Medical Staff, other than those nominated, to serve as tellers. The procedure to be followed in the counting of ballots will be determined by the tellers.

i. A quorum is required to conduct the election of officers. A quorum, for these purposes, consists of the Members of the Medical Staff who are eligible to vote and have timely submitted completed electronic ballots or are present at the meeting of the Medical Staff at which the election is to be conducted. An abstention is considered a vote for purposes of calculating a quorum.

j. Members of the Medical Staff eligible to vote will cast their votes. The candidate for each office receiving the plurality of the votes for that office will be presented to the Board of Directors for approval. Officers elected in the Fall according to the above procedure will assume office in January; officers and Members At Large elected during special elections will assume office immediately following approval by the Board of Directors.

k. When election of an additional MEC member(s) is recommended by the MEC, a call for nominees will be made as soon as possible following the recommendation and a special election held as soon as possible at a regular meeting of the Medical Staff.

4. **Term of Office.** All officers shall serve a two (2)-year term or until a successor is elected, unless they are removed as set forth below. No officer may serve more than two (2) successive terms in the same officer position except that an officer may serve two (2) full terms and a partial term if the office was assumed due to a vacancy as described below.

5. **Vacancies in Office.** If there is a vacancy in the office of Chief of Staff, the Chief of Staff-Elect shall serve out the remaining term and a new Chief of Staff-Elect will be elected by the membership in a special election according to the election process set forth in Article XVI, Section 3. If there is a vacancy in the office of Secretary/Treasurer, Chief of Staff-Elect or At-Large Member, the vacancy will be
filled through election by the membership in a special election according to the
election process set forth in Article XVI Section 3. If there is a vacancy in the office
of Past-Chief of Staff, upon recommendation of the MEC, an additional Member At
Large may be elected by the membership in a special election according to the
election process set forth in Article XVI, Section 3.

6. Removal of Officers. The Board, by resolution, following written notice to and
discussion with the MEC, may remove an officer of the Medical Staff on its own
initiative or upon receipt of a recommendation of a two-thirds (2/3) majority of the
eligible voting members of the Medical Staff. Permissible bases for removal include,
without limitation, failure to continuously meet the qualifications for office and failure
to timely and appropriately perform the duties of the office held.

An officer may be temporarily removed from office by a majority vote of the MEC.
The temporary removal will be effective until the next meeting of the Medical Staff at
which time removal may become permanent if approved as set forth below. At the
Chief of Staff’s discretion, electronic voting may be authorized for these purposes.
Removal requires a two-thirds (2/3) majority vote of the eligible voting Members of
the Medical Staff who have timely submitted completed electronic ballots (when
permitted) or are present at the meeting at which the removal vote is conducted.
Notice of this vote will be provided at least ten (10) days prior to the meeting at which
the vote will be taken. Following a vote of removal, notice of such removal will be
provided by the Chief of Staff to the Hospital Board.

7. Duties.

a. Chief of Staff. The Chief of Staff shall serve as the chief administrative officer of
the Medical Staff and:

i. Ensure, with the CEO, that the Hospital’s quality assurance program is
implemented and effective for all patient care related services; that the
findings of the program are incorporated into a well-defined method of
accessing Staff performance; and that the findings, actions and results of
the program are reported to the Board of Directors as necessary;

ii. Act in coordination and cooperation with the CEO of the Hospital in all
matters of mutual concern within the Hospital;

iii. Call, preside at, and be responsible for the agenda of all general
meetings of the Medical Staff;

iv. Be responsible for the enforcement of Medical Staff Bylaws, rules,
regulations, policies and procedures; for implementation of sanctions
where these are stipulated for non-compliance; for the Medical Staff’s
compliance with procedural safeguards in all instances where corrective
action has been requested against a member; and for presentation to the
MEC in those instances where corrective action may be recommended to
the Board;

v. Appoint committee members to all standing, special, on-call and multi-
disciplinary Medical Staff committees except the MEC;
vi. Serve on the MEC as chairperson;

vii. Serve as an ex-officio member of all Medical Staff committees;

viii. Represent the views, policies, needs and grievances of the Medical Staff to the Board and CEO;

ix. Serve as the responsible representative of the Medical Staff to receive, understand and interpret the policies of the Board to the Medical Staff and to report and interpret to the Board, in return, on the performance and maintenance of quality of the Medical Staff's designated responsibility to provide medical care;

x. Be responsible for the educational activities of the Medical Staff, subject to the policies of the Board;

xi. Be the spokesperson for the Medical Staff in its external professional and public relations;

xii. Resolve disputes and address concerns between Medical and Allied Staff Members and Hospital staff in consultation with the applicable Hospital administrator; and

xiii. Perform such other functions as may reasonably be delegated from time to time by the Medical Staff or the Board.

b. Past Chief of Staff. In the absence of the Chief of Staff, the Past Chief of Staff shall assume all the duties and have the authority of the Chief of Staff. That Past Chief of Staff shall be a member of the MEC and the Code of Conduct Committee, and shall perform such duties as may be assigned by the Chief of Staff, the MEC or the Board.

c. Chief of Staff Elect. The Chief of Staff-Elect shall automatically succeed the Chief of Staff when the latter fails to serve for any reason. The Chief of Staff-Elect shall be a member of the MEC and the Code of Conduct Committee and shall perform such additional duties as may be assigned by the Chief of Staff, the MEC or the Board.

d. Secretary-Treasurer. The Secretary-Treasurer shall keep or provide for the taking of accurate and complete minutes of all meetings, call meetings on the order of the Chief of Staff, attend to all correspondence, and perform such other duties as ordinarily pertain to his/her office. He/she shall be a member of the MEC and accountable for funds received through dues or other means and the disbursement of all such funds, and responsible for preparing and presenting a medical staff budget for approval by the Medical Staff.

XVII. Meetings of the Medical Staff.

1. Staff Meetings. There shall be regular meetings of the general Medical Staff monthly, as appropriate, but at least a minimum of nine (9) times per year, on a day and time
to be established by the MEC and approved by a majority of the voting Members. Regular meetings shall consist of such business and education as deemed pertinent by the Chief of Staff and include, from time to time, reports of review and evaluation of the work done in the Hospital as well as the performance of required Medical Staff functions.

2. **Special Meetings.** Special meetings of the Medical Staff may be called at any time by the Chief of Staff, and shall be called within 30 days of the written request of the Board, the MEC, or 30% of the members of the Active Medical Staff. Any such written request must contain a statement of the purpose for such meeting. At any special meeting, no business shall be transacted except that stated in the notice calling the meeting. The MEC shall designate the time and place of any special meeting.

Notice of a special meeting shall be given to each Member of the Medical Staff in writing or by telephone not less than ten (10) days before the date set for the special meeting. If mailed, the notice shall be deemed delivered when deposited, postage prepaid, in the US mail, addressed to the Member at his/her address as it appears in the Hospital's records. The attendance of a Member at a meeting shall constitute a waiver of notice of such meeting.

3. **Attendance at Meetings.** All Medical and Allied Staff members are encouraged to attend all meetings of the Medical Staff. Members' attendance will be recorded and may be considered in the citizenship evaluation of the Member at reappointment.

The Chief of Staff may require that staff recuse themselves from meetings, or portions of meetings, consistent with the Medical Staff Conflict of Interest Policy.

4. **Quorum and Voting.** Unless otherwise expressly set forth by these Bylaws, a quorum shall be constituted by the eligible voting Members present for all regular and special Medical Staff meetings as well as all Medical Staff committee meetings. Votes shall be numerically tabulated -- for, against, and abstaining -- and entered into the minutes of the meeting. Unless otherwise expressly required by these Bylaws, every question shall be decided by a plurality vote of those present at a meeting.

At the Chief of Staff's discretion, electronic voting may be authorized for specific issues. The Chief of Staff will be responsible for establishing the procedure for and communicating the availability of electronic voting to Members when so authorized. Unless otherwise expressly set forth by these Bylaws, when electronic voting is authorized, a quorum shall be constituted by the Members of the Medical Staff who are eligible to vote and have timely submitted completed electronic ballots or are present at the meeting of the Medical Staff at which the election is to be conducted. An abstention is a vote for purposes of establishing the quorum.

5. **Eligibility to Vote.**

a. **Medical Staff Matters.** To vote at a Medical Staff meeting on Medical Staff business, a Medical Staff Member must be a member of the Active Medical Staff.
b. **Good Standing.** In addition to the eligibility requirements set forth above, a Medical Staff Member must be in good standing at the time of the vote for such vote to be counted in any Medical Staff matter. "Good standing" for purposes of this Section means that the Member is licensed to practice medicine in the state of Wisconsin, has no license or DEA limitation, restriction or sanction, and has no limitation or restriction on his/her Hospital privileges.

6. **Minutes.** Minutes of each regular and special meeting of the Medical Staff shall be prepared and shall include a record of attendance of Members and the vote taken on each matter. The minutes shall be signed by the presiding officer. Copies thereof shall be submitted to those in attendance for approval, and the minutes shall thereafter be forwarded to the MEC. A permanent file of the minutes of each meeting will be maintained by the Executive Assistant. All Medical Staff members may have access to Medical Staff meeting minutes that are not otherwise privileged or confidential, upon sufficient notice to the CEO and Chief of Staff. **Conduct at Meetings.** All Medical Staff meeting attendees are expected to conduct themselves professionally, extending the courtesy of contributing and listening to all other attendees. Disruptive conduct such as yelling, interrupting, profanity, etc. will not be tolerated at any meeting of the Medical Staff. The Chief of Staff, in his/her sole discretion, may ask any attendee to leave the meeting at any time due to disruptive conduct. Confidential documents must be returned to the Chief of Staff, if requested, prior to an attendee's exit. The inappropriate treatment of confidential documents or information (including, but not limited to email distributions, careless disregard of printed materials, tape recordings, etc.), will be considered a violation of the Disruptive Conduct Policy and will be addressed accordingly.

7. **Dues.** Annual dues may be levied in an amount to be recommended by the MEC and approved by the Medical Staff. Only Honorary Members are excused from the payment of dues.

**XVIII. Committees of the Medical Staff.**

Among other things, the Medical Staff shall be responsible for providing oversight of care, treatment and services provided at the Hospital by Practitioners, as well as engaging in activities to improve these aspects of the Practitioners' performance. The Medical Staff utilizes various committees and individuals to accomplish these responsibilities. Medical Staff Committees may be standing, special or on-call.

The standing committees shall be as follows:

1. Medical Executive Committee;
2. Credentials Committee;
3. Performance Improvement Committee;
4. Clinical Care Committee; and
5. Code of Conduct Committee
Each standing committee, other than the MEC, should submit an annual report to the Medical Staff via the MEC.

On-call committees shall include the Bylaws Committee, the Clinical Interest Committees (as approved by the MEC) and the Education Committee.

Special committees shall be formed, as needed, as set forth herein. A Hearing Committee, as provided for in these Bylaws, shall be deemed a special committee and its members shall be appointed as so provided.

A. Designation and Substitution.

Whenever these Bylaws require that a function be performed by, or that a report or recommendation be submitted to:

1. A named Medical Staff committee but such committee is ineffective or otherwise deemed by the Chief of Staff in need of substitution, the MEC may perform such function, receive such report or recommendation, or shall assign the functions of such committee to a new or existing committee or Member(s) of the Medical Staff;

2. The MEC, but a committee has been formed to perform the function, the committee so formed shall act in accordance with the authority delegated to it.

B. Composition and Appointment of Standing and Special Committees (other than the MEC).

A Medical Staff standing or special committee established to perform one or more of the Medical Staff functions required by these Bylaws shall be composed of Active Members of the Medical Staff and should includemembers of the other categories of the Medical Staff, Allied Staff, representation from Hospital administration and such other Hospital clinical services as are appropriate to the function(s) to be discharged so long as physicians comprise the majority of the committee's membership. Unless otherwise specifically provided, the Medical and Allied Staff members shall be appointed by the Chief of Staff, and the administrative members shall be appointed by the CEO. The Chief of Staff will designate a chairperson from the Active Medical Staff with a minimum of one (1) year's membership. Should the Chief of Staff desire to name a Member with less than one (1) year's membership as Chairperson, approval of the MEC and CEO is required. The Chief of Staff and the CEO will serve as ex officio members of all committees. The chairperson of the committee votes only in the event of a tie; the Chief of Staff and CEO serve without a vote.

C. Composition and Appointment of On-Call Committees.

A Medical Staff on-call committee established to perform one or more of the staff functions required by these Bylaws shall be composed of members of the Active Medical Staff and should include members of the other categories of the Medical Staff, Allied Staff, representation from Hospital administration and such other Hospital clinical services as are appropriate to the function(s) to be discharged so long as physicians comprise the majority of the committee's membership. The Medical and Allied Staff members shall be appointed by the Chief of Staff, and the administrative members shall be appointed by the CEO. The Chief of Staff will designate a chairperson with a minimum of one (1) year's membership. Should the Chief of
Staff desire to name a chairperson with less than one (1) year’s membership on the Medical or Allied Staff of BDCH, approval of the CEO and MEC is required. The chairperson will invite participation from others as appropriate to the function(s) to be discharged. The Chief of Staff and the CEO will serve as ex officio members of all committees.

D. Medical Executive Committee.

1. Composition. The MEC shall consist of the Chief of Staff, Chief of Staff – Elect, Past Chief of Staff, Secretary/Treasurer of the Medical Staff and a minimum of three (3) elected Members At Large of the Medical Staff. Members At Large will be elected according to the election process set forth for officers in Article XVI, Section 3. Upon recommendation of the MEC, additional Members At Large may be elected by the membership, according to the election process set forth in Article XVI, Section 3, to a maximum of nine (9) total members of the MEC (not including ex-officio member(s)). Officers serve a two (2) year term and Members At Large are elected annually on a staggered basis and serve a three (3) year term. The majority of MEC members will be physician members of the Active Medical Staff. The CEO shall be an ex-officio member without vote. The Chief of Staff shall serve as chairperson of the committee and shall serve without a vote except when there is a tie. See Article XVI, Section 5 for vacancies created in officer positions. Subject to the following, vacancies created in Member At Large positions will be filled through election by the membership in a special election according to the election process for officers set forth in Article XVI, Section 3. However, if at the time of an At Large Member vacancy, there remain at least seven (7) members of the MEC, the MEC may determine, in its discretion, to complete that term without filling the vacancy.

2. Duties. The MEC shall:

a. Receive or act upon reports and recommendations from the committees and officers of the Medical Staff concerning the patient care audit and other quality reviews: evaluate and monitor the functions of the Medical Staff; discharge delegated administrative responsibilities; and recommend to the Board specific programs and systems to implement these functions;

b. Coordinate the activities of the Medical Staff and its committees;

c. Approve nuclear services director’s specifications for the qualifications, training, functions and responsibilities of the nuclear medicine staff;

d. Develop and implement rules, regulations, policies and procedures for the Medical Staff;

e. Account to the Board and to the Medical Staff for the overall quality, safety and efficiency of patient care in the Hospital, including through reports of Medical Staff committees and other activity;

f. Take reasonable steps to insure professionally ethical conduct and competent clinical performance on the part of Medical and Allied Staff members, including initiating investigations and evaluations, and initiating and pursuing corrective action, when warranted;
g. Make recommendations on medical/administrative and Hospital management matters;

h. Educate the Medical Staff of the accreditation program and the accreditation status of the Hospital;

i. Assist in the identification of community health needs, the setting of Hospital goals, and the implementation of programs to meet those needs;

j. Represent and act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws, between meetings of the Medical Staff;

k. Approve all changes to policies and procedures of the Medical Staff committees prior to implementation;

l. Direct Medical Staff organizational activities, including Medical Staff Bylaws review and revision and Medical Staff officer and committee nominations;

m. With all Members, present qualified candidates for elective positions in the Medical Staff organization;

n. Consult with members of the Medical Staff and administration concerning the qualifications and acceptability of prospective nominees;

o. Submit, at the appropriate times as provided in these Bylaws, nomination(s) for each elective office of the Medical Staff to be filled, each of the Member at Large positions on the MEC and/or such other elective positions as may be required by these Bylaws; and

p. Assume other responsibilities as determined by the Chief of Staff.

3. Meetings. The MEC shall meet at least once a month, as appropriate, and maintain a record of its proceedings and actions.

4. Attendance Requirements. Continued membership on the MEC requires that the Member attend a minimum of 50% of the MEC meetings scheduled per calendar quarter. If a member fails to do so, s/he will be considered for removal subject to Section 5, below.

5. Removal of MEC Members. An MEC member shall be considered for removal from service by the MEC upon written request of twenty percent (20%) of the Active Medical Staff directed to the Chief of Staff or CEO or upon motion by another member of the MEC. Such request/motion shall include a list of the allegations or concerns precipitating the request for removal. Reasons for removal may include, but are not limited to: removal from current office or medical director position; loss or suspension of medical staff appointment or a clinical privilege(s); relocation of practice; failure to meet MEC attendance requirements; existence of an irreconcilable conflict of interest. An MEC member being considered for removal may not vote on his/her removal but is considered in the calculation of the quorum.

6. Minutes. Minutes of each meeting of the MEC shall be prepared and shall include a record of attendance of members and the vote taken on each matter. The minutes
shall be signed by the presiding officer and copies thereof shall be submitted to those in attendance for approval. A permanent file of the minutes of each meeting will be maintained by the Executive Assistant. All Medical Staff Members may have access to MEC meeting minutes that are not otherwise privileged or confidential, upon sufficient notice to the CEO and Chief of Staff.

E. Other Standing Committees of the Medical Staff

1. Credentials Committee. The Credentials Committee shall establish a committee charter, setting forth its responsibilities, and shall comply therewith. Such responsibilities to include:

a. Conduct, coordinate and review all of the applications and reapplications for membership and clinical privileges from members of the Medical and Allied Staffs and make recommendations to the MEC for approval or denial of same.

b. Review all requests for changes in clinical privileges for Practitioners requesting a change in Medical Staff category or requesting additional privileges.

c. Conduct, coordinate and review all of the applications and reapplications for privileges/permission for Hospital practice from non-Practitioner others who seek to assist/accompany Members, or perform surgical duties, and make recommendations to the MEC for approval or denial of same;

d. Serve as a review committee for requests for Leave of Absence as provided by these Bylaws and Medical Staff policy;

e. Document the mental and physical health status of Practitioners and manage matters of Practitioner health consistent with Medical Staff policy;

f. Conduct focused and ongoing professional practice evaluations to monitor Practitioner quality and to identify professional practice trends that affect quality of care and patient safety;

g. Approve the qualifications set forth by the Hospital for each Radiology staff position which involves the use of equipment or administration of procedures; and

h. Other responsibilities as determined by the MEC or Chief of Staff.

2. Performance Improvement Committee (PIC). PIC shall establish a committee charter, setting forth its responsibilities, and shall comply therewith. Such responsibilities to include:

a. Adopt and conduct specific programs and procedures for reviewing, evaluating and maintaining the quality and appropriateness of care provided and procedures performed within the Hospital, including mechanisms for establishing objective criteria, measuring actual practice against the criteria, and analyzing practice variations from criteria by peers; taking appropriate action to correct identified
problems, and following up on action taken; and reporting the findings and results of the activity to the MEC; and

b. Other responsibilities as determined by the MEC or Chief of Staff.

3. Clinical Care Committee. The Clinical Care Committee shall establish a committee charter, setting forth its responsibilities, and shall comply therewith. Such responsibilities to include:

a. Monitor and evaluate the quality and appropriateness of patient care and the clinical performance of all Practitioners by performing reviews of subjects such as drug utilization, medical records, blood usage, transfusions, pathology, pharmacy and therapeutics, case management (utilization review), and infection control;

b. Provide advice to Hospital administration concerning the sources of clinical services to be provided to the Hospital through contractual arrangements;

c. Receive and consider recommendations of the Clinical Interest Committees and forward those which warrant further action to the MEC; and

d. Other responsibilities as determined by the MEC or Chief of Staff.


a. The Code of Conduct Committee shall be responsible for evaluating and addressing violations by Members and Allied Staff of the Hospital Code of Conduct, the conduct requirements of these Bylaws, and those of the Medical Staff Rules and Regulations and policies.

b. Other responsibilities as determined by the MEC or Chief of Staff.

e. 

F. On-Call Committees.

1. Bylaws.

a. Monitor changes in the law, regulations, accreditation standards and healthcare practice that should or could be addressed through the Medical Staff Bylaws.

b. Utilize all necessary references, and internal and external expertise to develop the most appropriate governance structure of the Medical Staff.

c. Regularly recommend to the MEC, updates to the Bylaws as needed to maintain compliance with laws, regulations, accreditation standards and healthcare practice.

d. Other responsibilities as determined by the MEC or Chief of Staff.

2. Clinical Interests.

a. Advise, through recommended action, the various standing committees on issues of concern among the clinical practice areas; and
b. Other responsibilities as determined by the MEC or Chief of Staff.

c. Notwithstanding other provisions of these Bylaws, and so long as there is some physician representation, the Allied Health Practitioner Interest Committee need not be composed primarily of physicians.

3. **Education.**

   a. Develop, plan, and/or participate in programs of continuing education that are designed to keep the Medical and Allied Staffs informed of significant new developments and new skills in medicine and that are responsive to patient care evaluation findings;

   b. Maintain a record of such programs and Practitioner participation, and evaluate, through the patient care studies function, the effectiveness of the education programs developed and implemented;

   c. Act upon continuing education recommendations from the MEC or other committees responsible for patient care studies and other quality evaluation and monitoring functions;

   d. Evaluate and make recommendations on the Hospital's medical library and other educational facilities available to members of the Medical and Staffs, Hospital personnel, patients and visitors; and

   e. Other responsibilities as determined by the MEC or Chief of Staff.

G. **Participation on Interdisciplinary Hospital Committees.**

Certain Medical Staff functions and responsibilities (i.e., Ethics/Research, acting as liaison with the Board and Hospital administration, Hospital accreditation activities, disaster planning, Emergency Services Committee, facility and services planning and financial management) may be discharged by the appointment of Medical Staff members to participate in such Hospital functions.

H. **Committee Term and Removal.**

Unless otherwise specifically provided, a Medical or Allied Staff committee member (other than one serving ex officio) continues as such until the end of his/her normal period of staff appointment and until his/her successor is elected or appointed, unless he/she shall sooner resign or be removed from the committee. A Medical or Allied Staff committee member (other than one serving ex officio) may be removed by a majority vote of the MEC. An administrative committee member shall serve for a term equivalent to that of the Medical/Allied Staff committee member and until his/her successor is appointed, unless he/she shall sooner resign or be removed from the committee. An administrative committee member may be removed by action of the CEO. .
I. Committee Vacancies.

Unless otherwise specifically provided, vacancies on any Medical Staff committee shall be filled in the same manner in which original appointment to such committee is made.

J. Committee Meetings and Attendance at Committee Meetings.

A Medical Staff standing or special committee (other than the MEC) established to perform one or more of the functions required by these Bylaws shall meet as often as is necessary to discharge its assigned duties, but no less often than quarterly unless or until such committee's function has been accomplished. An on-call committee will meet as needed to discharge its function. A Member of a standing or special committee who is compelled to be absent from any meeting should promptly submit the reason for the absence to the Executive Assistant. Members' attendance will be recorded and considered in the citizenship evaluation of the member at reappointment.

K. Committee Meeting Minutes.

Minutes of each meeting of a standing or special committee of the Medical Staff (other than the MEC) shall be prepared and shall include a record of attendance of members and the vote taken on each matter. The minutes shall be signed by the presiding officer and copies thereof shall be submitted to those in attendance for approval, and the minutes shall thereafter be forwarded to the MEC. A permanent file of the minutes of each meeting will be maintained by the Executive Assistant. All Medical and Allied Staff members may have access to meeting minutes (other than the MEC) that are not otherwise privileged or confidential, upon sufficient notice to the committee chairperson.

Minutes will be taken at each on-call committee meeting in which a matter is being reviewed for recommendation to the MEC. Such minutes will be maintained by the Executive Assistant and available to staff members, if not otherwise privileged or confidential, upon sufficient notice to the committee chairperson.

L. Voting at Committee Meetings.

Recommendations of any Standing and Special Committee to the MEC, and MEC recommendations to the Board, require a quorum of fifty percent (50%) of the current committee membership.

A consensus of on-call committee members is needed for a recommendation from such a committee to the MEC.

Except as otherwise stated in these Bylaws, only Medical or Allied Staff Members appointed in accord with these Bylaws to the committee that is conducting the business at issue shall be entitled to vote upon matters before that committee. Additionally, only a Medical or Allied Staff Member in good standing at the time of the vote is permitted to vote. "Good standing" for purposes of this Section means that the member is licensed to practice in the State of Wisconsin, has no license or DEA limitation, restriction or sanction, and has no limitation or restriction on his/her Hospital privileges.
XIX. Medical Directors

The CEO may, on behalf of the Hospital, contract for medical director services as a part of a larger contract for professional and/or admin-medico services.

When medical director services are desired or required other than through such a CEO-negotiated agreement, the Chief of Staff in conjunction with the CEO may appoint Members of the Active Medical Staff as Medical Director. Medical Directors will be utilized in the areas of Emergency Services, Anesthesia, Nuclear Medicine, Respiratory Therapy, Cardiac Rehabilitation, Pulmonary Rehabilitation, Rehabilitation (PT/OT) and other clinical areas as determined appropriate. A Other than those assuming the position through a contract for services as described above, and except as expressly permitted by the MEC, only those Members with a minimum of one (1) year's membership, Board certified and in good standing with the Medical Staff, will be considered for appointment as, or may continue to serve as a Medical Director. When so appointed, the Medical Director may also, but need not serve as the Chairperson of the respective Clinical Interest Committee. "Good standing" for purposes of this Section means that the Member is licensed to practice medicine in the state of Wisconsin, has no license or DEA limitation, restriction or sanction, and has no limitation or restriction on his/her Hospital privileges.

Medical Directors are accountable to the Chief of Staff, CMO and CEO, specifically responsible for those duties outlined in their respective Medical Director Agreement, if applicable, and generally responsible for:

1. Understanding, respecting, and upholding the philosophy of the Hospital, supporting the dignity of the individual and serving as a liaison with the Medical Staff;

2. Supervising the medical operation of the clinical service and the provision of medical services in the clinical service. Such supervision shall include planning, organizing, directing, controlling and evaluating the medical operations of the clinical service;

3. Quality aspects of the clinical service including using reasonable efforts to ensure compliance with (i) the ethical and professional standards established by these Bylaws, rules, regulations and policies of the Medical Staff and the Hospital; (ii) all applicable laws and regulations; and (iii) the Hospital's continuous quality improvement programs.

4. Regular evaluation of the quality and appropriateness of the medical services performed at the Hospital;

5. Developing, adopting and implementing policies and procedures to meet the compliance responsibilities including taking appropriate action to correct problems identified in the quality assurance process and working with the Hospital to identify the best methods of accomplishing the goals of the Hospital's continuous quality improvement programs;

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A qualified full-time, part-time or consulting radiologist who is a doctor of medicine or osteopathy, supervises ionizing radiology services.

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6. Assisting in the development and implementation of written policies, procedures, and regulations for the clinical service and assuring that such policies and procedures are reviewed and approved by the Medical Staff and reviewed at least annually;

7. As appropriate, setting monthly schedules indicating responsibility for full medical coverage of the clinical service by the Practitioners;

8. Using of reasonable efforts to develop constructive rapport between the clinical service, the Practitioners practicing in that service, and other members of the Medical Staff;

9. Serving on Hospital Committees as reasonably requested by the Hospital;

10. Maintaining accurate and complete records, preparation of written reports, and monitoring of the accuracy and completeness of reports of the Practitioners in the applicable clinical service;

11. Participating in the annual planning process of the Hospital and the clinical service and recommending annual goals for the clinical service;

12. Reviewing and making recommendations to the Hospital regarding the Hospital’s budget and the need for equipment, facilities, personnel, and services necessary or desirable to facilitate the improved delivery of medical services in the clinical service;

13. Participating in identifying and evaluating the educational needs of the clinical service’s personnel by participating in or directing periodic educational lectures, presentations, and/or direct clinical teaching for the clinical service’s personnel, and as reasonably requested by the Hospital, assisting in educating the Medical Staff regarding the services and equipment available through the clinical service;

14. Performing such other duties as are consistent with those duties typically performed by medical directors and which from time to time may be reasonably assigned by the MEC, the Chief of Staff, CMO, or the CEO.

XX. Privileges and Immunities.

The Board, any committees of the Medical Staff and/or of the Board who conduct professional review activities and any individuals within the Hospital authorized to conduct professional review activities, hereby constitute themselves as Professional Review Bodies as used or defined by applicable state and federal law, including the Wisconsin Peer Review Statute, the Wisconsin Health Records Statute, and the Health Care Quality Improvement Act of 1986. These Professional Review Bodies claim all privileges and immunities afforded to them by all relevant state and federal statutes. Any adverse action taken by a Professional Review Body pursuant to these Bylaws or Hospital or Medical Staff policies or procedures will be in the reasonable belief that it is in furtherance of quality health care (including in the provision of care in a manner that is not disruptive to the delivery of quality medical care at the Hospital) only after a reasonable effort has been made to obtain the true facts of the matter, after adequate notice and hearing procedures are afforded to the Member or Prospective Member, and only in the reasonable belief that the action is warranted by the facts known after a reasonable effort has been made to obtain the facts.
XXI. Confidentiality.

The Medical Staff recognizes that it is vital to maintain the confidentiality of certain information, for reasons of both law and policy. Practitioners participate in credentialing, peer review, and quality improvement activities, and others contribute to these activities, in reliance upon the preservation of confidentiality. The confidentiality of these activities, and of all Medical Staff records, is to be preserved and these communications, information and records will be disclosed only in the furtherance of credentialing, peer review, and quality improvement activities, and only as specifically permitted under the conditions described in these Bylaws and Medical Staff policy. This requirement of confidentiality extends to the records and minutes of all Medical Staff committees, to the records of all Medical Staff credentialing, peer review and quality improvement activities, to the credentials and peer review files concerning individual Practitioners, and to the discussions and deliberations which take place within the confines or under the aegis of Medical Staff committees.

Each member of the Medical and Allied Staff, by acceptance of appointment or reappointment, therefore pledges to: (a) maintain all such information and any and all discussions and deliberations regarding the same in strict confidence; (b) agree to make no disclosures of such confidential information outside of appropriate meetings, except when (i) the disclosures are to another authorized member of the Medical or Allied Staff or authorized employee of Hospital and are for the purposes of conducting legitimate Medical Staff affairs; (ii) the disclosures have been authorized, in writing, by the CEO and the Chief of Staff; or (iii) as otherwise permitted by the Medical Staff Policy. Any such disclosures shall be made only in a private setting for the specified purpose regarding the disclosure.

XXII. Corrective Action for Medical Staff Members.

The following procedures address the rights and obligations of Medical Staff Members in the event that the Member has allegedly engaged in unacceptable clinical practice or professional conduct. Such concerns of AHPs are addressed otherwise in these Bylaws. Therefore, except for the Section entitled "Automatic Relinquishment" below, this "Corrective Action for Medical Staff Members" provision, does not apply to AHPs.

Corrective action may be requested by any Member of the Medical Staff or a senior member of the Hospital's administrative staff. All requests for corrective action must be made in writing to the CEO and Chief of Staff and must be supported by reference to the specific activities or conduct which constitutes the grounds for the request.

Documentation created and obtained in the review or evaluation of practitioners is confidential and shall not be disclosed or released except as permitted by law and Hospital policy.

A. Collegial Efforts to Correct Behaviors.

The CEO and Chief of Staff will strive to use informal collegial and education efforts, to address questions relating to a Member's clinical practice and/or professional conduct. The goal of collegial intervention is to help the Member voluntarily respond and resolve questions that have
been raised. All collegial intervention efforts by the CEO and Chief of Staff shall be considered confidential and part of the Hospital's performance improvement and professional peer review activities as defined by applicable state and federal law, and as addressed in "Privileges and Immunities," above.

Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the Chief of Staff and CEO. Collegial intervention efforts may include but are not limited to the following:

1. Educating and advising Members of applicable bylaws, policies, procedures, rules and/or regulations including those related to appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;

2. Following up on any questions raised about clinical practice and/or conduct;

3. Sharing summary comparative quality, utilization, and other relevant information to assist Members to conform their practices to appropriate norms.

Collegial intervention is not a precursor to a professional review action, but is a separate and distinct part of the culture of collaboration at the Hospital. If following collegial intervention efforts, it appears that the Member's performance does not improve, or in cases where it appears that collegial intervention is inappropriate, the CEO and Chief of Staff may request that the MEC authorize an investigation into the matter. If the CEO and Chief of Staff disagree whether an investigation is needed, the MEC will make the determination.

**B. Initiation of Investigation.**

The MEC shall address and appropriately document its determination and reasons for determining that an investigation should or should not be commenced following a request by the CEO and Chief of Staff. In the event the Board believes the MEC has incorrectly determined that an investigation is unnecessary, it may direct the MEC to proceed with an investigation. The date of the determination by the MEC to conduct an investigation (or the date on which the MEC receives direction from the Board to so act) shall be considered the investigation commencement date.

**C. Investigation.**

The MEC may conduct the investigation itself or may assign the task to an appropriate standing or special committee of the Medical Staff.

The investigating body shall proceed with the investigation promptly. It shall notify the Member in question that the investigation is being conducted and provide an opportunity for the Member to meet to provide information in a manner and upon such terms as the investigating body deems appropriate. Any meeting between the Member in question and the investigating body (and meetings with any other individuals the investigating body chooses to interview) will not constitute a hearing, is preliminary in nature, and none of the procedural rules provided in these Bylaws, including but not limited to right to representation, apply.
The investigating body has the authority to review all documents and previous findings it considers relevant, to interview individuals, to consider appropriate clinical literature and practice guidelines, and to utilize the resources of an external consultant if it deems a consultant is necessary and such action is approved by the CEO and Chief of Staff. The investigating body may also require the Member under review to undergo a physical and/or mental examination and may access the results of such examinations.

An external peer review consultant should be considered when:

1. Litigation seems likely.

2. The Hospital is faced with ambiguous or conflicting recommendations from Medical Staff or Hospital leaders, or where there does not appear to be a strong consensus for a particular recommendation.

3. There is no one on the Medical Staff with expertise in the subject under review, or when the only physicians on the Medical Staff with appropriate expertise are direct competitors, partners, or associates of the physician under review.

The Member under review cannot compel the Medical Staff to engage external consultation. The investigating body shall forward a written report of its findings, conclusions, and recommendations to the MEC as soon as practicable.

Despite the status of any investigation, the CEO or Chief of Staff shall retain the authority and discretion to take whatever action may be warranted by the circumstances, including suspension, termination of the investigative process, or other action within their authority pursuant to these Bylaws.

**D. MEC Action.**

As soon as practicable after the conclusion of its investigation, the MEC will take action that may include, without limitation:

1. Determining no corrective action will be taken.

2. Issuing letters of admonition, censure, reprimand, or warning, although nothing herein should be deemed to preclude the issuance of informal written or oral warnings prior to an investigation. In the event such letters are issued, the affected Member may make a written response which will be placed in the Member's Medical Staff file.

3. Recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring/proctoring (so long as the Member's ability to practice independently is not otherwise affected).

4. Recommending denial, restriction, modification, reduction, suspension or revocation of clinical privileges.

5. Recommending reductions of membership status or limitation of any prerogatives directly related to the Member's delivery of patient care.
6. Recommending suspension, revocation, or probation of Medical Staff membership.

7. Taking other actions deemed appropriate under the circumstances.

E. Subsequent Action.

If the MEC recommends any termination or restriction of the Member's membership or privileges, that recommendation shall be transmitted in writing to the Member, as set forth in "Medical Staff Hearing and Appellate Review" below, and to the Board. Such adverse recommendation shall be held in abeyance until the Member has waived or exercised his/her rights to hearing and, if applicable, appeal, under these Bylaws.

The Board may accept the MEC report and recommendations or it may prescribe other actions or interventions. If the Board recommends termination or restriction of the Member's membership or privileges, that recommendation shall be transmitted in writing to the affected Member. The recommendation of the Board shall become final unless the Member timely requests a hearing. Such a request and hearing is permitted only if the decision of the Board is more severe than the recommendation of the MEC and the Member has not previously had a hearing concerning the matters that gave rise to the adverse action. In those circumstances in which the Board decision is more severe than the recommendation of the MEC and the Member has previously had a hearing concerning the matters, the Member will have ten (10) days from his/her receipt of such determination in which to submit a written appeal to the CEO for consideration by the Board. The written appeal must be sent to and received by the CEO within the ten (10)-day period. Such written appeal shall be based only upon the records upon which the adverse decision was made, and may be accompanied by the appellant's written statement. The Board may, however, at its sole discretion, accept additional oral or written evidence.

A Member who fails to request a hearing or, if applicable, appeal within the time specified is deemed to have waived all rights to any hearing and appeal to which he/she might otherwise have been entitled. Such waiver constitutes acceptance of that action, which then becomes and remains effective pending the final decision of the Board.

If the affected Member is employed by the Hospital, the Board will copy the Chief Talent Officer on its determination. Members who are employed by the Hospital may be subject to employment action consistent with the Hospital's employment policies and procedures. Such employment action is separate and distinct from any action taken by the Board regarding membership or privileges and is not subject to the hearing or appeal rights of the Bylaws.

F. Administrative Time Out.

As a part of its progressive approach to Member conduct and performance issues, the MEC may, with approval of the CEO, give a Member one or more Administrative Time Outs, not to exceed five (5) total days of Administrative Time Out in a calendar year. The Administrative Time Out is intended, in good faith, to serve as a last resort by the MEC prior to making a recommendation to suspend or terminate membership or privileges for a signification period or permanently. During an Administrative Time Out, the Member must continue to fulfill his/her emergency patient call obligations, if any, but may not exercise any other clinical privileges except in an emergency situation or to address an imminent delivery. An Administrative Time Out may be instituted only under the following circumstances:
1. When the action that has given rise to the time out relates to an administrative policy of the Hospital or Medical Staff such: completion of medical records, practitioner behavior or requirements for emergency department coverage; and

2. When the action(s) have been reviewed by the MEC and the MEC has determined that one or more of the above policies have been violated; and

3. When the Member has received at least two (2) written notices within the last twelve (12) months regarding the conduct in question; and

4. When the affected Member has been offered an opportunity to meet with the MEC prior to the imposition of the Administrative Time Out. Failure on the part of the Member to comply with the MEC’s request for a meeting will constitute a violation of the Bylaws and will not prevent the MEC from issuing the Administrative Time Out.

An Administrative Time Out will take effect after the Member has been given an opportunity to either arrange for his/her patients currently at the Hospital to be cared for by another qualified Member or until he/she has had an opportunity to provide needed care prior to discharge, but in no event later than forty-eight (48) hours after written notice from the MEC of the imposition of the Administrative Time Out. During this period, the Member will not be permitted to schedule any elective admissions, surgeries, or procedures. The Chief of Staff will determine details of the extent to which the Member may continue to be involved with hospitalized patients prior to the effective date of the Administrative Time Out.

Issuance of an Administrative Time Out does not trigger hearing or appeal rights.

G. Precautionary Restriction or Suspension.

1. Criteria for Initiation. A precautionary restriction or suspension may be imposed when the CEO and Chief of Staff believe in good faith that they need to take immediate action to carefully consider any event, concern, or issue that, if confirmed, has the potential to significantly affect patient or employee safety, the effective operation or the reputation of the Medical Staff and/or the Hospital. For example, a suspension of all or any portion of a Member’s clinical privileges at another hospital may be grounds for a precautionary suspension of all or any of the Member’s clinical privileges at this Hospital.

Unless otherwise stated, such precautionary restriction or suspension shall become effective immediately upon imposition and prompt written notice shall be given to the Member. The restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein.

The precautionary suspension or restriction is an interim step in which an investigation is being conducted to determine the need for a professional review action. It is not punitive, but is a temporary, administrative remedy that implies no finding of incompetent medical practice or improper conduct. It is not a complete professional review action in and of itself. A precautionary suspension or restriction does not imply any finding of responsibility for the situation(s) that triggered the suspension or restriction.
2. **MEC Action.** As soon as practicable and within five (5) calendar days after such precautionary suspension has been imposed, the MEC shall meet to review and consider the action and, if necessary, engage in collegial intervention or begin the investigation process as noted above. Upon request, the Member will be given the opportunity to address the MEC concerning the action, on such terms and conditions as the MEC may impose, although in no event shall any meeting of the MEC, with or without the Member, constitute a "hearing" as the term is used in these Bylaws, nor shall any procedural rules with respect to hearing and appeal apply. The MEC may modify, continue, or terminate the precautionary restriction or suspension, but in any event it shall furnish the Member with written notice of its decision.

3. **Procedural Rights.** The Member shall be entitled to the procedural rights afforded by these Bylaws if the restriction or suspension extends for more than fourteen (14) calendar days.

**H. Automatic Relinquishment.**

In the following circumstances, a Practitioner’s privileges and/or membership may be considered relinquished or limited as described, and the action will generally be final without a right to hearing or appeal.

Privileges/membership may be deemed automatically relinquished by the Chief of Staff or CEO. Where a bona fide dispute exists as to whether the circumstances have occurred, the relinquishment, suspension, or limitation will stand until the MEC determines it is not applicable. The MEC will make such a determination as soon as practicable.

The CEO and Chief of Staff may reinstate the Practitioner’s privileges or membership after determining that the triggering circumstances have been rectified or are no longer present. If the triggering circumstances have not been resolved within sixty (60) days, the Practitioner will have to reapply for membership and/or privileges. In addition, further corrective action may be recommended in accordance with these Bylaws whenever any of the following actions occur.

1. **Licensure.**

   a. **Revocation and Suspension.** Whenever a Practitioner's license, certification and/or registration or other legal credential authorizing practice in this state is revoked, suspended, expired, or voluntarily relinquished, Medical or Allied Staff membership, as applicable, and clinical privileges shall be automatically relinquished by the Practitioner as of the date such action becomes effective.

   b. **Restriction.** Whenever a Practitioner's license, certification and/or registration or other legal credential authorizing practice in this state is limited or restricted by an applicable licensing or certifying authority, any clinical privileges that the Practitioner has been granted at this Hospital that are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

   c. **Probation.** Whenever a Practitioner is placed on probation by the applicable licensing or certifying authority, his/her membership status and/or clinical privileges shall automatically become subject to the same terms and conditions
of the probation as of the date such action becomes effective and throughout its term.

d. Medicare, Medicaid, Tricare or Other Federal Programs. Whenever a Practitioner is sanctioned or barred from Medicare, Medicaid, Tricare, or other federal programs, staff membership and/or clinical privileges shall be considered automatically relinquished as of the date such action becomes effective. Any Practitioner listed on the United States Department of Health Services Office of the Inspector General's List of Excluded Individuals/Entities will be considered to have automatically relinquished his/her privileges as of the date so listed.

2. Controlled Substances.

a. DEA Certificate. Whenever a Practitioner's United States Drug Enforcement Agency ("DEA") certificate is revoked, limited, or suspended, the Practitioner will automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.

b. Probation. Whenever a Practitioner's DEA certificate is subject to probation, the Practitioner's right to prescribe such medications shall automatically become subject to the same terms of the probation as of the date such action becomes effective and throughout its term.

3. Medical Record Completion Requirements. A Practitioner will be considered to have voluntarily relinquished the privilege to admit/attend new patients and/or schedule new procedures whenever he/she fails to complete medical records within time frames established by Medical Staff and/or Hospital policy, after having received written notice of such deficiency. This relinquishment of privileges shall not apply to patients admitted prior to the time of relinquishment, or to imminent deliveries. The relinquished privileges will be automatically restored upon completion of the medical records and compliance with medical records policies.

4. Professional Liability Insurance. Failure of a Practitioner to maintain professional liability insurance in the amount required by the Hospital and sufficient to cover the clinical privileges granted shall result in immediate automatic relinquishment of a Practitioner's clinical privileges. If, within sixty (60) calendar days of the relinquishment, the Practitioner does not provide evidence of required professional liability insurance (including tail coverage for any period during which insurance was not maintained), the Practitioner shall not be considered for reinstatement and shall be considered to have voluntarily resigned from the Medical or Allied Staff as applicable. The Practitioner must notify the Executive Assistant immediately of any change in professional liability insurance carrier or coverage.

5. Caregiver Status. All privileges of a Practitioner shall be automatically suspended upon notification received by the Hospital that the Practitioner:

a. Has been convicted of a serious crime, act or offense or has pending charges for a serious crime, act or offense as defined in Chapter DHS 12 of the Wisconsin Administrative Code; or
b. Has been found by a unit of government to have abused or neglected a patient or misappropriated a patient's property.

As soon as possible after such automatic suspension, the MEC shall convene to review and determine whether the Practitioner is barred from providing services under Chapter DHS 12 of the Wisconsin Administrative Code. If the Practitioner provides evidence that rehabilitation review approval has been received from the State, the MEC must determine whether the rehabilitation review approval in any way limits the Practitioner's ability to practice the privileges granted and/or if it wishes to retain the Practitioner on Staff. The MEC may then take such further corrective action as is appropriate under the circumstances.

6. **Failure to Satisfy the Appearance Requirement.** A Practitioner who fails without good cause to appear at a meeting where his/her appearance is required in accordance with these Bylaws shall be considered to have automatically relinquished all clinical privileges with the exception of emergencies and imminent deliveries. These privileges will be restored when the Practitioner complies with the appearance requirement. Failure to comply within thirty (30) calendar days will be considered a voluntary resignation from the staff.

7. **Failure to Participate in an Evaluation.** A Practitioner who fails to participate in an evaluation of his/her qualifications, performance or conduct as required under these Bylaws, Medical Staff or Hospital policy (including, but not limited to, an evaluation of physical or mental health, of clinical management skills or generally of professional performance or competence), shall be considered to have automatically relinquished all privileges. These privileges will be restored when the Practitioner complies with the requirement for an evaluation. Failure to comply within thirty (30) calendar days will be considered a voluntary resignation from the staff.

8. **Failure to Become or Remain Board Certified.** A Practitioner who fails to become or remain board certified in compliance with these Bylaws and/or Medical Staff policy will be deemed to have immediately and voluntarily relinquished his/her staff appointment and clinical privileges unless an exception is granted by the Board, upon recommendation from the MEC, for good cause shown.

9. **Failure to Execute Release and/or Provide Documents.** A Practitioner who fails to execute a general or specific release and/or provide documents when requested by the Chief of Staff or CEO to evaluate the competency and/or qualifications of the Practitioner shall be considered to have automatically relinquished all privileges. If the release is executed and/or documents provided within thirty (30) calendar days of the automatic relinquishment, the Practitioner may be reinstated. Thereafter, the Practitioner will be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.

10. **Exclusive Contracts.** All Practitioners providing services under an exclusive contract for professional services with the Hospital shall automatically lose clinical privileges at the Hospital upon termination or expiration of said contract. A Practitioner who has been terminated by or voluntarily leaves the employ of another Practitioner or entity that has executed an exclusive contract with the Hospital shall automatically lose clinical privileges at the Hospital upon such termination. In addition, a Practitioner shall have no right to continued clinical privileges if the Hospital enters
into an exclusive contract with another Practitioner or entity, and the Practitioner is not employed by or affiliated with that Practitioner or entity.

11. **Contracted Services.** A Practitioner whose individual contract to provide services at the Hospital expires or otherwise terminates shall automatically lose clinical privileges at the Hospital upon such expiration or termination.

I. **Summary Suspension.**

The CEO and Chief of Staff each shall have the authority, whenever he/she believes, in good faith, that immediate action must be taken to protect the life of any patient or to reduce the likelihood of imminent danger to the health or safety of any individual and that no further investigation of the Member or matter is necessary, to summarily suspend all or any portion of the clinical privileges of a Member. Such summary suspension shall become effective immediately. Written notice of the adverse action must be provided to the Member consistent as provided below.

1. A Member whose clinical privileges have been summarily suspended shall be entitled to request that the MEC hold a hearing on the matter, as soon as practicable, but not later than five (5) business days following the Member’s request for the hearing.

2. Following the hearing, the MEC may recommend modification, continuance or termination of the terms of the summary suspension. If, as a result of such hearing, the MEC does not recommend immediate termination of the summary suspension, the affected Member shall be entitled to submit a written appeal to the Board, but the terms of the summary suspension as sustained or as modified by the MEC shall remain in effect pending a final decision by the Board.

J. **Patient Care Applicable to All Suspensions.**

Immediately upon the imposition of any suspension, the Chief of Staff shall provide for alternative medical coverage for the patients of the affected Member still in the Hospital at the time of such suspension. The wishes of the patients shall be considered in the selection of such alternative provider. All Members have a duty to cooperate with the Chief of Staff in these circumstances.

K. **Loss of Voting and Office.**

Any suspension of membership and/or privileges also suspends voting on Medical Staff matters and right to serve as an officer of the Medical Staff until such suspension is lifted.

XXIII. **Medical Staff Hearing and Appellate Review.**

These following procedures address the rights and obligations of Medical Staff members in the event that adverse action has been recommended for a Member. Such concerns of AHPs are addressed otherwise in these Bylaws. This Section, Medical Staff Hearing and Appellate Review, does not apply to AHPs.
A. **Right to Hearing.**

1. The following actions, if deemed a professional review action as described below, entitle the affected Member/Prospective Member to a hearing upon a timely and proper request:

   a. Denial of initial Medical Staff appointment except for rejection of Fast Track consideration and administrative denial.
   
   b. Denial of reappointment except for administrative denial.
   
   c. Suspension of Medical Staff membership except for Administrative Time-Outs, pre-cautionary suspensions lasting fourteen (14) days or less, or automatic suspensions.
   
   d. Revocation of Medical Staff membership.
   
   e. Denial of requested appointment to or advancement in Medical Staff category.
   
   f. Reduction in Staff category.
   
   g. Limitation of the right to admit patients.
   
   h. Denial of requested clinical privileges.
   
   i. Involuntary reduction in clinical privileges.
   
   j. Suspension of clinical privileges except for Administrative Time-Outs, precautionary suspensions lasting fourteen (14) days or less, or automatic suspensions.
   
   k. Revocation of clinical privileges.

2. An action listed above is a professional review action only when it is or has been:

   a. Recommended by the MEC;
   
   b. Taken by the Board subject to the limitation below;
   
   c. A summary suspension; or
   
   d. A precautionary restriction or suspension lasting more than fourteen (14) days.

3. In formulating such action or recommendation, the acting body should conclude that:

   a. There is a reasonable belief that the action is in furtherance of quality health care; and
   
   b. Reasonable efforts are taken to obtain the pertinent facts; and
   
   c. A reasonable belief exists that the action is warranted by the facts.
When the action involves a decision of the Board, the Member/Prospective Member may request a hearing only if the decision of the Board is more severe than the recommendations of the MEC and the Member/Prospective Member has not previously had a hearing concerning the matters that gave rise to the adverse recommendation or action.

4. The following are examples of recommendations that will not adversely affect the individual's appointment to or status as a Member of the Medical Staff or the exercise of clinical privileges, and therefore are not professional review actions:

a. Administrative denials;

b. Letters of warning, censure or admonition;

c. Imposition of monitoring, proctoring, consultation or review requirements that do not restrict the Member's ability to exercise clinical privileges and are not reportable to the National Practitioner Data Bank;

d. Requiring provision of information or documents, such as office records, or notice of events or actions;

e. Imposition of educational or training requirements;

f. Placement on probationary or other conditional status;

g. Failure to place a Member on any on-call or interpretation roster, or removal of any Member from any such roster;

h. Appointment or reappointment for less than two (2) years;

i. Continuation of Focused Professional Practice Evaluation period;

j. The refusal of the Board to waive or extend the time for compliance with any requirement of these Bylaws;

k. Termination or refusal to reappoint for failure to comply with any objective requirement such as but not limited to board certification or recertification, malpractice insurance coverage, licensure, or failure to meet any objective requirement imposed on all Members that specific numbers of procedures be performed to maintain or demonstrate clinical competence;

l. Employment action;

m. Administrative Time-Out, precautionary suspensions lasting fourteen (14) days or less, and automatic suspensions;

n. Any action that is not related to the Member's professional conduct or competence and not reportable to the state or the National Practitioner Data Bank, such as termination for failure to pay dues or assessments, denial of request for privileges because the Hospital does not permit certain services or procedures to be performed in the Hospital, or the Hospital elects to enter into an exclusive contract for the provision of certain services.
If any action is taken that does not entitle a Member to a hearing, the Member shall be offered the opportunity to submit a written statement or any information which the Member wishes to be considered. Such statement or information shall be included in the Member’s Medical Staff records along with the documentation regarding the action taken.

5. All hearings shall be in accordance with the procedural safeguards set forth in this Section to assure that the affected Member/Prospective Member is accorded all rights to which he/she is entitled.

B. Notice of Adverse Action.

The CEO shall promptly give the Member/Prospective Member written notice of the action which shall:

1. Advise that a professional review action has been taken or proposed to be taken, set forth the reasons for the action and advise that the Member/Prospective Member has the right to request a hearing pursuant to the provisions of these Bylaws.

2. Specify that the Member/Prospective Member has forty-five (45) days after receiving the notice within which to submit a request for a hearing and that the request must satisfy the conditions of below.

3. State that the Member/Prospective Member’s failure to request a hearing within the forty-five (45)-day time period and in the proper manner constitutes a waiver of rights to a hearing and any appeal on the matter.

4. Summarize the hearing procedure and the Member/Prospective Member’s rights including:
   a. The right to be represented by an attorney or other person of the individual’s choice;
   b. The right to have a record made of the hearing proceedings, copies of which may be obtained upon payment of reasonable charges associated with the preparation of such copies;
   c. The right to call, examine and cross-examine witnesses;
   d. The right to present evidence and exhibits determined to be relevant by the Hearing Officer, or Hearing Committee Chairperson regardless of their admissibility in a court of law; and
   e. The right to present a written statement at the close of the hearing.

5. State that he/she will be notified of the date, time, and place of the hearing after he/she has made a timely and proper request.

6. Advise of the right to review the hearing record and report, if any, and to submit a written statement on his/her own behalf as part of the hearing.
C. Request for Hearing.

Other than following a summary suspension, the Member/Prospective Member must file a written request for a hearing within forty-five (45) days after receipt of the notice described above. The Member/Prospective Member’s request must be sent to and received by the CEO within the forty-five (45)-day period.

Following a summary suspension, the Member must file a written request for a hearing within five (5) days after receipt of the notice of same. The Member’s request must be sent to and received by the CEO within the five (5) day period.

D. Waiver by Failure to Request a Hearing.

A Member/Prospective Member who fails to request a hearing within the time specified above is deemed to have waived all rights to any hearing to which he/she might otherwise have been entitled.

Such waiver in connection with an adverse action by the Board constitutes acceptance of that action, which then becomes the final decision of the Board.

Such waiver in connection with an adverse recommendation by the MEC constitutes acceptance of that action, which then becomes and remains effective pending approval of the Board.

E. Notice of Hearing.

Within ten (10) days after receipt of a timely and proper request for hearing, the MEC or the Board, whichever is appropriate, shall schedule and arrange for such a hearing and shall, through the CEO, notify the individual, in writing, of the hearing. The hearing date shall be not less than thirty (30) nor more than sixty (60) days following the date the individual is notified of the hearing unless the Member has been suspended, in which case the time limits may be adjusted in order to expedite the process.

The notice of hearing given to the Member/Prospective Member must include the following:

1. The place, time, and date of the hearing;

2. A preliminary list of the witnesses (if any) expected to testify at the hearing in support of the professional review action and a statement that each party must submit a final list of witnesses expected to testify at least ten (10) days prior to the hearing; and

3. A summary of the individual’s alleged acts or omissions or the other reasons forming the basis for the professional review action that is the subject of the hearing.

F. Composition of Hearing Committee.

When a hearing relates to an adverse recommendation of the MEC, the hearing shall be conducted by a special committee appointed by the Chief of Staff, consisting of at least two (2) Members of the Active Medical Staff and two (2) other Members of the Medical Staff who have not previously participated in the formulation of the decision and who are not in direct economic competition with the Member/Prospective Member. The Chief of Staff will appoint one of these
committee members as Hearing Committee Chairperson. For purposes of this Section, direct economic competition shall be defined to mean those practitioners actively engaged in practice in the primary medical community of the affected Member, and who practice in the same medical specialty or subspecialty as the affected Member/Prospective Member. The Hearing Committee may use, on a non-voting consulting basis, members of the same medical specialty or subspecialty.

When a hearing relates to an adverse decision of the Board under circumstances where no prior right to a hearing existed, the Board shall appoint a Hearing Committee to conduct the hearing and shall designate one of the members of this committee as chairperson.

As an alternative to a Hearing Committee, a sole Hearing Officer may be selected to conduct the hearing. The use and appointment of a Hearing Officer shall be determined by the chairperson of the body whose decision is being contested, after consultation with the CEO. The Hearing Officer shall act in an impartial manner as the chairperson and presiding officer of the hearing.

A Medical Staff Member or member of the Board shall not be disqualified from serving on a Hearing Committee because he/she has requested the corrective action or heard of the case or has knowledge of the facts involved, or what he/she supposes the facts to be, or has participated in the investigation of the matter at issue. All members of a Hearing Committee shall be required to consider and decide the case with good faith objectivity.

**G. Conduct of Hearing.**

At least a majority of the members of the Hearing Committee must be present when the hearing and deliberations takes place, and no member may vote by proxy or electronically. If a committee member is absent for any significant part of the proceedings, as determined in the chairpersons sole discretion, he/she shall not be permitted to participate in the deliberations or decision.

An accurate record of the hearing must be kept. The mechanism shall be established by the Hearing Committee, and may be accomplished by use of a court reporter, electronic recording unit, detailed transcription or by taking of adequate minutes. The affected Member/Prospective Member may obtain copies of the record upon the payment of reasonable fee.

The affected Member/Prospective Member must personally appear at the hearing. An affected individual who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his/her rights in the same manner as provided above and to have accepted the adverse recommendation or decision involved.

Postponement of hearings beyond the time set forth in these Bylaws shall be made only with the express approval of the Hearing Committee for good cause shown.

The affected Member/Prospective Member shall be entitled to be accompanied by or represented at the hearing by a Member of the Medical Staff in good standing or by a member of his/her local professional society. "Good standing" for purposes of this Section means that the Member is licensed to practice medicine in the state of Wisconsin, has no license or DEA limitation, restriction or sanction, and has no limitation or restriction on his/her Hospital privileges.
Either the Hearing Officer, if one is appointed, or the Hearing Committee Chairperson shall preside over the hearing to determine the order of procedure during the hearing, to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum.

The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objection in civil or criminal action. The affected Member/Prospective Member and the body taking or recommending the professional review action shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of procedure or of fact. These memoranda shall become a part of the hearing record.

The Chief of Staff, when the MEC action has prompted the hearing, shall present the reasons for the recommended course of action and may present witnesses and other evidence in support of the adverse recommendation. The Board, when its action has prompted the hearing, shall appoint one of its members to represent it at the hearing, to present the reasons for the recommended course of action and may present witnesses and other evidence in support of its adverse decision. The affected Member/Prospective Member is responsible for supporting his/her challenge to the adverse recommendation or decision by an appropriate showing that the charges or grounds involved lack any factual basis or any action based thereon is arbitrary or capricious.

During the hearing, each party has the right:

1. To have a record made of the proceedings, copies of which may be obtained by the Member/Prospective Member upon payment of any reasonable charges associated with the preparation of such copies;
2. To call, examine, and cross-examine witnesses;
3. To present evidence and exhibits determined to be relevant by the Hearing Officer, or the Hearing Committee Chairperson regardless of their admissibility in a court of law and to rebut the same; and
4. To present a written statement at the close of the hearing.

Either side may formally request assistance of legal counsel or of some other person in these proceedings by giving the Hearing Committee notice at least ten (10) days prior to the hearing of such assistance. In such cases, the Hearing Committee Chairperson or Hearing Officer may define the role of such legal counsel or other person, as a participant or strictly as an observer in the proceeding. Any Member/Prospective Member who incurs legal fees in his/her behalf shall be solely responsible for payment.

In reaching a decision, the Hearing Officer or Hearing Committee may take official notice, either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration. All other information that can be considered under these Bylaws in connection with credentialing matters may also be considered.
The Member/Prospective Member has the burden of proving by clear and convincing evidence that the professional review action or recommendation lacks any substantial factual basis or that the conclusions drawn from the facts are arbitrary or capricious.

The Hearing Committee may, without notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Hearing Committee may then, at a time convenient to itself, conduct its deliberations outside the presence of the Member/Prospective Member for whom the hearing was convened.

H. Hearing Committee Report and Further Action.

Within thirty (30) days after close of the hearing, the Hearing Committee or Hearing Officer shall submit a written report of its findings and recommendations to the body whose review action occasioned the hearing. The report must include a statement of the bases for the recommendation.

Within thirty (30) days after receiving the recommendation of the Hearing Committee or Hearing Officer, the body whose review action occasioned the hearing shall consider the report and prepare its own report affirming, modifying, or reversing its previous action. This report must include a statement of the bases for the decision. Notice of the body's determination must be provided, in writing, to the Member/Prospective Member within ten (10) days of its decision, and include a summary of the bases for the determination, any rights of appeal, and the procedure for obtaining such appeal.

If the recommendation resulted from MEC action and remains adverse to the Member/Prospective Member, he/she will have ten (10) days from his/her receipt of such determination in which to submit a written appeal to the CEO for consideration by the Board. The written appeal must be sent to and received by the CEO within the ten (10)-day period.

Such written appeal shall be based only upon the records upon which the adverse decision was made, and may be accompanied by the appellant's written statement. The Board may, however, at its sole discretion, accept additional oral or written evidence.

A Member/Prospective Member who fails to request an appeal within the time specified above is deemed to have waived all rights to any appeal to which he/she might otherwise have been entitled. Such waiver constitutes acceptance of that action, which then becomes and remains effective pending the final decision of the Board.

The Board shall, within forty-five (45) days following receipt of the final MEC recommendation, consider the Member/Prospective Member's appeal, if any, and render its final decision in the matter. The decision of the Board shall be sent to the Member/Prospective Member and shall not be subject to further review.

Notwithstanding any other provision of these Bylaws, no Member/Prospective Member shall be entitled as a right to more than one (1) hearing and one (1) appeal, if applicable, on any matter which shall have been the subject of professional review action by the MEC, or by the Board, or by a duly authorized committee of the Board, or by both.
I. **Substantial Compliance.**

Technical or insignificant deviations from the procedures set forth in this Section shall not be grounds for invalidating action taken.

J. **Waiver of Time Limits.**

Any time limits set forth in this Section may be extended or accelerated by mutual agreement of the Member/Prospective Member and the CEO. The time periods specified in this Section for action by the MEC, the Board, the CEO and the committees are to guide those bodies in accomplishing their tasks and shall not be deemed to create any right for reversal of the professional review action if the hearing process is not completed within the time periods specified.

K. **Notices Under This Section.**

All notices under this Section shall be sent by certified or registered mail, or by such other means as to evidence receipt by the Member/Prospective Member.

L. **Agreements with Practitioners.**

Notwithstanding any other provision of the Bylaws, the Hospital may provide by agreement that a Practitioner's membership on the Medical or Allied Staff and clinical privileges are contingent on and shall expire simultaneously with such agreement or understanding. In the event that a Member’s agreement has such a provision or there is such an understanding, the provisions of these Bylaws with respect to hearings, appeals, appellate review, etc., shall not apply (the provisions addressing hearings, appeals, etc. do not apply to Allied Staff).

XXIV. **Leaves of Absence.**

Any Practitioner may apply for a Leave of Absence consistent with the Medical Staff Leave of Absence Policy. Absence without advance approval may be considered a voluntary resignation as described below.

XXV. **Resignation from the Medical or Allied Staff.**

1. Any Practitioner may resign his/her membership and privileges at any time by providing written notice to the CEO and Chief of Staff. However, in order to ensure the provision of quality patient care, resignations taken without a minimum of six (6) weeks' notice from Members, and two (2) weeks' notice from AHPs, except as expressly authorized by the MEC and CEO, may be considered to be an inadequate resignation.

2. Except when a Practitioner has taken an approved leave of absence, inadequate resignation may be deemed to have occurred when a Practitioner who provided inpatient services or utilized Hospital space for procedures, has relocated his or her practice outside the Hospital's service area and has not provided inpatient care to or
performed procedures for Hospital patients for thirty (30) days or more and done so without notice as required hereunder. Written notification to the Practitioner will be provided by the Executive Assistant prior to implementation of any resignation under this subsection 2.

3. An inadequate resignation may be also be deemed to have occurred when a Practitioner no longer meets eligibility criteria, is absent without notice for two (2) consecutive scheduled procedures/call coverage/shifts or fails to complete his/her application for reappointment within required time frames.

4. Practitioners are expected to complete all clinical and record-keeping responsibilities including call and rounding obligations. Practitioners are required to notify the Hospital, in writing, of the arrangements made for continued care of post-operative patients following the Practitioner's resignation. A Practitioner who resigns without having completed and signed medical records and fulfilling other clinical responsibilities as described herein will be considered to have inadequately resigned and may be reported to the Medical Examining Board or otherwise as permitted or required by law.

5. The designation of "inadequate resignation" will be made by the MEC, placed in the Practitioners' Medical/Allied Staff file, and if applicable, may be placed in his/her employment file. The designation will be communicated to employers, hospitals, credentialing organizations and others seeking references on the Practitioner or otherwise inquiring about the Practitioner's practice at the Hospital.

6. Provisions of these Bylaws relating to hearings and appellate review shall not apply to a determination of a designation of "inadequate resignation" based upon a Practitioner's resignation hereunder.

XXVI. Rules, Regulations, Policies and Procedures.

The MEC shall have the authority to make, adopt and amend such rules, regulations, policies and procedures as may be necessary for the proper conduct of its work and to implement more specifically the general principles set forth in these Bylaws.

Rules, regulations, policies and procedures should be reviewed periodically and revised as necessary. The review may be performed by the MEC or a committee appointed by the Chief of Staff. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely and responsible manner, so that the rules, regulations, policies and procedures are of generally recognized quality, provide a basis for acceptance by accreditation agencies, comply with supervising licensing authorities, and provide a system of ongoing effective professional review. When a committee has conducted such review, it will make its recommendations to the MEC.

Should the need for an immediate amendment to the Rules and Regulations be necessary to comply with law or regulation, the MEC may provisionally adopt such amendment and the Board may provisionally approve such amendment, without prior notification of the Medical Staff. In this circumstance, the Medical Staff will be immediately notified by the MEC and have the opportunity for review and comment of the provisional amendment. If there is no conflict, the amendment stands. If there is conflict, the Conflict Resolution process described in Article
XVIII below, will be followed. In all other circumstances, the MEC will provide the Medical Staff with notice of proposed changes to Rules and Regulations prior to submitting to the Board. Rules and Regulations and any amendments thereto, shall become effective when approved by the Board. Neither the MEC nor the Board may unilaterally amend the Rules and Regulations.

The MEC will provide the Medical Staff with notice of newly adopted or amended policies and procedures.

Any Member of the Medical Staff may propose amendments, additions and repeals of any rule, regulation, policy or procedure by submitting such request in writing to the MEC. Moreover, the Medical Staff may prepare and present proposed amendments, additions and repeals of a rule, regulation, policy or procedure which are supported by the Medical Staff, as evidenced by a vote of the Medical Staff using the methodology described in Article XXVII (2), directly to the Board.

**XXVII. Adoption and Amendment of Bylaws.**

1. **Medical Staff Responsibility.** These Medical Staff Bylaws may only be adopted or amended by the voting Members with the approval of the Board. The MEC shall have the initial responsibility and delegated authority to formulate, adopt, and recommend to the Medical Staff, Medical Staff Bylaws and amendments thereto, which shall be effective when approved by the Board. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely and responsible manner, so that the Bylaws are of generally recognized quality, provide a basis for acceptance by accreditation agencies, comply with supervising licensing authorities, and provide a system of ongoing effective professional review.

2. **Methodology.** Medical Staff Bylaws may be adopted, amended, or repealed by the affirmative vote of two-thirds (2/3) of the Members of the Medical Staff eligible to vote at a meeting at which a quorum is present, as defined below, and provided at least ten (10) days written notice, accompanied by the proposed Bylaws and/or amendments, has been given of the intention to take such action. At the Chief of Staff’s discretion, electronic voting may be authorized for these purposes consistent with these Bylaws. A quorum, for this Section, consists of the Members of the Medical Staff eligible to vote who have timely submitted completed electronic ballots by the close of business on the day of the meeting at which the vote is taken, or are present the meeting at which the vote will be taken.

3. **Effective Date.** The Medical Staff Bylaws shall be adopted or amended at any regular meeting of the Medical Staff and shall become effective when approved by the Board.

4. **Review and Revision.** The Medical Staff Bylaws should be reviewed periodically and revised as necessary. The review may be performed by the MEC or a committee appointed by the Chief of Staff whose recommendations shall be made to the MEC. Any proposed amendments and revisions shall be adopted by the Medical Staff and Board as provided herein. Neither the Medical Staff nor the Board may unilaterally amend the Medical Staff Bylaws. Provided however, that any Member of the Medical Staff may propose amendments, additions and repeals of the Bylaws by submitting
such request in writing to the MEC. Moreover, the Medical Staff may prepare and present proposed Bylaw amendments which are supported by the Medical Staff, as evidenced by a vote of the Medical Staff using the methodology described in Article XXVII (2), directly to the Board.

XXVIII. Conflict Resolution

In the event a Member is unable to resolve a difficulty or conflict through discussion with an officer of the Medical Staff directly, that Member may, upon presentation of a written notice, meet with the MEC to discuss the issue.

If a Member remains unsatisfied, s/he may prepare and present the issue at a regularly scheduled Medical Staff meeting. If the issue is supported by the Medical Staff, as evidenced by a vote of the Medical Staff using the methodology described in Article XXVII (2), such issue may proceed directly to the Board according to the Hospital's corporate bylaws.

In the event the Board is unable to resolve a difficulty or conflict with a Medical Staff matter through discussion with the Chief of Staff directly, the Board will convene a joint meeting between the Board and the MEC to discuss the issue.

XXIX. Board Action.

The procedures specified herein shall not preclude the Board from taking any direct action authorized under the Hospital Bylaws, policies and/or procedures.

XXX. Governing Law.

These Bylaws shall be governed by, and construed in accordance with the Health Care Quality Improvement Act of 1986 and, to the extent not inconsistent therewith, the Wisconsin Statutes Sections 146.37 and 146.38, and to the extent not so governed, with the other laws of the State of Wisconsin without giving effect to its conflict of laws principles.
APPROVALS

These Bylaws of the Beaver Dam Community Hospitals, Inc. Medical Staff were recommended to the Board of Directors by the Medical Executive Committee and adopted by the Board in accordance with and subject to the Medical Staff Bylaws.

By: [Signature]
Chief of Staff
Date: [Signature] 4/16/2020

These Bylaws of the Beaver Dam Community Hospitals, Inc. Medical Staff were approved and adopted by the Board of Directors after considering the Medical Executive Committee's recommendation and in accordance with and subject to the Hospital's Corporate Bylaws.

By: [Signature]
Chairperson
Date: [Signature]