Document Owner:	**Reviewed By:**	**Approved By:**
Medical Staff Office	NMH Robbinsdale Hospital Medical Executive Committee (MEC)	Robbinsdale Hospital Board of Trustees

TABLE OF CONTENTS

BUSINESS CONFIDENTIAL
Printed copies are for reference only.
Please refer to the electronic
copy for the latest version.
Internal Distribution Only

BUSINESS CONFIDENTIAL
Printed copies are for reference only.
Please refer to the electronic
copy for the latest version.
Internal Distribution Only

BUSINESS CONFIDENTIAL
Printed copies are for reference only.
Please refer to the electronic
copy for the latest version.

Internal Distribution Only

PREAMBLE

WHEREAS, North Memorial Health – Robbinsdale Hospital ("Hospital"), is a hospital owned and operated by North Memorial Health Care, a Minnesota nonprofit corporation; and

WHEREAS, the purpose of the Hospital is to serve as a hospital providing patient care;

WHEREAS, it is recognized that the Medical Staff is responsible for the quality of medical care in the Hospital and must accept and discharge its responsibility, subject to the authority of the Board of Trustees, and that the cooperative efforts of the Medical Staff, the officers of the Hospital, the Chief of the Medical Staff, and the Board of Trustees are necessary to fulfill the Hospital's obligations to its patients; and

NOW, THEREFORE, the Physicians, Dentists, and Podiatrists practicing in the Hospital hereby organize the activities and governance of the Medical Staff of North Memorial Health - Robbinsdale Hospital and do hereby adopt the following Medical Staff Bylaws (these "Bylaws").

BUSINESS CONFIDENTIAL
Printed copies are for reference only.
Please refer to the electronic
copy for the latest version.
Internal Distribution Only

ARTICLE 1 NAME AND PURPOSE

1.1 Name. The name of this organization shall be the Medical Staff of North Memorial Health Robbinsdale Hospital ("Medical Staff").

1.2 Purpose. The purposes of the Medical Staff are:

A. To ensure that all patients admitted to or treated in any of the facilities of the Hospital shall receive quality medical and health care services that are consistent with recognized community standards of care, regardless of age, race, gender, color, creed, or any other basis prohibited by law;

B. To assist in the continuing education of all members of the Medical Staff;

C. To ensure an appropriate level of professional performance of all members of the Medical Staff through the delineation of clinical privileges and an ongoing review and evaluation of each Medical Staff member's performance in the Hospital;

D. To provide an appropriate educational setting that will maintain professional standards, assist in the continuing education of all members of the Medical Staff, and lead to continuous advancement in professional knowledge and skill as well as scientific and educational standards;

E. To initiate and maintain the policies for self-governance of the Medical Staff;

F. To participate in and promote activities designed to improve and protect the general health of the community served by the Hospital;

G. To provide a means whereby issues concerning the Medical Staff and the Hospital may be discussed by the Medical Staff in a cooperative manner with the officers of the Hospital, Chief of the Medical Staff or the Board of Trustees; and

H. To review and evaluate the services of all Practitioners in relation to quality, factors necessary to meet accreditation and licensure standards, federal and state law, peer review standards, and cost-effectiveness, and to report regularly to the Board of Trustees through the officers of the Hospital or Chief of the Medical Staff.

1.3 Definitions.

A. "Advance Practice Providers (APPs)" shall refer to those non-physician practitioners qualified by academic and clinical training to practice independently within the scope of their individual licenses as either a Nurse Practitioner (NP), Physician Assistant (PA), Certified Nurse Anesthetist (CRNA), Certified Nurse Midwife (CNM), Clinical Nurse Specialist (CNS), Licensed Independent Clinic Social Workers (LICSW), Licensed

BUSINESS CONFIDENTIAL
Printed copies are for reference only.
Please refer to the electronic
copy for the latest version.
Internal Distribution Only

Professional Counselors (LPC), Licensed Mental Health Counselors (LMHC), Licensed Marriage and Family Therapist (LMFT), or Doctor of Psychology (PsyD/PhD). APPs are appointed to the Professional Staff in accordance with the Credentialing Policy.

B. "Clean File Criteria" shall include the following criteria relating to an applicant for initial appointment to the Medical Staff:

1. The applicant has no clinical practice gaps exceeding ninety (90) days at any time between the graduation of medical/dental school and the date of the application at issue (whether initial or renewal);

2. All professional references requested of the applicant by the Medical Staff have been primary source verified, completed and returned with only positive recommendations;

3. There has been no malpractice claim involving the applicant in the ten (10) years immediately preceding the application, and no more than one malpractice case involving the applicant in total;

4. There is no history of or currently pending adverse clinical privileges actions against the applicant by a hospital, surgery center, or other health care facility, and the applicant has not resigned from a hospital, surgery center, or other health care facility during an investigation or pending an adverse clinical privileges action;

5. The applicant has no history of negative or adverse license action (including but not limited to reprimands, warnings, or agreements for corrective action) in any jurisdiction;

6. All training and experience disclosed by the applicant has been primary source verified, and no negative information from institutions where such training and experience took place has been provided;

7. The results of a National Practitioner Data Bank query contained no adverse information of concern;

8. The applicant has not been excluded, disbarred, terminated, or suspended from participation in a government health care program as determined by an inquiry of the Office of Inspector General publicly available databases;

9. The applicant has affirmatively stated on his/her application for membership that he/she has no physical or mental condition that would affect his/her ability, with or without reasonable accommodation, to provide appropriate care to patients and otherwise perform the essential functions of a practitioner in his/her areas of practice without posing a health or safety risk to patients; and

BUSINESS CONFIDENTIAL
Printed copies are for reference only.
Please refer to the electronic
copy for the latest version.
Internal Distribution Only

10. The appropriate Department/Section Chair(s) has reviewed and approved the applicant's completed privilege request form.

C. "Designee" shall mean an individual who is charged by a person with authority under these Bylaws (e.g., the Chief of Staff) to exercise such person's authority, provided the Designee acts within the scope of their privileges, licensed scope of practice, and the scope of authority granted by the person with the authority under these Bylaws.

D. "Executive Session" shall mean the portion of a meeting of a Medical Staff committee, Department, or Section during which only the voting Medical Staff members may attend, along with the Vice President of Medical Affairs and/or other Officers of the Hospital.

E. "Hospital" shall mean the licensed hospital located in Robbinsdale, Minnesota operated by North Memorial Health Care and known as North Memorial Health – Robbinsdale Hospital.

F. "Medical Staff" shall mean all duly licensed Physicians, Dentists, and Podiatrists who are appointed to the Medical Staff of the Hospital in accordance with these Bylaws.

G. "Officers of the Medical Staff" shall include the Chief of Staff, the Vice Chief of Staff, the Credentials Committee Chair, and the Chair of the Multispecialty Peer Review Committee.

H. "Rules and Regulations" shall mean those Rules and Regulations of the Medical Staff that are adopted by the Medical Staff and specifically made a part of these Bylaws.

ARTICLE 2 MEMBERSHIP

2.1 Members. Membership on the Medical Staff is a privilege which shall be extended only to those individuals who are competent in their respective fields and who continuously meet the standards and requirements set forth in these Bylaws, the Rules and Regulations, and the policies of the Medical Staff. All practitioners who admit patients or provide medical or health-related services in the Hospital must be members of the Medical Staff and shall be subject to these Bylaws, the Rules and Regulations, and the policies of the Medical Staff. Only Medical Staff members and other practitioners (when granted the right to do so under the Credentialing Policy) may admit patients to the Hospital.Classes of Membership.

A. Active Medical Staff. The Active Medical Staff shall consist of all Physicians, Dentists, and Podiatrists who require hospital privileges as part of their clinical practice and are regularly involved in the clinical or administrative activities of the Hospital, as may be further defined in the Credentialing Policy. Members of the Active Medical Staff shall be eligible to vote on matters submitted to the Medical Staff, hold Medical Staff office, and serve as voting members of Medical Staff committees.

BUSINESS CONFIDENTIAL
Printed copies are for reference only.
Please refer to the electronic
copy for the latest version.
Internal Distribution Only

B. Courtesy Staff. The Courtesy Staff shall consist of all new Physicians, Dentists and Podiatrists who have been initially appointed to the Medical Staff or who only occasionally provide care for patients at the Hospital, as may be further defined in the Credentialing and Discipline Policy. Courtesy Staff may not hold Medical Staff office. Courtesy Staff may serve as voting members on any and all Medical Staff committees but may not vote on matters submitted to the Medical Staff.

C. Clinic Medical Staff. The Clinic Medical Staff shall consist of all Physicians, Dentists and Podiatrists who see patients in the clinics owned and/or operated by North Memorial Health Hospital (the "NMH Clinics") and who do not require hospital privileges as part of their clinical practice. Clinic Medical Staff may vote on matters submitted to the Medical Staff, hold Medical Staff office, and serve as voting members of the Medical Staff committees.

D. Associate Staff. The Associate Staff shall consist of those Physicians, Dentists and Podiatrists who do not meet the definitions of any of the other Medical Staff categories and who do not exercise clinical privileges, but who participate in the administrative or operational activities of the Medical Staff. Associate Staff are not eligible to admit patients, vote, or hold Medical Staff office.

E. Honorary Staff. The Honorary Staff shall consist of all Physicians, Dentists and Podiatrists who do not exercise clinical privileges in the Hospital or who are honored by emeritus positions. These may be individuals who have active hospital practices in other hospitals or Physicians, Dentists and Podiatrists of outstanding reputation who are not necessarily residing in the community. Honorary Staff are not eligible to admit patients, order tests or procedures, vote, hold Medical Staff office, or serve on Medical Staff committees.

2.3 Professional Staff. Professional Staff are those APPs who are permitted to provide patient care services in the Hospital within the scope of their individual licenses and applicable law and/or pursuant to a collaborative agreement with a member(s) of the Medical Staff. Clinic Professional Staff shall consist of all APPs who see patients in the NMH Clinics and who do not require hospital privileges as part of their clinical practice. Professional Staff (including Clinic Professional Staff) may serve as voting members on any and all Medical Staff committees but may not vote on matters submitted to the Medical Staff. Professional Staff may not hold Medical Staff office.

2.4 Allied Health Staff. Allied Health Staff are those individuals qualified by academic and clinical training to practice in a medical support role providing medical services under the supervision of a member of the Medical Staff, including but not limited to Registered Nurses, Surgical Technicians, First Assistants, Orthotists, Prosthetists, and Audiologists. Allied Health Staff may not hold Medical Staff office, may not serve on Medical Staff committees, and may not vote on matters submitted to the Medical Staff or Professional Staff. Allied Health Staff appointment is subject to the Credentialing Policy.

BUSINESS CONFIDENTIAL
Printed copies are for reference only.
Please refer to the electronic
copy for the latest version.
Internal Distribution Only

2.5 Telemedicine Staff. Telemedicine Staff shall consist of all Physicians, Dentists, and Podiatrists who require only telemedicine privileges as part of their clinical practice and who are granted only telemedicine privileges. Any telemedicine privileges that are granted in conjunction with a contractual agreement will expire when the agreement is terminated, regardless of reason, is not renewed, or otherwise expires. Telemedicine Staff may not hold Medical Staff office, may not serve as voting members on any Medical Staff committees, and may not vote on matters submitted to the Medical Staff.

2.6 Moonlighting Staff. Moonlighting Staff shall consist of Physician Residents who are working in the Hospital as employees with only moonlighting privileges. Moonlighting Staff may not independently admit patients, may not hold Medical Staff office, may not serve as voting members on Medical Staff committees, and may not vote on matters submitted to the Medical Staff.

2.7 Terms of Appointment.

A. An appointment to the Medical Staff shall be made by the Board of Trustees upon recommendation of the Medical Staff.

B. Appointments shall be for a period of three (3) years or less.

C. Appointment to the Medical Staff shall confer on the appointee only membership to the applicable class of Medical Staff. The granting of membership does not carry with it the accordance of clinical privileges. Application for delineated clinical privileges must be pursued according to the pertinent provisions of these Bylaws, the Credentialing Policy, Rules and Regulations, and other Medical Staff policies.

D. In the event all of a Medical Staff member's privileges are resigned, revoked, or suspended, the member's Medical Staff membership shall be automatically relinquished.

E. A Medical Staff member's membership shall be automatically relinquished upon suspension or termination of his/her state license through action of the State Board of Medical Practice, State Board of Dentistry, or other applicable State Board.

F. A Medical Staff member's membership shall be automatically relinquished if his/her employment contract with the Hospital or an affiliate of North Memorial Health Care is no longer in force.

2.8 No Discrimination. The Medical Staff will not discriminate against members of any protected category. This principle shall be applicable to all decisions subject to these Bylaws, as well as to proceedings governed by the Credentialing Policy. Medical Staff membership and privileges shall not be denied on the basis of age, sex, religion, race, creed, color, national origin, or any physical or mental impairment, except that membership may be denied or restricted if a practitioner's impairment prevents or materially impairs the practitioner's ability to provide

quality patient care, fulfill the duties of Medical Staff membership, or otherwise comply with the Bylaws, Rules and Regulations, and policies of the Medical Staff and North Memorial Health Care.

2.9 Eligibility.

A. To be eligible to apply for initial appointment and reappointment to the Medical Staff, an applicant must meet the following threshold eligibility criteria, as more particularly described in the Credentialing Policy:

1. The applicant has the appropriate education;

2. The applicant has the appropriate clinical training;

3. The applicant has the appropriate clinical experience and current clinical competence;

4. The applicant has not engaged in unprofessional conduct;

5. The applicant has the ability to safely and competently perform all requested privileges;

6. The applicant holds an unrestricted license (i.e., such license has not been restricted, suspended, conditioned, or otherwise limited in any respect) to practice in the state of Minnesota;

7. The applicant holds an unrestricted DEA certificate (i.e., such certificate has not been restricted, suspended, conditioned, or otherwise limited in any respect), if applicable;

8. The applicant has provided a current certificate of liability insurance that meets the Medical Staff requirements;

9. The applicant has provided a complete malpractice claims history;

10. The applicant is board certified, or eligible for board certification in accordance with the applicable specialty or subspecialty board's eligibility requirements;

11. The applicant is eligible to participate in Medicare, Medicaid and all other applicable federal or state healthcare programs, without limitation, restriction, sanction, exclusion, or condition;

12. The applicant has not had a license, membership, or clinical privileges denied, suspended, conditioned, restricted, or revoked, or their employment terminated, by

BUSINESS CONFIDENTIAL
Printed copies are for reference only.
Please refer to the electronic
copy for the latest version.
Internal Distribution Only

any licensing board, peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization;

13. The applicant has not resigned from any medical or facility staff appointment at any health care facility (including the Hospital), or relinquished their clinical privileges during an investigation or appeal, or in exchange for such medical or facility staff not conducting an investigation;

14. The applicant is physically and mentally capable of providing safe and appropriate care to patients and otherwise performing the essential functions of clinical practice and their privileges without posing a health or safety risk to patients; and

15. The applicant is not currently under a criminal investigation or indictment and has not been required to pay a civil monetary penalty or been convicted of or entered a plea of guilty or no-contest to any felony or misdemeanor related to: (i) controlled substances; (ii) illegal drugs; (iii) violent acts; (iv) sexual misconduct; (v) moral turpitude; or (vi) patient, child, or elder abuse.

B. Failure to meet one or more of the threshold eligibility criteria in Section 2.9A.12) above or in the Credentialing Policy (whether at initial appointment or reappointment) does not constitute a denial of membership and/or clinical privileges and does not entitle the applicant to a fair hearing.

C. After a practitioner has been appointed to the Medical Staff, if at any time they no longer meet the threshold eligibility criteria in Section 2.9A.12) above or in the Credentialing Policy, then the practitioner's membership and privileges may be automatically relinquished.

2.10 Basic Obligations of Individual Practitioners. Each member of the Medical Staff, regardless of assigned staff category, each practitioner exercising temporary privileges under these Bylaws, and each Professional Staff and Allied Health Staff, as applicable, shall:

A. provide patients with continuous care at the generally recognized professional level of quality and efficiency;

B. abide by these Bylaws, the Rules and Regulations, the policies and procedures of the Medical Staff, and all other standards, policies, and rules of the Hospital;

C. discharge staff, committee, and Hospital functions for which the practitioner is responsible by staff category assignment, appointment, election, or otherwise;

D. provide services to patients who do not have a personal physician at the Hospital in accordance with protocols which may be adopted by the Medical Staff delineating responsibilities for services to such patients;

BUSINESS CONFIDENTIAL
Printed copies are for reference only.
Please refer to the electronic
copy for the latest version.
Internal Distribution Only

E. prepare and complete in a timely fashion the medical and other required records for all patients he or she admits or in any way provides care to in the Hospital;

F. work effectively and appropriately with other Medical Staff members and with Hospital personnel, administration, and others, and behave in a manner that does not adversely affect patient care in the Hospital;

G. agree to be subject to review as part of the Hospital's quality assessment and improvement programs and to comply with the Hospital's Corporate Bylaws and any policies or rules adopted by the Board of Trustees;

H. be in compliance and provide documentation demonstrating such compliance, with the continuing education requirements of the Minnesota State Board of Medical Practice, Minnesota State Board of Dentistry, Minnesota State Board of Podiatric Medicine, or other professional licensing board, as applicable;

I. notify the Medical Staff Office of any adverse action by any licensing board, peer review organization, third party payor, clinic, hospital, medical staff, or any health-related agency or organization within five (5) days of the adverse action, including:

1. the reduction, restriction, suspension, revocation, denial, non-renewal, or voluntary surrender of his/her professional license by any state;

2. the reduction, restriction, suspension, revocation, denial, non- renewal, or voluntary surrender of medical staff membership, clinical privileges, or employment at any hospital or other health care institution;

3. the commencement of a formal investigation, the filing of charges, or final action by the United States Department of Health and Human Services or any other health regulatory agency of the United States or any state, including but not limited to Minnesota, or by any state or federal law enforcement agency;

4. the filing of any suit against the practitioner alleging professional liability; or

5. any final judgments or settlements regarding any litigation or claims have and maintain professional liability insurance in adequate amounts, as established from time to time by resolution of the Board of Trustees, to cover claims and suits arising from alleged professional negligence or misconduct in the Hospital.

J. promptly notify the Medical Staff Office of any change in practice address, phone number, or pager number;

K. work with and provide supervision for residents as needed for high quality patient care and graduate medical education;

BUSINESS CONFIDENTIAL
Printed copies are for reference only.
Please refer to the electronic
copy for the latest version.
Internal Distribution Only

L. maintain the confidentiality of patient clinical information and of the minutes, records, and work product of Medical Staff committees engaged in the peer review process. This provision shall not prohibit mandatory disclosures under state or federal law, nor disclosures made for a permitted purpose of a peer review organization, in accordance with applicable law;

M. refrain from performing any procedures, assuming any patient care responsibilities, or applying for or exercising any specific privileges for which such individual is not licensed, currently trained, and currently qualified;

N. participate in a cooperative manner in the Medical Staff's efforts to review and improve the quality, efficiency and appropriateness of care provided at the Hospital, including full participation in the review of patient encounters with the Medical Staff's peer review process. Participation includes submission of review forms in a timely manner;

O. notify the Medical Staff Office of any arrest or if charged with any offense including, but not limited to, any substance-abuse related issue (including driving under the influence, impaired driving, or driving while intoxicated), domestic abuse, child abuse or maltreatment, or maltreatment of a vulnerable adult. Reports are required within ten (10) days of such an arrest or within ten (10) business days of being charged with such an offense. The arrested or charged individual shall meet with the Vice President of Medical Affairs after such report; and

P. obtain, when requested, an appropriate fitness for practice evaluation, which may include diagnostic testing (such as blood and/or urine test) or a complete physical, mental, and/or behavioral evaluation, as set forth in these Bylaws and associated policies.

2.11 Emergency Call Duty. By applying for appointment and reappointment, all Medical Staff and Professional Staff members agree to participate in on-call coverage arrangements, including but not limited to coverage for the Emergency Department and for obstetrics. The schedule for this on-call duty shall be established by the Medical Staff in collaboration with Hospital leadership.

2.12 Membership Dues. All persons appointed to the Medical Staff, Professional Staff, and Allied Health Staff shall pay annual staff dues. The Medical Executive Committee shall determine the staff dues for each category of membership or staff. Membership and privileges shall be automatically relinquished upon the failure to pay dues within ninety (90) days of the due date.

ARTICLE 3 OFFICERS

3.1 Officers. The Officers of the Medical Staff shall be the Chief of Staff, Vice Chief of Staff, Chair of the Credentials Committee, and Chair of the Multispecialty Peer Review Committee. No person may hold more than one office at a time.

BUSINESS CONFIDENTIAL
Printed copies are for reference only.
Please refer to the electronic
copy for the latest version.
Internal Distribution Only

3.2 Election and Term.

A. Officers of the Medical Staff must be members of the Active Medical Staff at the time of nomination and election, and must remain members of the Active Medical Staff in good standing during their term of office.

B. Officers of the Medical Staff shall be elected bi-annually by electronic ballot. Only members of the Active Medical Staff shall be eligible to vote. Ballots will list the candidates nominated by the Nominating Committee and approved by the Medical Executive Committee, and will provide space to reject the names or to write in other names. Each nominated candidate shall be elected unless rejections or write-ins returned within thirty (30) days of the initial mailing of the ballots amount to more than fifteen (15) percent of the ballots mailed out.

C. If a candidate is rejected, the Nominating Committee shall select at least one other candidate. The new slate of candidates shall be posted in the doctor's lounge for thirty (30) days immediately following the Medical Executive Committee's approval of the new slate. A new ballot will be mailed out in the same manner as the original ballot, and the election or rejection process for the new slate shall be as described in Section 3.2(B).

D. The Nominating Committee shall be appointed by the Medical Executive Committee from among the Active Medical Staff members. The Nominating Committee shall offer one nominee for Chief of Staff, one nominee for Vice Chief of Staff, one nominee for Chair of the Multispecialty Peer Review Committee, and one nominee for Chair of the Credentials Committee.

E. All Officers of the Medical Staff shall serve two-year terms, and shall take office on the first day of the Medical Staff year.

3.3 Qualifications. Officers of the Medical Staff and Department Chairs must meet the following qualifications, unless waived by the Medical Executive Committee:

A. Have no past or pending adverse recommendations concerning Medical Staff appointment or clinical privileges;

B. Not currently be serving as a medical staff officer, board member, or department chair at another hospital system;

C. Be willing to faithfully discharge the duties and responsibilities of the position;

D. Attend continuing education relating to medical staff leadership and/or credentialing functions prior to or during his/her term of office;

E. Have demonstrated an ability to work well with others; and

BUSINESS CONFIDENTIAL
Printed copies are for reference only.
Please refer to the electronic
copy for the latest version.
Internal Distribution Only

F. Not have any financial relationship with an entity that competes with the Hospital or one of its affiliates.

3.4 Chief of Staff. The Chief of Staff shall preside at all meetings of the Medical Staff and the Medical Executive Committee, and shall serve as an ex officio member of all committees of the Medical Staff. The Chief of Staff, in conjunction with the Vice Chief of Staff, Vice President of Medical Affairs, and the Manager of the Medical Staff Office, shall be responsible for Medical Staff activities with respect to the accreditation by the Hospital's accrediting agency and any appropriate state or federal agencies, and shall act in coordination and cooperation with the President of the Hospital in all matters of mutual concern with the Hospital. The Chief of Staff shall appoint committee members and chairs to special Medical Staff committees, except the Medical Executive Committee. The Chief of Staff shall be the spokesperson of the Medical Staff in its external professional and public relations; and represent the views, policies, needs, and grievances of the Medical Staff to the Board of Trustees and to the President of the Hospital. The Chief of Staff shall be responsible for the educational activities of the Medical Staff, subject to policies of the Board of Trustees. The Chief of Staff shall receive the policies of the Board of Trustees, and deliver and interpret these policies to the Medical Staff. The Chief of Staff shall report to the Board of Trustees on the performance and maintenance of quality with respect to the delegated responsibility of the Medical Staff to provide medical care. The Chief of Staff shall be responsible for the conduct and organization of the Medical Staff. The Chief of Staff shall be responsible for the enforcement of these Bylaws, the Credentialing Policy, and the Rules and Regulations; for the implementation of sanctions where these are stipulated for noncompliance; and for presentation to the Medical Executive Committee in those instances where corrective action may be recommended by the Board of Trustees. The Chief of Staff shall perform all duties incident to the office of Chief of Staff, and such other duties as may from time to time be prescribed by the Medical Staff. If necessary, the Chief of Staff shall fulfill the role or function of a Department Chair or appoint another Active Medical Staff member to fulfill such role or function, due to the absence of a Department Chair or a Department Chair's inability or refusal to fulfill such role or function and the unavailability of a Department Vice Chair. The Chief of Staff shall act as Secretary/Treasurer of the Medical Staff. He or she shall perform all duties incident to the office of Secretary/Treasurer, and such other duties as may from time to time be prescribed by the Medical Staff or the Medical Executive Committee.

A. The Chief of Staff shall serve for a term of two years and may be re-nominated to serve one additional consecutive two-year term. Nominees for the position of Chief of Staff must be current or past members of the Medical Executive Committee.

B. The immediate past Chief of Staff may serve on the Credentials Committee or the Multispecialty Peer Review Committee.

3.5 Vice Chief of Staff. The Vice Chief of Staff shall assume all the duties and have the authority of the Chief of Staff in the event of the Chief of Staff's temporary inability to perform his/her duties due to illness, being out of the community, or being unavailable for any other reason. The Vice

BUSINESS CONFIDENTIAL
Printed copies are for reference only.
Please refer to the electronic
copy for the latest version.
Internal Distribution Only

Chief of Staff shall serve on the Medical Executive Committee as a voting member. The Vice Chief of Staff shall perform such duties as are assigned by the Chief of Staff. The Vice Chief of Staff shall be considered by the Nominating Committee to succeed the Chief of Staff upon the completion of the Chief of Staff's term, but the Nominating Committee shall not be obligated to nominate the Vice Chief of Staff to become the Chief of Staff, and the selection of the Chief of Staff shall be conducted as set forth in Section 3.2. The Vice Chief of Staff shall automatically succeed the Chief of Staff for the remainder of the Chief of Staff's term when the Chief of Staff cannot complete his or her term for any reason.

3.6 Chair of the Credentials Committee. The Chair of the Credentials Committee shall preside over meetings of the Credentials Committee and be responsible for coordinating its activities. The Chair of the Credentials Committee shall serve on the Medical Executive Committee as a voting member.

3.7 Chair of the Multispecialty Peer Review Committee. The Chair of the Multispecialty Peer Review Committee shall preside over meetings of the Multispecialty Peer Review Committee and be responsible for coordinating its activities. The Chair of the Multispecialty Peer Review Committee shall serve on the Medical Executive Committee as a voting member.

3.8 Removal. Removal of an Officer of the Medical Staff or a Medical Executive Committee member may be effectuated by a two-thirds vote of the Medical Executive Committee; a two-thirds vote of all members of the Active Medical Staff; or by the Board of Trustees.

A. Grounds for removal shall be:

1. failure to comply with applicable policies and these Bylaws;

2. failure to perform the duties of the position held;

3. conduct detrimental to the interests of the Hospital and/or its Medical Staff;

4. an infirmity that renders the individual incapable of fulfilling the duties of that office; or

5. failure to continue to satisfy the qualifications for the position.

B. Prior to scheduling a meeting to consider removal, a representative from the Medical Staff, the Medical Executive Committee, or the Board of Trustees will meet with and inform the individual of the reasons for the proposed removal proceedings.

C. The individual will be given at least ten (10) days' notice of the date of the meeting at which his/her removal is to be considered. The individual will be afforded and opportunity to address the Medical Executive Committee, the Active Medical Staff, department, or the Board of Trustees, as applicable, prior to a vote on removal.

BUSINESS CONFIDENTIAL
Printed copies are for reference only.
Please refer to the electronic
copy for the latest version.
Internal Distribution Only

D. Removal will be effective when approved by the Board.

3.9 Vacancies. A vacancy in any office during the Medical Staff year shall be filled in accordance with this Section. Any vacancy in the office of the Chief of Staff shall be filled by the Vice Chief of Staff. In the event of a vacancy in any other office of the Medical Staff, the Medical Executive Committee shall select an acting officer to temporarily fill such vacancy, who will serve until the Nominating Committee can present a slate of candidates before a meeting of the Medical Staff for filling the vacancy. Upon accession or election of an officer to fill a vacancy in an office, the new officer shall fill the unexpired term of the person whose office was vacated.

3.10 Resignation. Any Officer of the Medical Staff may resign at any time by giving written notice to the Medical Executive Committee. Such resignation, which may or may not be made contingent on formal acceptance, shall take effect on the date of receipt or any later time specified in the written notice.

ARTICLE 4 DEPARTMENTS

4.1 Departments. The Medical Staff shall be organized into the following Clinical Departments: Anesthesiology, Surgery, Family Medicine, Internal Medicine, Neurology and Psychiatry, Pediatrics, Emergency Medicine and Radiology. The Surgery Department shall include practitioners practicing in the Sections of Oral & Maxillofacial Surgery & Hospital Dentistry, Obstetrics and Gynecology, Surgery and Surgical Specialties, Orthopedics, Neurosurgery, Anesthesiology and Pathology.

4.2 Assignment to Department. The Medical Executive Committee, upon the recommendation of the Department, shall recommend the final Department assignment of each applicant and reapplicant to the Medical Staff, subject to the approval of the Board of Trustees.

4.3 Functions of Departments.

A. Each Department shall be responsible for maintaining quality patient care by continuing observation and evaluation of the professional performance of the Medical Staff with privileges in its Department.

B. Each Department shall establish its own criteria for recommending clinical privileges. Clinical privileges must be delineated for each Department Medical Staff member in a comprehensive manner and must be commensurate with the individual's documented training, experience, and current clinical competence. Through regular review, each Department will endeavor to assure that all individuals with privileges provide services within the scope of those privileges granted.

C. In the event privileges are requested in more than one Department, the recommendation regarding privileges will be made by chair of the primary Department after consultation

BUSINESS CONFIDENTIAL
Printed copies are for reference only.
Please refer to the electronic
copy for the latest version.
Internal Distribution Only

with the other Department(s) to determine whether the applicant demonstrates competence for the requested privileges.

D. The Department will perform regular reviews and evaluations of the quality and appropriateness of patient care. Minutes shall be maintained and shall include topics discussed and actions taken. All minutes shall be forwarded to the Medical Executive Committee.

E. Department policies and regulations shall be reviewed periodically by the Department. All policies and regulations adopted by a Department shall be subject to approval by the Medical Executive Committee and shall bear the date of such approval.

F. Each Department shall be responsible for the delineation of privileges for all Professional Staff and Allied Health Staff being supervised by the members of that Department. Recommendations of the Department shall be referred to the Medical Executive Committee for approval.

4.4 Department Organization.

A. The Department Chair and Department Vice Chair shall be Active Medical Staff members qualified by training, experience, and demonstrated ability, and elected by the Active Medical Staff members of the Department. Terms of service shall be two years, unless such term of service is changed or modified as determined by the individual Department. The Department Chair and Department Vice Chair may be re-elected for multiple successive terms. In the absence of the Department Chair, the Department Vice Chair will assume all duties of the Department Chair including chairing the Department and representing the Department in the Medical Executive Committee.

B. The Department Chair or Department Vice Chair may be removed from office if he or she fails to perform the duties of the office. The Medical Executive Committee shall review the performance of the person in question and may remove him or her from office by a majority vote. The Department Chair and Department Vice Chair shall not have a vote.

C. The Department Chair or Department Vice Chair may resign at any time by giving written notice to the Medical Executive Committee. Such resignation, which may or may not be made contingent on formal acceptance, shall take effect on the date of receipt or any later time specified in the written notice.

D. In the event that a Department Chair is unable, unwilling, or ineligible to perform the duties of the office, is removed from office, or resigns from office, such office shall be declared vacant by the Medical Executive Committee. Such vacancy shall be filled by the Department Vice Chair. If the Department Vice Chair is unable to fill the vacancy, then the office shall be filled by the Chief of Staff.

BUSINESS CONFIDENTIAL
Printed copies are for reference only.
Please refer to the electronic
copy for the latest version.
Internal Distribution Only

4.5 Functions of Department Chairs. Department Chairs shall serve as members of the Medical Executive Committee and perform all duties incident to the office of Department Chair and such other duties as may from time to time be prescribed by the Chief of Staff, the Medical Executive Committee, or the Medical Staff as a whole. In no way limiting the foregoing, each Department Chair is responsible for the following:

A. all clinically related activities of the Department;

B. all administrative activities related to the Department, unless otherwise provided for by the Hospital, including acting as the liaison between the Department and the Medical Staff;

C. continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Department;

D. recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the Department;

E. recommending clinical privileges for each member of the Department;

F. reviewing applications and reapplications for privileges in the Department;

G. assessing and recommending to the relevant Hospital authority off-site sources for needed patient care treatment and services not provided by the Department or the organization;

H. the integration of the Department or service into the primary functions of the Hospital;

I. the coordination and integration of interdepartmental and intradepartmental services;

J. the development, review, and implementation of policies and procedures that guide and support the provision of care, treatment, and services;

K. the recommendation for a sufficient number of qualified and competent persons to provide care, treatment and services;

L. the determination of the qualifications and competence of Department or service personnel who provide patient care, treatment, and services;

M. the continuous assessment and improvement of the quality of care, treatment, and services;

N. the maintenance of utilization, review and quality control programs, as appropriate;

O. the orientation and continuing education of all persons in the Department;

P. recommendations for space and other resources needed by the Department;

BUSINESS CONFIDENTIAL
Printed copies are for reference only.
Please refer to the electronic
copy for the latest version.
Internal Distribution Only

Q. membership on the Medical Executive Committee and regular attendance at Medical Executive Committee meetings; and

R. other duties as outline in the current accreditation standards for Department chairs.

4.6 Jurisdictional Disputes. Disputes or conflicts in jurisdiction between the Departments shall be submitted to the Medical Executive Committee for determination and resolution.

ARTICLE 5 SECTIONS

5.1 Medical Staff Sections. Medical Staff Sections shall be established to perform functions relating to various clinical specialties providing services at the Hospital. Sections may be created, disbanded, or changed from time to time by the Medical Executive Committee. The Sections are listed below:

A. Oral & Maxillofacial Surgery & Hospital Dentistry;

B. Obstetrics and Gynecology;

C. Surgery and Surgical Specialties;

D. Pathology;

E. Orthopedic Surgery; and

F. Neurosurgery.

5.2 Section Duties. The Section Chief shall be appointed by the relevant Department Chair. The Section Chief shall perform the necessary functions determined by the Department Chair, including assistance with credentialing, for the proper operation of the Section.

5.3 Section Meetings. Sections shall meet with such frequency and at such times as they may determine, provided that the Hospital-based Sections, which are Anesthesiology and Pathology, shall meet at least quarterly. All Section meetings are open to every member of the Medical Staff.

ARTICLE 6 MEETINGS AND COMMITTEES

6.1 General Medical Staff Meetings. General Medical Staff meetings shall be held at least once a year on a schedule to be established by the Medical Executive Committee. The primary objective of the meetings shall be to report on the activities of the Medical Staff and to conduct such other business as may be on the agenda. One of the meetings shall be designated as the annual Medical

BUSINESS CONFIDENTIAL
Printed copies are for reference only.
Please refer to the electronic
copy for the latest version.
Internal Distribution Only

Staff meeting, and the medical directors/advisors and committee membership may be appointed at this meeting.

6.2 Departmental Meetings. Departments shall meet with such frequency and at such times as the Department may determine to consider the findings resulting from the ongoing monitoring and evaluation of quality assessment and improvement activities, and to discuss other matters concerning the Department. All Department meetings are open to every member of the Medical Staff.

6.3 Meeting Requirements. Medical Staff members are strongly encouraged but not required to attend meetings of the Medical Staff. In addition, Departments may establish attendance requirements for Department meetings.

6.4 Special Meetings. Special meetings of the Medical Staff may be called by the Board of Trustees, the Chief of Staff or, in his or her absence, by the Vice Chief of Staff, or by a written call signed by fifteen (15) percent of the members of the Active Medical Staff. Such a meeting shall be convened within thirty (30) days of the receipt of the formal written request for a special meeting. The Chief of Staff shall provide notice of any special meetings in writing to all members of the Active Medical Staff at least five (5) days prior to the meeting. No business may be transacted at any special meetings of the Medical Staff, except for those matters which have been included in the written call and the written notice issued for the meeting.

6.5 Election and Action Requirements. Election and action requirements for the transaction of business shall be as follows:

A. Election of the Officers of the Medical Staff shall be by emailed ballot. The process for nomination and election of the Officers of the Medical Staff shall be as described in Article 3 of these Bylaws.

B. Those members of the Active Medical Staff present at a duly called meeting shall constitute a quorum. A majority vote of those present shall be required to approve an action, except as provided in Section 10.2 with regard to amendment of these Bylaws.

C. A majority of Medical Executive Committee members shall constitute a quorum of the Medical Executive Committee. For all other committees and for Departments, a majority of those committee or Department members present at a duly called meeting shall constitute a quorum.

D. The Medical Staff may take action by written or email ballot. Any member of the Active Medical staff present at a duly called meeting of the full Medical Staff may request a written ballot of the membership of the entire Active Medical Staff on any issue properly coming before the meeting. Twenty-five (25) percent of those present must vote to approve any such request. In addition, the Medical Executive Committee may, at its discretion,

BUSINESS CONFIDENTIAL
Printed copies are for reference only.
Please refer to the electronic
copy for the latest version.
Internal Distribution Only

order a ballot on any issue properly coming before the Medical Staff. Ballots shall be sent to all Active Medical Staff members and provide a final return date not less than thirty (30) days from the date of the ballot sent date. Those ballots returned as of the return date shall constitute a quorum and a majority of those voting shall determine the action.

6.6 Records. Complete and accurate minutes of all meetings required to be held under this Article 6 shall be maintained. Such minutes shall, at a minimum, include a record of attendance of the members, the facts considered, and the conclusions, recommendations and actions taken at the particular meeting. The minutes shall be signed by the presiding officer. Each committee and Department shall maintain a permanent file of the minutes of each meeting. All minutes shall be kept in a permanent file.

6.7 Executive Session. An executive session is a meeting of a Medical Staff Committee, Department, or Section which only the voting Medical Staff members may attend, along with the Vice President of Medical Affairs and/or other senior Hospital management. Executive sessions may be called by the presiding officer or the Vice President of Medical Affairs, and are intended to be utilized to discuss peer review issues, personnel issues, or any other issues requiring confidentiality. The conduct and activities of the Committee, Department, or Section while in executive session shall be consistent with the duties and responsibilities of the Committee, Department, or Section. In addition, each executive session shall be conducted in a manner consistent with applicable federal and state law which includes maintaining the strict confidentiality of the proceedings.

6.8 Committee Structure. The Medical Staff and its Committees and Sections shall perform the Medical Staff's peer review responsibilities, including, but not limited to monitoring and evaluating the quality of patient care rendered by all Departments and their members; performing credentialing activities; providing programs of continuing education; developing policies, rules and regulations; and performing such other functions as are required to ensure quality of care. Unless otherwise provided, the Chief of Staff shall select committee chairpersons from the membership of the Medical Staff. Committees other than the Medical Executive Committee may include participation of physicians and staff who are not members of the Medical Staff. Participants who are not members of the Medical Staff may be members of committees, except the Medical Executive Committee, and are eligible to vote. Members of the Medical Staff shall be assigned to committees by the Chief of Staff for terms to coincide with the election of Officers of the Medical Staff. Subject to the approval of the Board of Trustees, the Medical Executive Committee may, from time to time, appoint such other committees as determined to be appropriate, determine the functions and duties of such committees, and set the terms of membership of committee members.

6.9 Medical Executive Committee. The Medical Executive Committee shall be comprised of the Chief of Staff, the Vice Chief of Staff, the immediate past Chief of Staff, the Chair of the Credentials Committee, the elected Department Chairs, the elected Section Chiefs, an elected member of the Professional Staff, and the Chair of the Multispecialty Peer Review Committee.

BUSINESS CONFIDENTIAL
Printed copies are for reference only.
Please refer to the electronic
copy for the latest version.
Internal Distribution Only

In addition, the following persons shall also serve ex-officio as non-voting members of the Medical Executive Committee, unless already serving on the Medical Executive Committee in some other official capacity: the President of the Hospital, the Chief Medical Officer, the Vice President of Medical Affairs, the Chief Operating Officer, the Chief Nursing Officer, the Medical Director of Quality, the Chair of Wellness Committee, and the Director of the Family Medicine Residency Program. The President of the Hospital and the Chief Nursing Officer, or their designees, shall attend each Medical Executive Committee meeting on an ex-officio basis. The Medical Executive Committee shall meet as needed to coordinate the activities and policies of the Medical Staff and shall act on behalf of and under the limitations imposed by the Medical Staff as a whole. The Medical Executive Committee may meet as a body or via use of any other confidential manner currently available (e.g., conference call or e-mail). The functions of the Medical Executive Committee include, but are not necessarily limited to, the following:

A. Reporting at each regular meeting of the Medical Staff on actions taken by the Medical Executive Committee since the last preceding Medical Staff meeting;

B. Performing the duties and acting on behalf of the Medical Staff in the interim between regular meetings of the Medical Staff, in accordance with the authority delegated to the Medical Executive Committee by the Medical Staff, which authority may be delegated, revised or removed by an action of the Medical Staff taken in accordance with Section 6.5;

C. Receiving, acting upon, and sharing with the Board of Trustees the reports and recommendations from Medical Staff committees, Departments, Sections, and assigned activity groups regarding at least the following: medication management oversight, infection prevention and control oversight, tissue review, utilization review, medical record review, and quality management;

D. Developing and implementing policies of the Medical Staff that are not otherwise the responsibility of an individual committee;

E. Advising the Board of Trustees on all matters relating to the structure of the Medical Staff, credentialing, appointments and reappointments, staff categorization, Department assignments, clinical privileges, and corrective action, except where such recommendation is a function of the Medical Staff as a whole;

F. Fulfilling the Medical Staff's accountability to the Board of Trustees for the quality of the overall care, treatment and services rendered to the patients in the Hospital;

G. Preparing the annual Medical Staff budget and submitting it to the Medical Staff for information;

H. Initiating and pursuing corrective action when warranted, in accordance with these Bylaws;

BUSINESS CONFIDENTIAL
Printed copies are for reference only.
Please refer to the electronic
copy for the latest version.
Internal Distribution Only

I. Requesting evaluations of privileges, when there is doubt as to the ability of an applicant or Medical Staff member's ability to perform the privileges requested;

J. Taking all reasonable steps to ensure professional ethical conduct and competent clinical performances on the part of all members of the Medical Staff, including the initiation and/or participation in medical corrective or review measures when warranted;

K. Addressing issues which involve unusual occurrences and/or claims involving allegations of malpractice within the Hospital;

L. Informing the Medical Staff of all accreditation programs and the accreditation status of the Hospital; and

M. Organizing quality improvement activities of the Medical Staff and Professional Staff as well as evaluation and review of such activities.

6.10 Credentials Committee. The Credentials Committee shall include the Chief of Staff; the Vice Chief of Staff; and five or more Medical Staff members and three Professional Staff members, each appointed by the Chief of Staff, with approval of the Medical Executive Committee, who will serve as permanent members of the Credentials Committee until they choose to resign or are removed by the majority vote of the Medical Executive Committee. In addition, the Credentials Committee shall include five past Department Chairs or Section Chiefs designated by the Chief of Staff to serve two-year terms. The Vice President of Medical Affairs shall act as an ex-officio non-voting member of the Credentials Committee. The Credentials Committee shall perform the functions ascribed to them in these Bylaws and in the Credentialing Policy, and shall perform such other duties as may be assigned by the Medical Executive Committee.

6.11 Multispecialty Peer Review Committee. The Multispecialty Peer Review Committee (the "MSPR Committee") shall include voluntary members representing each Department from the Medical Staff. The MSPR Committee shall perform the functions described in the North Memorial Health Hospital Peer Review Policy, including: determination of whether appropriate care was provided in the Hospital; determination of whether physician review or auditing, education, conversation, or other remedial measures are warranted; oversight of other peer review committees; reporting to the Medical Executive Committee on peer review actions; and reporting to Medical Executive Committee immediately in the case of egregious or emergent situations.

6.12 Nominating Committee. The Nominating Committee shall be appointed by the Medical Executive Committee from among the Active Medical Staff members. The Chief of Staff shall appoint one member of the Nominating Committee to serve as chair of the Nominating Committee, and shall consider the immediate past Chief of Staff for this appointment. The Nominating Committee shall present a slate of at least one candidate for each office of the Medical Staff which is to be filled by election.

BUSINESS CONFIDENTIAL
Printed copies are for reference only.
Please refer to the electronic
copy for the latest version.
Internal Distribution Only

6.13 Biomedical Ethics Committee. The Biomedical Ethics Committee shall be responsible for reviewing and advising on reported ethical matters within the Hospital and NMH Clinics. The Biomedical Ethics Committee does not direct clinical care in the Hospital or make clinical decisions in a particular case. Any Medical Staff, Professional Staff, or Allied Health Staff may request a Biomedical Ethics Committee consultation through the process outlined in Medical Staff and Hospital policies.

6.14 Minutes. Each committee of the Medical Staff shall keep regular minutes or other records of its proceedings, which shall be maintained permanently.

ARTICLE 7 CREDENTIALING AND PRIVILEGES

7.1 Process for Evaluating Appointment and Privileges. All applicants must submit any requested documentation of his or her background, relevant training and experience, current clinical competence, adherence to the ethics of his or her profession, good reputation, ability to work with others and, if requested, health status, with sufficient adequacy to meet the requirements of the Medical Staff and the Board of Trustees. The process for appointment to the Medical Staff and granting of clinical privileges is further set forth in the Credentialing Policy.

A. The Medical Staff Office will process only completed applications, providing a report of whether the applicant meets the applicable requirements to the Credentials Committee.

B. The Credentials Committee will review the application and supporting documentation. The Credentials Committee may require that the applicant submit to an interview to clarify any aspect(s) of his/her application. The Credentials Committee will make a recommendation regarding appointment and the request for privileges to the Medical Executive Committee.

C. The Medical Executive Committee will adopt the recommendation of the Credentials Committee, refer the application back to the Credentials Committee for further consideration, or reject the recommendation of the Credentials Committee. The Medical Executive Committee may require that the applicant submit to an evaluation of his or her physical and/or mental health status by a physician or physicians acceptable to the Medical Executive Committee or the Board of Trustees, as a prerequisite to the further processing of his or her application for appointment. If the applicant fails to undergo such evaluation, the application shall be deemed incomplete and withdrawn. If the recommendation of the Medical Executive Committee is to grant initial appointment or reappointment and clinical privileges, the recommendation will be forwarded to the Board of Trustees. If the recommendation of the Medical Executive Committee is that the application be denied or fewer privileges be granted than are requested by the applicant, the applicant will be notified of his/her right to request a hearing as provided in the Credentialing Policy.

BUSINESS CONFIDENTIAL
Printed copies are for reference only.
Please refer to the electronic
copy for the latest version.
Internal Distribution Only

D. Temporary privileges may be granted to qualified initial applicants for membership and privileges for a period of up to one hundred twenty (120) days by the Department Chair or their designee under two circumstances, and in every case subject to the ultimate review and approval of the application and request for privileges by the Credentials Committee, the Medical Executive Committee, and the Board of Trustees:

1. Temporary privileges are necessary to fulfill an urgent patient care need; or

2. The applicant meets the Clean File Criteria.

7.2 Expedited Board Approval. To expedite appointment, the Board of Trustees may delegate the authority to render appointment and related credentialing decisions to a committee consisting of at least two members of the Board of Trustees (the "Board Committee"). Following a positive recommendation from the Medical Executive Committee on an application, the Board Committee shall review and evaluate the qualifications and competence of the applicant and shall render its decision. A positive decision by the Board Committee results in the status or privileges requested. The full Board of Trustees shall consider and, if appropriate, ratify all positive Board Committee decisions at its next regularly scheduled meeting. If the Board Committee's decision is adverse to an applicant, the matter is referred back to the Medical Executive Committee and shall follow the process set forth in Section 7.1 above.

An applicant is ineligible for the expedited process if at the time of appointment, any of the following has occurred:

A. The applicant submits an incomplete application;

B. The Medical Executive Committee makes a final recommendation that is adverse or with limitation;

C. There is a current challenge or a previously successful challenge to the applicant's licensure or registration;

D. The applicant has received an involuntary termination of medical staff membership at another organization;

E. The applicant has received an involuntary limitation, reduction, denial, or loss of clinical privileges; or

F. There has been a final judgment adverse to the applicant in a professional liability action, unless previously reviewed and recommended by the Credentials Committee.

7.3 Board Action on Application. At each regular and annual meeting of the Board of Trustees, or at such other time or times as are designated by the Board of Trustees, the Board of Trustees shall act on Medical Staff applications that have been forwarded to it by the Medical Executive

Printed copies are for reference only.
Please refer to the electronic
copy for the latest version.

Committee. The Board of Trustees shall, by a majority vote, approve the application, deny the application, or return the application to the Medical Executive Committee for further information. The Board of Trustee's decision to approve or deny an application shall be communicated to the applicant within ten (10) days of the decision. If the Board of Trustees denies an application, then the applicant shall immediately be notified of their right to a hearing under the Credentialing Policy.

7.4 Emergency and Disaster Privileges. When the Hospital activates its disaster plan (Emergency Management Plan) and the Hospital is unable to meet immediate patient needs with the current members of the Medical Staff, the Vice President of Medical Affairs or their Designee may use a modified credentialing process to grant disaster privileges after primary source verification of the applicant's identity and licensure. In an emergency, any Medical Staff member with clinical privileges is temporarily granted approval to provide any type of patient care necessary as a lifesaving measure or to prevent serious harm regardless of their current clinical privileges, provided the care provided is within the scope of the individual's license. Properly supervised residents may provide such emergency care.

7.5 Delineation of Privileges. Subject to any limitation contained in applicable policies and procedures or these Bylaws setting forth the privileges offered at the Hospital, and subject to the provisions of applicable agreements between the Hospital and practitioners which are consistent with these Bylaws, clinical privileges shall be granted to each applicant (and/or renewed for each practitioner) commensurate with his or her training, experience, current competence, judgment, character, and current capabilities, in accordance with the criteria and procedures set out in these Bylaws. No practitioner may perform a service or procedure in the Hospital unless he or she is privileged to do so as provided herein. When a new procedure is developed, the appropriate Department shall recommend whether to delineate a clinical privilege for the procedure and, if so, shall recommend appropriate criteria for granting such privilege.

7.6 Temporary Privileges-Clean File Criteria. Temporary privileges may be granted for up to one hundred and twenty (120) calendar days when the applicant for membership is waiting for recommendation by the Credentials Committee, the Medical Executive Committee, and approval by the Board of Trustees. These applicants must meet the Clean File criteria defined in these Bylaws. Consideration for temporary privilege criteria is at the discretion of the Department Chair or Credentials Committee.

7.7 Temporary Consulting Privileges. In order to allow members of the Medical Staff and Professional Staff to obtain appropriate consulting services for patients at the Hospital, temporary consulting privileges of one (1) week duration may be granted to physicians, dentists, or podiatrists who are not members of the Medical Staff by an Officer of the Hospital on the recommendation of a member of the Medical Executive Committee, the applicable Department Chair, or the Chief of Staff.

BUSINESS CONFIDENTIAL
Printed copies are for reference only.
Please refer to the electronic
copy for the latest version.
Internal Distribution Only

In situations where a patient has been admitted to the Hospital, temporary consulting privileges will be granted if:

A. The patient's condition requires the services of a physician, dentist, or podiatrist who has cared for the patient in the past or the patient's condition requires a physician, dentist, or podiatrist with expertise not provided by a member of North Memorial Health Hospital's Medical Staff; and

B. If there is a request for the services of such physician, dentist, or podiatrist by a physician, dentist, or podiatrist on the Medical Staff at North Memorial Health Hospital.

C. Temporary consulting privileges will not be granted until the Medical Staff Office has verified that the applicant is on the active staff in good standing at another Minnesota hospital and has been granted the privilege requested as well as current license, insurance, DEA, board status and the individual's statements relative to:

1. physical, mental health and chemical dependency;

2. past or pending professional liability cases and if insurance coverage has ever been canceled;

3. license or registration limitations, suspensions, investigations, voluntary relinquishments or revocations;

4. refusal of membership on a hospital's medical staff;

5. denial, suspension, or revocation of clinical privileges;

6. denial, exclusion from certification, or past action in any private, federal or state health insurance program (e.g. Medicare, Medicaid);

7. denial of membership or disciplinary action in any medical organization; and

8. felony or misdemeanor convictions.

D. When the Medical Staff Office is not available to confirm the above, such as on weekends or nights, temporary consulting privileges may be granted for a period of up to seventy-two (72) hours by the President of the Hospital or, in his/her absence, another administrative designee on the recommendation of the Chief of Staff, the immediate past Chief of Staff or, in their absence, the Vice President of Medical Affairs. The Chief of Staff, the immediate past Chief of Staff, or the Vice President of Medical Affairs shall contact the department chair, chief of staff, or vice president of medical affairs at the individual's primary hospital to verify that he or she is in good standing and has privileges to perform the requested procedure, and shall document this verification. If such

BUSINESS CONFIDENTIAL
Printed copies are for reference only.
Please refer to the electronic
copy for the latest version.
Internal Distribution Only

verification cannot be obtained, the application for temporary consulting privileges will be denied.

E. Physicians, dentists, and podiatrists granted temporary consulting privileges will be asked to wear an I.D. badge for identification purposes.

F. Once granted, temporary consulting privileges may be renewed for up to two (2) additional seven (7)-day periods if requested by the Medical Staff member attending the patient.

G. Physicians, dentists, or podiatrists who are granted temporary consulting privileges more than two (2) times within a calendar year will be required to apply for Medical Staff membership. Physicians, dentists, or podiatrists who fail to do so will not be granted further temporary consulting privileges.

H. Denial of temporary consulting privileges is a non-appealable decision.

7.8 Scope of Practice for Residents. Resident practitioners shall be governed by this Section. Interns or residents participating in a program that either (1) is not ACGME approved, or (2) does not have a formal agreement with the Hospital, must receive specific permission from the President of the Hospital before providing care in the Hospital. They must provide care in accordance with the Intern and Resident Scope of Practice adopted by the Medical Executive Committee, other requirements set by the Officers of the Hospital, and under the supervision of a member of the Medical Staff holding an appropriate appointment with the training program and holding clinical privileges reflective of the patient care responsibilities given the residents that they are supervising. Resident practitioners who are members of an approved residency program affiliated with North Memorial Health Hospital shall be governed by the following:

A. They must be members in good standing of the residency program in question;

B. They must demonstrate the qualifications, ability and judgment to exercise a resident practitioner's scope of practice;

C. The scope of practice shall extend to the care of patients whom the resident has admitted and for whom the residency program supervisor is the attending practitioner, as well as to the writing of patient care orders for the care of other patients;

D. The scope of practice shall extend to services performed by residents while directly participating in the approved residency program. In addition, the scope of practice shall extend to services performed outside the approved residency program under the supervision of a member of the Medical Staff;

E. The residents shall at all times be subject to the quality improvement activities conducted by the Hospital, and any resident's scope of practice may be limited, modified, suspended or terminated by the Medical Executive Committee, based upon data and findings

BUSINESS CONFIDENTIAL
Printed copies are for reference only.
Please refer to the electronic
copy for the latest version.
Internal Distribution Only

generated as part of said quality improvement activities, or for any other justified reason contemplated under these Bylaws;

F. Residents shall at all times be supervised in accordance with Medical Staff Policy and Procedure on Residents; and

G. Residents may serve as non-voting members on Medical Staff committees.

7.9 Scope of Practice for Moonlighting Residents. A moonlighting resident is a resident who is: (1) licensed under Minnesota law as a physician, and (2) is performing services at the Hospital within the scope, but outside the auspices, of his/her approved GME program.

A. Moonlighting residents must be credentialed through the Medical Staff process as required by the Medical Executive Committee;

B. Moonlighting residents must be members in good standing in an ACGME-approved residency program;

C. Moonlighting residents must demonstrate the qualifications, ability, and judgment to exercise the scope of practice of a resident physician, dentist, or podiatrist;

D. The Medical Program Director of the relevant residency program shall certify to the Medical Executive Committee and/or the Chief Executive Officer of the Hospital that the above requirements have been met;

E. The scope of practice for moonlighting residents shall extend to services performed under the general supervision of a member of the Medical Staff holding clinical privileges reflective of the patient care responsibilities given to the resident(s) that he or she is supervising; and

F. Moonlighting residents shall at all times be subject to the quality improvement activities conducted by the Hospital, and any moonlighting resident's scope of practice may be limited, modified, suspended, or terminated by the Medical Executive Committee based upon data and findings generated as part of said quality improvement activities, or for any other justified reason contemplated under these Bylaws or the Rules and Regulations of the Medical Staff.

7.10 Clinical Privileges for New Procedures. Requests for clinical privileges to perform a procedure not currently being performed at the Hospital or a new technique to perform an existing procedure will not be processed until the Medical Executive Committee has determined that the procedure will be offered by the Hospital and criteria for the clinical privilege(s) have been adopted.

BUSINESS CONFIDENTIAL
Printed copies are for reference only.
Please refer to the electronic
copy for the latest version.
Internal Distribution Only

ARTICLE 8 INVESTIGATIONS AND CORRECTIVE ACTION

8.1 Grounds for Inquiry and Review. An inquiry into the activities and professional conduct of any Medical Staff member or other practitioner may be requested, in accordance with Section 8.2 herein, whenever questions arise concerning the following:

A. Clinical competence;

B. Care or treatment of a patient or patients;

C. Management of a case or cases;

D. Known or suspected violation of these Bylaws; the policies, rules and regulations of the Medical Staff; or the responsibilities of staff membership set forth in the Bylaws;

E. Known or suspected noncompliance with the ethical rules of their profession;

F. Behavior or conduct adversely affecting patient welfare by reason of being below Hospital and/or Medical Staff standards or by reason of interfering with the orderly operation of the Hospital; or

G. Any conduct or activities adversely affecting patient care that are reasonably suspected of or reasonably believed to be disruptive, below professional standards of practice (including standards relating to the provision of quality and cost-effective health care), or detrimental to the interests of proper patient care at the Hospital.

8.2 Initiation of Inquiry and Review. Any person may bring a concern regarding a Medical Staff member to the attention of the Quality Department, the Screening Leadership Committee, the Multispecialty Peer Review Committee, the Chief of Staff, or the Vice President of Medical Affairs, each of which shall address the concern as set forth in the North Memorial Health Hospital Peer Review Policy.

8.3 Cooperation. It is the responsibility of every practitioner who is privileged by the Medical Staff or a member of the Professional Staff or Allied Health Staff to cooperate with any inquiry or investigation under this Article and/or under the North Memorial Health Hospital Peer Review Policy. Any practitioner or member subject to an inquiry or investigation must provide all information deemed by the inquiring body or investigating review committee to be relevant to any concerns regarding the practitioner's or member's qualification for continued appointment and/or clinical privileges, including but not limited to details of any adverse action taken with respect to such practitioner or member by any licensing or credentialing authority. A practitioner's or member's refusal or failure to provide requested information shall be independent grounds for suspension of appointment and/or clinical privileges.

BUSINESS CONFIDENTIAL
Printed copies are for reference only.
Please refer to the electronic
copy for the latest version.
Internal Distribution Only

8.4 Multispecialty Peer Review Committee. The Multispecialty Peer Review Committee will review inquiries in accordance with the North Memorial Health Hospital Peer Review Policy and may make a recommendation for disciplinary action(s) to the Medical Executive Committee. These recommendations may include, but are not limited to, the reduction, curtailment or suspension of clinical privileges, or the suspension or revocation Medical Staff, Professional Staff or Allied Health Staff membership.

8.5 Medical Executive Committee. Upon receipt of a written request or recommendation for discipline or corrective action or other referral of a matter from the Multispecialty Peer Review Committee, the Medical Executive Committee shall take one of the following actions:

A. Accept and ratify the request or recommendation;

B. Modify the request or recommendation;

C. Reject the request or recommendation;

D. Remand the matter to the Multispecialty Peer Review Committee for additional investigation, along with a request for answers to specific questions or inquiries; or

E. Appoint an investigative subcommittee of the Medical Executive Committee to further look into the matter.

F. The affected practitioner or member shall be notified within five (5) working days of any adverse action or recommendation approved by the Medical Executive Committee.

8.6 Hearings and Appeals. In the event the Medical Executive Committee recommends disciplinary or corrective action that constitutes grounds for requesting a fair hearing as provided in the Credentialing Policy, the procedures set forth in Credentialing Policy shall be followed.

8.7 Records. To ensure that complete and accurate records are maintained, the Medical Staff Office shall be custodian of all documents, reports and records that arise out of proceedings conducted pursuant to this Article 8. The Chief of Staff, Medical Executive Committee, and the Departments shall forward true and complete original copies of all documents, reports and records to the Medical Staff Office for the purpose of maintaining such records, and such records shall be kept by the Medical Staff Office for such time as is required by the applicable policy. Nothing in this Section shall preclude the Chief of Staff, the Medical Executive Committee, or a Department from maintaining its own files and records.

8.8 Suspension, Restriction, Relinquishment of Privileges. In addition to the provisions governing suspension and corrective action contained elsewhere herein, a Practitioner's or Professional Staff member's privileges may be suspended, restricted, or relinquished in the following circumstances:

BUSINESS CONFIDENTIAL
Printed copies are for reference only.
Please refer to the electronic
copy for the latest version.
Internal Distribution Only

A. Precautionary Suspension or Restriction of Privileges.

1. Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the President of the Hospital, the Chief of Staff, the relevant Department Chair, the Vice President of Medical Affairs, the Medical Executive Committee, or the Chairperson of the Board of Trustees is authorized to (1) afford the individual an opportunity to voluntarily refrain from exercising clinical privileges while the matter is being reviewed; or (2) suspend or restrict all or any portion of any individual's clinical privileges.

2. A precautionary suspension can be imposed at any time, including after a specific event, a pattern of events, or a recommendation by the Medical Executive Committee that would entitle the individual to request a hearing. When possible, prior to the imposition of a precautionary suspension, the person(s) considering the suspension will meet with the individual and review the concerns that support the suspension and afford the individual an opportunity to respond.

3. Precautionary suspension is an interim step in the professional review activity and does not imply any final finding regarding the concerns supporting the suspension.

4. A precautionary suspension is effective immediately and will be promptly reported to the President of the Hospital and the Chief of Staff. A precautionary suspension will remain in effect unless it is modified by the President of the Hospital or Medical Executive Committee.

5. Within five (5) days of the imposition of a suspension, the individual will be provided with a brief written description of the reason(s) for the suspension, including the names and medical record numbers of the patient(s) involved (if any). The notice will advise the individual that suspensions lasting longer than thirty (30) days must be reported to the National Practitioner Data Bank.

6. The relevant Collaborating Physician will be notified when the affected individual is a Professional Staff member.

7. In the event of a precautionary suspension, the Medical Executive Committee shall take the following steps:

a) Within a reasonable time, not to exceed fourteen (14) days of the imposition of the suspension, the Medical Executive Committee will review the reasons for the suspension and consider a formal investigative subcommittee.

b) After considering the reasons for the suspension, the Medical Executive Committee will determine whether the precautionary suspension should

BUSINESS CONFIDENTIAL
Printed copies are for reference only.
Please refer to the electronic
copy for the latest version.
Internal Distribution Only

be continued, modified, or lifted. The Medical Executive Committee may also determine whether to begin an investigation.

c) If the Medical Executive Committee decides to continue the suspension, it will send the individual written notice of this decision, including the basis for it.

d) There is no right to a hearing based on the imposition or continuation of a precautionary suspension. The procedures outlined above are deemed to be fair under the circumstances.

e) Upon the imposition of a precautionary suspension, the Chief of Staff will assign responsibility for the care of any hospitalized patients to another individual with appropriate clinical privileges. Whenever possible, consideration will be given to the wishes of the patient in the selection of a covering physician.

B. Automatic Relinquishment of Privileges. A Medical Staff, Professional Staff, or Allied Health Staff member's privileges and membership shall be automatically relinquished upon the occurrence of any of the following events:

1. Suspension, termination, limitation, or restriction of the member's state license through action of the Minnesota Board of Medical Practice, Minnesota Board of Dentistry, Minnesota Board of Podiatric Medicine, or other Minnesota professional licensing board;

2. Revocation, suspension, limitation, restriction, or probation of the member's Federal Narcotics Registration Certificate (DEA number);

3. Failure to maintain the specified amount of professional liability insurance;

4. Termination or revocation of the practitioner's Medicaid participation status, including termination of such status by the practitioner;

5. Disqualification of the practitioner by the Minnesota Department of Health or Minnesota Department of Human Services from having direct contact with patients;

6. The termination of the practitioner's employment with North Memorial Health Hospital; or

7. Upon an event triggering automatic relinquishment of privileges and/or membership as provided elsewhere in these Bylaws, the Credentialing Policy, the Rules and Regulations of North Memorial Health Hospital, or Department policy.

BUSINESS CONFIDENTIAL
Printed copies are for reference only.
Please refer to the electronic
copy for the latest version.
Internal Distribution Only

C. Temporary Suspensions. A temporary suspension of admitting privileges of a practitioner who has already been appointed to the Medical Staff or Professional Staff shall be imposed for the following:

1. Failure to continue to satisfy Threshold Criteria in these Bylaws, when such failure is not grounds for automatic relinquishment of privileges in accordance with Section 8.8(B) above;

2. Failure to timely complete medical records;

3. Failure to provide information or documentation requested by the Credentials Committee, the Medical Executive Committee, or a peer review committee;

4. Failure to attend a mandatory meeting; or

5. Failure to comply with a request for fitness for practice evaluation.

A temporary suspension shall be lifted once the practitioner satisfies the Threshold Criteria, corrects the delinquency in record completion, provides the requested information or documentation, attends the mandatory meeting, or undergoes the requested fitness for practice evaluation. If the practitioner fails to meet the conditions within thirty (30) days of a temporary suspension, the practitioner's privileges will be automatically relinquished or the practitioner will deemed to have voluntarily resigned his/her membership and privileges.

8.9 Effect of Termination or Relinquishment of all Privileges. In the event that all of a practitioner's privileges are terminated or relinquished (whether automatically or otherwise), upon the conclusion of the appeal process related to the termination or relinquishment of such privileges, if any, the practitioner's membership with the Medical Staff or the Professional Staff shall be automatically relinquished without opportunity for hearing or appeal.

8.10 Review of the Chief of Staff or a Department Chair. In the event that the Chief of Staff or any Department Chair is the practitioner under review, then the following substitutions shall take place: If the Chief of Staff is under review, then the functions to be performed by the Chief of Staff under this Article 8 shall be performed by the Vice Chief of Staff. If a Department Chair is under review, then the functions of the Department Chair under this Article 8 shall be performed by the Chair-Elect of the Department or, if there is none, the immediate past Department Chair.

8.11 Voluntary Limitation of Privileges. At any time during the discipline or corrective action process outlined in this Article 8, but prior to final action taken by the Medical Executive Committee pursuant to Section 8.5, the involved practitioner may voluntarily limit his or her privileges at the Hospital. Any such voluntary limitation will be reviewed to determine whether a report to any licensing agency, the National Practitioner Data Bank, or any other entity is required.

BUSINESS CONFIDENTIAL
Printed copies are for reference only.
Please refer to the electronic
copy for the latest version.
Internal Distribution Only

8.12 Notice of Limitation of Privileges. Whenever a practitioner's privileges are limited, either voluntarily or by action taken under these Bylaws, the Chief of Staff and the President of the Hospital, or their respective designees, shall see that appropriate written notice is provided to all potentially affected areas of the Hospital and Medical Staff, including, for example, Surgery, the Emergency Department, Nursing Administration, appropriate nursing stations, etc.

ARTICLE 9 POLICIES AND PROCEDURES; RULES AND REGULATIONS

9.1 Rules and Regulations. The Medical Executive Committee may promulgate such other rules and regulations as it determines necessary for the effective administration of the Medical Staff and to implement the general provisions or principles found in these Bylaws and the Credentialing Policy. Such rules and regulations must be consistent with these Bylaws. Only Medical Staff rules and regulations adopted by the Medical Executive Committee, the Medical Staff, and the Board of Trustees are binding upon Medical Staff members. The Medical Staff Rules and Regulations are attached hereto and by this reference made a part of these Bylaws. The Rules and Regulations may be amended by a majority vote of the Medical Executive Committee with the approval of the Medical Staff and the Board of Trustees.

9.2 Policies and Procedures. The Medical Executive Committee may promulgate such other policies and procedures or amendments to such, as it determines necessary for the effective administration of the Medical Staff. Such policies and procedures must be consistent with these Bylaws.

9.3 Member Challenge. Any member of the Medical Staff may raise a challenge to any rule or policy established by the Medical Executive Committee. In the event a rule, regulation or policy is felt to be inappropriate, any member may submit a petition signed by fifteen (15) percent of the members of the Active Medical Staff. The Medical Executive Committee shall review any such petition and shall have the authority to determine whether any change to a rule or policy is needed.

9.4 Action by Medical Staff. Regardless of whether the Medical Executive Committee is empowered to act on behalf of the Active Medical Staff on a given issue, the Medical Staff as a whole may, through action taken in accordance with Article 9, adopt amendments to these Bylaws, rules and regulations, and policies and procedures and propose such amendments directly to the Board of Trustees for the Board of Trustee's approval.

9.5 Departmental Rules and Regulations. Each Department of the Medical Staff shall promulgate its own rules and regulations for the effective administration of such Department. All such rules and regulations must be approved by the Medical Executive Committee and the Board of Trustees. The rules and regulations for each Department shall include, but are not limited to, provisions for the following: Statement of purpose and objectives;

B. Qualifications for Physician, Dentist, or Podiatrist membership in the Department;

C. Procedures and criteria for the granting and delineation of privileges;

BUSINESS CONFIDENTIAL
Printed copies are for reference only.
Please refer to the electronic
copy for the latest version.
Internal Distribution Only

D. Organization of the Department, including selection of committee members, appointment of officers, and duties of the Department Chair;

E. Meetings and meeting requirements;

F. Specialized policies and protocols of the Department; and

G. Qualifications and privileges of Professional Staff and Allied Health Staff assigned to the Department.

ARTICLE 10 ADOPTION, AMENDMENTS AND PERIODIC REVIEW

10.1 Adoption. These Bylaws together with the Rules and Regulations, or other policies adopted in accordance with Article 9, shall be adopted at any regular or special meeting of the Active Medical Staff or by electronic ballot and shall become effective when approved by the Board of Trustees.

10.2 Amendment. Amendments to these Bylaws of the Medical Staff must be approved by a two-thirds majority of the Medical Executive Committee and then submitted to the Medical Staff by emailed ballot. Amendments shall pass unless thirty (30) percent of mailed ballots that are received with thirty (30) days reject the amendments. Amendments so made shall be effective when approved by the Board of Trustees. The Medical Executive Committee shall have the power to adopt such amendments to these Bylaws as are, in the Medical Executive Committee's judgment, technical or legal modifications or clarifications, reorganization or renumbering, or amendments made necessary because of punctuation, spelling or other errors of grammar or expression. Such amendments shall be effective immediately and shall be permanent if not disapproved by the Medical Staff or the Board of Trustees within sixty (60) days of adoption by the Medical Executive Committee. The action to amend may be taken by a motion acted upon in the same manner as any other motion before the Medical Executive Committee. Immediately upon adoption, such amendments shall be sent to the President of the Hospital and posted for review by the Medical Staff for fourteen (14) days.

10.3 Periodic Review. These Bylaws and the rules, regulations and policies and procedures promulgated in accordance with these Bylaws, shall be reviewed from time to time by the Medical Executive Committee.

ARTICLE 11 MISCELLANEOUS

11.1 Captions. The captions and section-headings used in these Bylaws are for organizational and informational purposes only. They shall not be deemed to modify or abrogate the content of any terms or provisions contained in these Bylaws.

BUSINESS CONFIDENTIAL
Printed copies are for reference only.
Please refer to the electronic
copy for the latest version.
Internal Distribution Only

11.2 Medical Staff Role in Exclusive Contracting. The Hospital may consult with the Medical Staff regarding issues of quality of care associated with the establishment of exclusive arrangements for physician and/or professional services, and the Medical Executive Committee may independently report on such issues to the Board of Trustees as it deems appropriate, all in keeping with the responsibility of the Medical Staff to work to improve the quality of care in the Hospital.

11.3 Effect of the Bylaws. Upon adoption and approval as provided in these Bylaws in consideration of the mutual promises and agreements contained in these Bylaws, the Hospital and the Medical Staff, intending to be legally bound, agree that these Bylaws shall constitute part of the contractual relationship existing between the Hospital and the Medical Staff members, both individually and collectively.

11.4 Indemnification. The Hospital shall defend (or cover the costs incurred for the defense by the affected member), and cover settlements, judgments, and damages amounts on behalf of any member of the Medical Staff serving on or assisting with any Hospital or Medical Staff committee, or assisting in peer review or quality management activities involving care provided at the Hospital, when such defense costs, settlements, judgments or damages arise from such services or assistance, so long as the member acted in good faith.

References/Attachments:

Rules and Regulations

BUSINESS CONFIDENTIAL
Printed copies are for reference only.
Please refer to the electronic
copy for the latest version.
Internal Distribution Only

Adopted by the Medical Staff of North Memorial Health Robbinsdale Hospital on:

Date: 8/21/2024

Katie Vogt, MD, Chief of Staff

Approved by the Board of Trustees of North Memorial Health Care on:

Date: 8/21/2024

Ted Ferrara, President of the Board of Trustees

TABLE OF REVISIONS:

Date	Description of Change
08/11/2005	Updated Bylaws approved by the Board of Trustees
02/04/2010	Updated Bylaws approved by the Board of Trustees
12/31/2012	Updated Bylaws approved by the Board of Trustees
01/31/2016	Updated Bylaws approved by the Board of Trustees
12/13/2018	Updated Bylaws approved by the Board of Trustees
04/18/2019	Updated Bylaws approved by the Board of Trustees
08/21/2024	Updated Bylaws approved by the Board of Trustees