BYLAWS

OF

THE MEDICAL STAFF

OF

SHAWANO MEDICAL CENTER, INC.

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PREAMBLE

WHEREAS, Shawano Medical Center, Inc. is a non-profit corporation organized and operating under the laws of the State of Wisconsin; and

WHEREAS, its purpose is to serve as a general hospital, licensed by the State of Wisconsin, providing patient care, education and research; and

WHEREAS, it is recognized that the Medical Staff is responsible for the quality of medical care in the Hospital and must accept and discharge this responsibility, subject to the ultimate authority of the Hospital Governing Body, and that the cooperative efforts of the Medical Staff, the Chief Executive Officer and the Governing Body are necessary to fulfill the Hospital's obligations to its patients.

THEREFORE, the Practitioners practicing in this Hospital hereby organize themselves into a Medical Staff in conformity with these Bylaws.

DEFINITIONS

1. The term "Allied Health Professional" means a health professional or technician (other than a Practitioner) who may or may not be a Hospital employee, but who exercises independent judgment within an area of professional competence and who is qualified to render medical or surgical care at the Hospital under the supervision or in collaboration with a Practitioner.

2. The term "Chief Executive Officer" means the individual appointed by the Governing Body to act in its behalf in the overall management of the Hospital.

3. The term "Executive Committee" means the Executive Committee of the Medical Staff, unless specific reference is made to the Executive Committee of the Governing Body.

4. The term "ex officio" means an individual's service as a member of a body by virtue of an office or position held. Unless otherwise expressly provided in these Bylaws, ex officio means without voting rights.

5. The term "Governing Body" means the corporate Board of Trustees of the Hospital.

6. The term "Executive Committee" means the Executive Committee of the Medical Staff, unless specific reference is made in these Bylaws to the Executive Committee of the Governing Body.

7. The term "Health Status" means the physical, emotional and mental health status of an individual.

8. The term "Medical Staff" means the Hospital's organized component of physicians, podiatrists and dentists who are appointed by the Governing Body and granted clinical privileges for the purpose of providing adequate medical, podiatric and dental care for patients of the Hospital.

9. The term "Medical Staff member" or "Medical Staff membership" means the prerogative of Medical Staff participation and does not necessarily include as an incident thereto any clinical privilege whatsoever.

10. "Medical Staff Year" shall be a twelve-month period commencing the first day of February and ending on the thirty-first day of January each year.

11. The term "Peer Reviewer" means a Medical Staff member who is assigned responsibility for reviewing applications for appointment and requests for clinical privileges or otherwise participates in peer review activities in accordance with the Medical Staff Bylaws, Rules and Regulations and policies."

12. The term "Practitioner" means an appropriately licensed medical or osteopathic physician, dentist or podiatrist.

13. The term "prerogative" means a participatory and conditional right granted, by virtue of staff category or otherwise, to a Medical Staff member and exercisable subject to the conditions imposed in these and the Hospital Bylaws and in other Hospital and staff policies.

14. The terms "privileges" and "clinical privileges" mean the permission granted to a Practitioner or Allied Health Professional to render specific diagnostic, therapeutic, medical, dental, podiatric, or surgical services, which may or may not include permission to admit patients.

15. The term "Special Notice" means written notification sent by certified or registered mail, return receipt requested, or hand delivered to the addressee, or sent by facsimile with electronic confirmation of receipt.

16. The term "Type 1 Application" and "Type 2 Application" mean Medical Staff applications, as defined by the Expedited Credentialing Process Policy.

ARTICLE I - NAME

The name of this organization shall be Shawano Medical Center Medical Staff.

ARTICLE II - PURPOSES AND RESPONSIBILITIES

2.1 PURPOSES

The purposes of this organization are:

2.1-1 To provide that all patients admitted to, or treated in, any of the facilities of the Hospital receive quality care;

2.1-2 To seek an appropriate level of professional performance of all Practitioners and Allied Health Professionals authorized to practice in the Hospital through the appropriate delineation of the clinical privileges that each may exercise in the Hospital and through an ongoing review and evaluation of their performance in the Hospital;

2.1-3 To provide an appropriate educational setting that will maintain scientific standards and that will lead to continuous advancement in professional knowledge and skill;

2.1-4 To initiate and maintain rules and regulations for the administration of the Medical Staff and to provide a formal organizational structure through which the benefits of membership on the Medical Staff may be obtained by Practitioners and the obligations of membership may be fulfilled;

2.1-5 To provide a means whereby issues concerning the Medical Staff and Hospital may be discussed by the Medical Staff with the Governing Body and the Chief Executive Officer; and

2.1-6 To foster ongoing education of Practitioners and all other Hospital personnel in a continuing effort to improve the quality of patient care.

2.1-7 To promote quality care through development and adherence to policies and standards of the Hospital, including but not limited to state and federal regulatory bodies and private accreditation agencies.

2.1-8 To participate with the Governing Body in ongoing, comprehensive self-assessment of the quality of care furnished by the Hospital, including medical necessity and appropriateness of care.

2.2 RESPONSIBILITIES

The responsibilities of the Medical Staff are:

2.2-1 To provide an appropriate level of professional performance of all Practitioners and Allied Health Professionals authorized to practice in the Hospital through the appropriate delineation of the clinical privileges that each may exercise in the

Hospital and through a continuing review and evaluation of each Practitioner's and Allied Health Professionals performance in the Hospital;

2.2-2 To provide a continuing education program fashioned, at least in part, on the needs demonstrated through the patient care audit and other quality assessment and improvement programs;

2.2-3 To provide a utilization review program to allocate inpatient medical and health services based upon determinations of individual medical needs;

2.2-4 To provide an organizational structure that allows continuous monitoring of patient care practices;

2.2-5 To conduct reviews and evaluation of the quality of patient care through patient care audit and other quality assessment and improvement programs;

2.2-6 To recommend to the Governing Body action with respect to appointments, reappointments, staff category and corrective action;

2.2-7 To assure the Governing Body that appropriate clinical procedures have been delineated;

2.2-8 To account to the Governing Body for the quality and efficiency of patient care rendered to patients at the Hospital through regular reports and recommendations;

2.2-9 To initiate and pursue corrective action with respect to members of the Medical Staff when warranted;

2.2-10 To develop, administer, and seek compliance with these Bylaws, the rules and regulations of the Medical Staff, and other patient care related Hospital and Medical Staff policies;

2.2-11 To assist in identifying community health needs and in setting appropriate institutional goals and implementing programs to meet those needs;

2.2-12 To conduct all its affairs involving the Medical Staff, patients and employees in a manner and an atmosphere free of unlawful discrimination because of race, creed, color, national origin, ancestry, religion, sex, sexual orientation, marital status, age, newborn status, handicap, source of payment or any other unlawful basis;

2.2-13 To work with the Hospital in obtaining and maintaining acceptable accreditation status; and

2.2-14 To carry out such other responsibilities as may be delegated by the Governing Body.

ARTICLE III - MEDICAL STAFF MEMBERSHIP

3.1 NATURE OF MEDICAL STAFF MEMBERSHIP

Membership on the Medical Staff of the Hospital is a prerogative which shall be extended only to professionally competent Practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws. Appointment to and membership on the Medical Staff shall confer on the Practitioner only such clinical privileges and prerogatives as have been granted by the Governing Body in accordance with these Bylaws.

3.2 QUALIFICATIONS FOR MEMBERSHIP

3.2-1 Basic Qualifications. To be qualified for Medical Staff membership, Practitioners must:

a. Be licensed to practice medicine, dentistry or podiatry in the State of Wisconsin;

b. Document and support their background, training, experience, current competence, their adherence to the ethics of their profession, their good reputation and ability to work competently with other Practitioners and Allied Health Professionals, as well as Hospital's clinical staff, support staff, employees, and patients, with sufficient adequacy to demonstrate to the Medical Staff and the Governing Body that they will provide care to patients at a generally recognized level of quality, in an economically efficient manner, taking into account patient needs, available Hospital facilities and resources, and utilization standards in effect at the Hospital;

c. Provide evidence of graduation from a medical or osteopathic school meeting the standards of the Accreditation Council of Graduate Medical Education or the American Osteopathic Association, a dental school meeting the standards of the Council on Dental Education of the American Dental Association, or a school of podiatry meeting the standards of the Council on Education of the American Podiatry Association and meet the continuing education hours required for state licensure in their profession.

d. Submit and maintain on file at all times current evidence of continued licensure, DEA registration (if applicable) and financial responsibility in amounts which shall be determined by the Governing Body after consultation with the Executive Committee, which responsibility may be satisfied by malpractice insurance coverage meeting the requirements of Chapter 655 of the Wisconsin Statutes. This requirement may be satisfied by submitting copies of the Practitioner's current license, DEA registration and insurance certificate each time these documents change or are updated. The requirements for malpractice insurance coverage may be fulfilled by submitting evidence of coverage under the FTCA.

e. As part of their appointment and reappointment to the Medical Staff, or at any other time upon request of the Governing Body or the Executive Committee, certify that their current Health Status does not in any way impair their ability to safely exercise the clinical privileges requested or to care for patients, and the Governing Body may precondition appointment, reappointment, or the continuing exercise of any or all clinical privileges upon the Practitioner undergoing a health examination by a physician acceptable to the Governing Body or upon submission of any other reasonable evidence of current Health Status that may be requested by the Executive Committee or the Governing Body. Medical Staff membership and clinical privileges will not be denied on the basis of disability if, with reasonable accommodation, the Practitioner can safely perform the clinical privileges requested and safely care for patients.

f. For membership on the active Medical Staff, be able to render continuous care and supervision of their patients admitted to the Hospital; agree to accept staff committee assignments and to provide emergency care and emergency consultation within the scope of their privileges for patients admitted to or treated at the Hospital.

g. Be willing to participate in the discharge of Medical Staff committee and Hospital functions for which they are responsible by staff status, assignment, appointment, election or otherwise and discharge such other responsibilities as may be required by the Medical Staff, subject to Governing Body approval.

h. Be willing to participate in and be subject to the quality assessment and improvement activities of the Hospital and the Medical Staff.

i. Prepare and complete in a timely fashion, in accordance with these Bylaws, the Hospital's policies and procedures and applicable law, the required medical, patient and Hospital records for all patients they admit or in any way provide care to in the Hospital.

j. Document their conformity with rules and regulations at other hospitals with which they have been associated.

k. Not be barred from providing services in the Hospital under Chapter HFS 12 of the Wisconsin Administrative Code or any other state or federal law, rule or regulations, including but not limited to being excluded from participation in any federally funded health care program.

3.2-2 Additional Qualification Provisions. The following standards also apply to applicants for appointment or reappointment:

a. No Practitioner shall be entitled to membership on the Medical Staff or to the enjoyment of particular privileges merely by virtue of the fact that he or she is duly licensed to practice medicine, dentistry or podiatry in this or

in any other state, or by virtue of membership in any professional organization, or past or present privileges at another hospital.

b. No person who is otherwise qualified shall be denied privileges by reason of race, color, creed, handicap, disability, sex, or national origin, or on the basis of any other criterion unrelated to: (i) the delivery of quality patient care in the Hospital, (ii) professional qualifications, ability or judgment, (iii) the Hospital's purposes, needs and capabilities, (iv) community need or (v) any requirements set forth in these Bylaws.

c. The Governing Body shall have the sole responsibility to determine whether to select or reject Medical Staff based on the limitations of facilities, services, staff, support capabilities or any combination thereof. Decisions not to appoint or reappoint or grant privileges to an otherwise qualified Practitioner in accord with criteria of a Medical Staff development plan or due to the existence of any contracts for exclusive provision of clinical services, shall be made by the Governing Body. To the extent the geographic location of the applicant and his or her practice affects the ability of the applicant to provide effective continuity of care for Hospital patients, it shall also be a consideration.

d. Acceptance of membership on the Medical Staff shall constitute the Medical Staff member's agreement to strictly abide by the Principles of Medical Ethics of the American Medical Association, the Code of Ethics of the American Osteopathic Association, the Code of Ethics of the American Dental Association, or the Code of Ethics of the American Podiatry Association, whichever is applicable.

e. Practitioners shall provide evidence of their ability to work competently and cooperatively with other practitioners and members of the supporting staff.

f. No applicant who is currently excluded from any health care program funded in whole or in part by the federal government, including Medicare or Medicaid, is eligible or qualified for Medical Staff membership.

g. As part of their appointment and reappointment to the Medical Staff, Practitioners have a continuing obligation to promptly notify (but no more than 15 days after the Practitioner becomes aware of the event) the Chief Executive Officer of, and to provide such additional information as may be requested regarding, each of the following:

    1. the revocation, limitation or suspension of his or her professional license or DEA registration, any reprimand or other disciplinary action taken by any state or federal governmental agency relating to his or her professional license, or the imposition of terms of probation or limitation by any state;

2. loss of staff membership or privileges at any hospital or other health care institution, whether temporary or permanent, including all suspensions;

3. cancellation or change of professional liability insurance coverage;

4. receipt of a quality inquiry letter, an initial sanction notice, notice of proposed sanction or of the commencement of a formal investigation, or the filing of charges regarding health care matters by a Medicare quality improvement organization, the Department of Health and Human Services, the Wisconsin Department of Health and Family Services, the Office of the Inspector General or any other law enforcement agency or health regulatory agency of the United States or the State of Wisconsin;

5. any proposed or actual exclusion from any federally-funded health care program, any notice to the individual or his or her representative of proposed or actual exclusion or any pending investigation of the individual from any health care program funded in whole or in part by the federal government, including Medicare and Medicaid;

6. receipt of notice of the filing of any suit against the Practitioner alleging professional liability in connection with the treatment of any patient in or at the Hospital; and

7. any criminal conviction or pending criminal charges, any finding by a governmental agency that the applicant has been found to have abused or neglected a child or patient or has misappropriated the property of any patient

h. No applicant will be considered for Medical Staff membership unless they are also requesting clinical privileges to treat patients.

3.2-3 Applicable Laws. The professional conduct of members of the Medical Staff shall at all times be governed by applicable Wisconsin and federal laws. In the event the provisions of these Bylaws or the Rules and Regulations are not be in conformity with any Wisconsin or federal law or regulation, these Bylaws and Rules and Regulations shall be deemed automatically amended to comply with such law or regulation. As soon thereafter as may be practicable, such change shall be made in writing in the Bylaws or Rules and Regulations.

3.3 CONDITIONS AND DURATION OF APPOINTMENT

3.3-1 Appointment. Initial appointments and reappointments to the Medical Staff shall be made by the Governing Body. The Governing Body shall act on appointments, reappointments, or revocation of appointments only after there has been a recommendation from the Medical Staff as provided in these Bylaws and such

other credentialing policies as may be created, approved, and adopted by the Executive Committee and the Governing Board (collectively called "Credentials Policies"), provided that in the event of unwarranted delay on the part of the Medical Staff, the Governing Body may act without such recommendation on the basis of documented evidence of the applicant's, or staff member's, professional and ethical qualifications obtained from reliable sources.

3.3-2 HIPAA Compliance. As a condition of appointment to the Medical Staff and the grant of any clinical privileges, all Medical Staff members and other individuals granted any clinical privileges to provide patient care in the Hospital acknowledge they participate in the organized health care arrangement comprised of all clinically integrated settings in which patients receive services at the Hospital (the Shawano Medical Center OHCA). As a condition of appointment and of the grant of any clinical privileges, all individuals with clinical privileges must follow the privacy practices of the Shawano Medical Center OHCA, as set forth in its privacy policies and procedures, including its Notice of Privacy Practices, with respect to protected health information received through the Shawano Medical Center OHCA.

3.3-3 Initial Appointments One Year. Initial appointments shall be for a period of one year. Reappointments shall be for a period of not more than two Medical Staff Years.

3.3-4 Privileges Specific. Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted by the Governing Body, in accordance with these Bylaws and the Credentials Policy.

3.3-5 Applicant Commitments. Every application for staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgment of every Medical Staff member's obligations to provide continuous care and supervision of their patients, to abide by the Medical Staff Bylaws, Rules and Regulations, and policies, to accept committee assignments, to accept consultation assignments and to participate in quality assurance activities.

3.3-6 Medical Staff Participation. All Medical Staff members who do not provide care to Hospital patients within two Medical Staff Years shall pay a fee of $100 as part of their application for reappointment to the Medical Staff.

3.3-7 Credentials Policy. The procedures for appointment and reappointment to the Medical Staff and for the grant of clinical privileges are set forth in the Credentials Policy, the Expedited Credentialing Process Policy, Article V and Article VI of these Medical Staff Bylaws and the Credentials Policies.

3.4 BASIC RESPONSIBILITIES OF INDIVIDUAL MEDICAL STAFF MEMBERS

3.4-1 Responsibilities. Each member of the Medical Staff shall:

a. Provide his/her patients with care at the generally recognized professional level of quality and efficiency.

b. Abide by the Medical Staff Bylaws and all other adopted standards, policies, rules and procedures of the Hospital and Medical Staff.

c. Discharge such staff, committee and Hospital functions for which he/she is responsible by staff status, assignment, appointment, election or otherwise.

d. Prepare and complete in a timely fashion the required medical, patient and Hospital records for all patients he/she admits or in any way provides care to in the Hospital.

e. Abide by the:

1. Recognized code of ethics applicable to the Practitioner's profession.

2. Ethical principles adopted by the Hospital.

3. Requirements for accreditation of the Joint Commission on Accreditation of Healthcare Organizations.

f. Work with and relate to other Practitioners, residents, students, Allied Health Professionals, members of quality improvement organizations and accreditation bodies in a manner essential for maintaining a hospital.

g. Pledge not to receive from or pay to another Practitioner, either directly or indirectly, any part of any fee received for professional services.

h. Provide for continuous care and supervision of patients, and refrain from delegating the responsibility for diagnosis or care of Hospital patients to any individual who is not qualified to undertake the responsibility and who is not adequately monitored.

i. Agree to furnish the Hospital with a current list of alternates, in accordance with the Rules and Regulations of the clinical area to which the Practitioner has been assigned, or the telephone answering service number, which then can supply the name of the available alternate when the Practitioner is unavailable. Further, all Practitioners must provide emergency specialty call coverage as such is established by each clinical committee pursuant to rules approved by the Executive Committee and the Governing Body pertaining to services offered at Hospital.

j. Promptly (no more than 15 days after becoming aware of the situation) notify the Chief Executive Officer of, and provide such additional information as may be requested regarding each of the following:

1. the revocation, limitation or suspension of his/her professional license or DEA registration, any reprimand or other disciplinary action taken by any state or federal governmental agency relating to his/her professional license, or the imposition of terms of probation by any state;

2. loss of staff membership or privileges at any hospital or other health care institution, whether temporary or permanent, including all suspensions;

3. cancellation or change of professional liability insurance coverage;

4. receipt of a quality inquiry letter, an initial sanction notice, notice of proposed sanction or of the commencement of a formal investigation, or the filing of charges relating to health care matters, by a Medicare peer review organization, the Department of Health and Human Services, or any law enforcement agency or health regulatory agency of the United States or the State of Wisconsin; and

5. receipt of notice of the filing of any suit, request for mediation, or demand for compensation against the Practitioner alleging professional liability in connection with the treatment of any patient and;

6. any criminal conviction or pending criminal charge, any investigation and findings by a governmental agency that the

applicant has been found to have abused or neglected a child or patient or has misappropriated the property of any patient.

k. Provide services to medical assistance patients and other patients without personal physicians in accordance with the protocol adopted by the staff or Hospital delineating responsibilities for services to such patients.

l. Comply, on a continuing basis with federal and state laws and regulations applicable to the practice of their profession, including but not limited to proof of immunity against rubella and compliance with bloodborne pathogen standards, and periodic tuberculosis testing.

m. Discharge such other responsibilities as may be required by the Medical Staff, subject to the Governing Body's approval.

n. Work cooperatively with the quality assurance committee, the utilization review committee, the Executive Committee and administration to meet and practice within the guidelines established by the Hospital, it's Medical Staff or the local quality improvement organization, to minimize or eliminate disallowed admissions, to eliminate technical diagnosis entry and coding errors, to order or use supporting and ancillary services only when necessary, and to shorten length of stay at the Hospital where medically appropriate.

3.5 EXCLUSIVE CONTRACTS

The Hospital may enter into contracts with a Practitioner or group of Practitioners for the provision of certain Hospital-based services such as radiology, pathology, anesthesiology, or emergency room services. Where the contracts grant the contracting Practitioners the exclusive right to provide the services at issue, all Medical Staff members or other Practitioners who are not parties to the contracts shall automatically lose the right to exercise those clinical privileges exclusively granted to the contracting parties, without right to any hearing or appeal.

ARTICLE IV - STAFF CATEGORIES

4.1 THE MEDICAL STAFF

The Medical Staff shall be divided into Active, Provisional, Courtesy, and Active/Consulting categories. Each category shall have such duties and responsibilities, including the payment of staff dues, as may be required by the Governing Body and Medical Staff.

4.1-1 The Active Medical Staff. The Active Medical Staff shall consist of those Practitioners who regularly admit or attend patients in the Hospital, who are located closely enough to the Hospital to provide continuous care to their patients,

and who assume all the functions and responsibilities of membership on the Active Medical Staff including, where appropriate, committee, emergency service care and consultation assignments. Members of the Active Medical Staff shall be eligible to vote, to hold office, and to serve on Medical Staff committees, and shall be required to attend Medical Staff meetings. New members of the Active Medical Staff must have been members of the Provisional Medical Staff for a minimum of one year.

4.1-2 The Provisional Medical Staff. The Provisional Medical Staff shall consist of Practitioners who are being considered for advancement to membership on the Active or Courtesy Staff. They shall serve in this category for a minimum of one year before being eligible for advancement to the Courtesy or the Active Medical Staff. They shall be eligible to serve on committees and to vote on matters before such committees, except that Provisional staff members seeking advancement to the Courtesy Staff shall not be eligible to serve on the Executive or Credentials Committee. They shall be ineligible to vote or hold office in the Medical Staff. Provisional staff members seeking advancement to the Active Medical Staff shall be required to attend Medical Staff meetings.

a. All initial appointments to any category of the Medical Staff shall be provisional. Reappointments to provisional membership may not exceed two full years, at which time the failure to advance an appointee from provisional to an appropriate staff status shall be deemed a termination of his/her staff appointment. A provisional appointee whose membership is so terminated shall have the rights accorded by these Bylaws to a member of the Medical Staff who has failed to be reappointed.

b. At the conclusion of at least six months of performance observation, or at the option of the Credentials Committee upon completion of a review and satisfactory evaluation of the Practitioner's initial 15 cases, the Credentials Committee shall recommend that the observation process be terminated or continued for an additional period of monitoring. The Executive Committee may then extend the observation period for an additional six months without Governing Body involvement and without creating any right of the Practitioner to a hearing or review of the decision under these Bylaws.

c. Provisional staff members seeking advancement to the Active Medical Staff shall have their performance observed by one or more Active Staff members coordinated by the Credentials Committee to determine the eligibility of the provisional staff member for appropriate staff membership and for exercising the clinical or other privileges provisionally granted to them.

4.1-3 The Courtesy Medical Staff.

a. The Courtesy Medical Staff shall consist of Practitioners qualified for staff membership, but who only occasionally admit or attend patients in the Hospital or who act only as consultants. Except as provided in Section 4.1-3d below, Courtesy Medical Staff members shall not be eligible to vote or hold office in the Medical Staff. Courtesy Staff members may be eligible for appointment to certain Medical Staff committees, but not the Executive or Credentials Committee. Practitioners who provide only consulting services to members of the Medical Staff shall be assigned to the Courtesy Staff.

b. To advance to Courtesy Medical Staff, the Practitioner must have successfully completed at least one year as a member of the Provisional Staff.

c. If a Courtesy Staff member admits more than twenty patients to the Hospital per year, the Practitioner will be required to apply for advancement to either the Active Medical or Active/Consulting Staff at time of reappointment.

d. Courtesy staff members who serve as department directors or their designee shall be eligible to vote, and to serve on Medical Staff committees but shall not be allowed to hold office.

4.1-4 Active/Consulting Staff. The Active/Consulting Medical Staff shall consist of physicians who regularly admit or render professional services to patient in the hospital, who are located closely enough to the hospital to provide continuous care to their patients, but whose primary office is not located in the community, and who will assume all the functions and responsibilities of the Active/Consulting Medical Staff where appropriate, emergency care and consultation. Members of the Active/Consulting Medical Staff shall not be eligible to vote, to hold office, or be required to serve on Medical Staff committees, but shall be allowed to participate in active Medical Staff committees (with the exception of the Credentials and Executive Committees) as an ex officio member. Members of the Active/Consulting Medical Staff must be on the Active Staff of one or more area hospitals.

ARTICLE V - PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

5.1 APPLICATION FOR APPOINTMENT

5.1-1 Request for Application. Practitioners desiring appointment to the Medical Staff shall obtain an application and privilege request form from the Chief Executive Officer or his or her designee who will, in addition to the forms, supply the applicant with a copy of the Medical Staff Bylaws, applicable policies as appropriate, and the Rules and Regulations of the Medical Staff. The principles of medical ethics of the American Medical, Dental, Podiatric or Osteopathic Association, as appropriate, and the Hospital philosophy and objectives are available for review upon request.

5.1-2 Credentials Evaluated. The completed application shall be submitted to the Chief Executive Officer. After collecting the references and other materials deemed pertinent, the Chief Executive Officer shall transmit the application and all supporting materials to the Credentials Committee for evaluation. The Chief Executive Officer shall promptly notify the applicant of any problem in obtaining the information required, and it shall then be the applicant's obligation to obtain the required information.

5.1-3 Burden on Applicant. The applicant shall have the burden of producing adequate information for the proper evaluation of his/her education, training, experience competence, character, ethics, and other qualifications, and for resolving any doubts about such qualifications. Failure to adequately complete the application form, the withholding of requested information, or the providing of false or misleading information, whether intentional or not, shall be a basis for denial of membership on or removal from the Medical Staff.

5.1-4 Consent: To Inspection and Evaluation.

a. By applying for appointment to the Medical Staff, each applicant signifies his/her willingness to appear for interviews in regard to the application; authorizes the Hospital to consult with members of medical staffs of other hospitals with which the applicant has been associated, and with others who may have information bearing on the applicant's competence, character, experience, health, and ethical qualifications; consents to the Hospital's inspection of all records and documents that may be material to an evaluation of his/her professional qualifications and competence to carry out the clinical privileges requested, as well as of his/her moral and ethical qualifications for staff membership; releases from any liability all representatives of the Hospital and its Medical Staff for their acts performed in connection with evaluating the applicant and his/her

credentials; releases from any liability all individuals and organizations who provide information to the Hospital concerning the applicant's competence, ethics, character, health, and other qualifications for staff appointment and clinical privileges, including otherwise privileged or confidential information; agrees that any lawsuit brought by the applicant against an individual or organization providing information to a Hospital representative, or against a Hospital representative, shall be brought in a court, federal or state, in the state in which the defendant resides or is located; and authorizes and consents to the Hospital's providing other hospitals, medical associations, licensing boards and other organizations concerned with provider performance and the quality and efficiency of patient care with information the Hospital may have concerning him/her, and releases the Hospital from liability for doing so. The applicant shall sign and submit along with the completed application other consents, authorizations, and releases as the Medical Staff may require for the proper evaluation of the applicant's qualifications for membership.

b. The terms "Hospital" and "all representatives of the Hospital and its Medical Staff" as used in this Section are intended to include the Governing Body and its committees and members, and the Chief Executive Officer and his/her designees, the Medical Staff and all members of the Medical Staff who have committee or other responsibility for collecting and/or evaluating the applicant's credentials and/or acting upon his/her application and any authorized representatives of any of the foregoing. The term "character" is intended to include mental and emotional stability.

5.1-5 Agrees to Bylaws. The application form shall include a statement that the applicant agrees to provide continuous care to his or her patients and that the applicant has received and read the Bylaws, Rules and Regulations and applicable policies of the Medical Staff as appropriate, and agrees to be bound by their terms if granted membership and clinical privileges, and to be bound by their terms without regard to whether or not he/she is granted membership and clinical privileges in all matters relating to consideration of his/her application.

5.2 APPOINTMENT PROCESS

5.2-1 Credentials Committee Reports.

a. Within 60 days, or in unusual circumstances 90 days, after receipt of the completed application for membership and all accompanying information, the Credentials Committee shall make a written report of its investigation to the Executive Committee. Prior to making this report, the Credentials Committee shall examine the evidence of the character, professional competence, qualifications, and ethical standing of the Practitioner and shall determine, through information contained in references given by the Practitioner and from other sources available to the committee, including

an appraisal from the clinical committees in which privileges are sought and the applicant's National Practitioner Data Bank report (if available), whether the Practitioner has established and meets all of the necessary qualifications for the category of staff membership and the clinical privileges requested.

b. Each committee chairperson in each area in which the Practitioner seeks clinical privileges shall provide the Credentials Committee with specific, written recommendations for delineating the Practitioner's clinical privileges, and these recommendations shall be made a part of the report.

c. Together with its report, the Credentials Committee shall transmit to the President of the Medical Staff the completed application, all other documentation considered in arriving at the recommendation, and a recommendation that the Practitioner be either provisionally appointed to the Medical Staff or rejected for Medical Staff membership, or that the application be deferred for further consideration.

d. Where the National Practitioner Data Bank has not responded to the Hospital's inquiry within the time periods specified for action by the Credentials Committee, the Credentials Committee shall make its report and recommendation without consideration of the Data Bank report. The recommendation shall be noted as contingent upon subsequent receipt of a Data Bank report that does not contradict information known to the Credentials Committee at the time it formulated its initial report and recommendation. Upon receipt of a Data Bank report after the application has been forwarded to the Executive Committee, the Credentials Committee shall review the report and report to the Executive Committee regarding whether the Data Bank report alters the Credentials Committee's recommendation and, if so, how the recommendation is affected.

5.2-2 Executive Committee Recommendation. At its next regular meeting after receipt of the application and the report and recommendation of the Credentials Committee, the Executive Committee shall vote to recommend to the Governing Body that the application be accepted, deferred, or rejected. If accepted by a majority vote of the members present, a recommendation shall be made as to the privileges to be granted. If the action by a majority vote is to reject or defer, the Executive Committee shall set forth the reasons for this position in its recommendations to the Governing Body. If the National Practitioner Data Bank report has not yet been received, any favorable recommendation shall be conditioned upon subsequent receipt of a Data Bank report that does not contradict the information known at the time.

5.2-3 Executive Committee May Defer Action. When the recommendation of the Executive Committee is to defer the application for further consideration, it must be followed up within 90 days with a subsequent recommendation for

appointment with specified clinical privileges, or for rejection for staff membership.

5.2-4 Health Information. Any recommendation for appointment will be conditioned upon the applicant's completing documentation of his or her Health Status.. Such documentation will be completed by the applicant and assessed by the Executive Committee prior to any referral of the recommendation to the Governing Body. The Practitioner, upon request of the Governing Body or the Executive Committee, may be required to undergo such physical examinations as are deemed necessary to show that the Practitioner's Health Status will not negatively impact the Practitioner's ability to provide an adequate level of patient care. When so requested, a Practitioner shall authorize the reviewing committees and Governing Body of the Hospital to have full access to any and all medical records or treatment information concerning his or her Health Status.

5.2-5 Continued Favorable Recommendation. Unless the health information obtained requires further evaluation and reconsideration, when the recommendation of the Medical Staff Executive Committee continues to be favorable, the Chief Executive Officer shall promptly forward the recommendation, together with all supporting documentation, to the Governing Body.

5.2-6 Condition Warranting Further Review. If the health information obtained reveals a condition that warrants further investigation or evaluation, the Medical Staff Executive Committee shall refer the application back to the Credentials Committee. The Credentials Committee shall investigate the matter and report its findings back to the Medical Staff Executive Committee with any change in its recommendation on appointment or privileges within 30 days. The Medical Staff Executive Committee shall then affirm or revise its previous recommendation within 30 days receipt of such report.

5.2-7 Forward Application to Governing Body. When the recommendation of the Executive Committee is favorable to the Practitioner, the Chief Executive Officer shall promptly forward the application, together with all supporting documentation including the extent of the privileges recommended, to the Governing Body.

5.2-8 Adverse Recommendation by Executive Committee. When the recommendation of the Executive Committee is adverse to the Practitioner either in respect to appointment or clinical privileges, the Chief Executive Officer shall promptly so notify the Practitioner by Special Notice. No such adverse recommendation need be forwarded to the Governing Body until after the Practitioner has exercised or has been deemed to have waived his/her right to a hearing as provided in the Fair Hearing Plan Addendum to these Bylaws.

5.2-9 Adverse Recommendation Reconsidered. If, after the Executive Committee has considered the report and recommendation of the Hearing Committee and the hearing record, the Executive Committee's reconsidered recommendation is favorable to the Practitioner, it shall be processed in accordance with Section 5.2-10. If such recommendation continues to be adverse, the Chief Executive Officer shall promptly so notify the Practitioner by Special Notice. The Chief Executive Officer shall also forward the recommendation and documentation to the Governing Body, but the Governing Body shall not take any action on the recommendation until after the Practitioner has exercised or has been deemed to have waived his/her right to an appellate review as provided in the Fair Hearing Plan Addendum to these Bylaws.

5.2-10 Governing Body Action. Within 30 days after receipt of the Executive Committee's recommendation, or upon its own initiative if the Executive Committee has failed to act on an application, the Governing Body or its Executive Committee shall act in the matter. The Governing Body shall:

a. Refer the application back to the Executive Committee, indicating the reasons for such referral back and setting a time limit within which a subsequent recommendation is to be made; or

b. Accept and take final action on the application. If the National Practitioner Data Bank report has not yet been received, any decision to appoint shall be conditioned upon subsequent receipt of a Data Bank report that does not contradict the information known at the time of appointment.

5.2-11 Adverse Decision. If the Governing Body's decision is adverse in respect to either appointment or clinical privileges and is contrary to a favorable recommendation of the Executive Committee under circumstances where no right to hearing existed at the Executive Committee level, the Chief Executive Officer shall promptly notify the Practitioner of the adverse decision by Special Notice, and the adverse decision shall be held in abeyance until the Practitioner has exercised or has been deemed to have waived his/her rights under the Fair Hearing Plan Addendum to these Bylaws. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.

5.2-12 Governing Body May Refer Back to Staff. At its next regular meeting after all of the Practitioner's rights under the Fair Hearing Plan have been exhausted or waived, the Governing Body or its duly authorized committee shall act in the matter. The Governing Body's decision shall be conclusive, except that the Governing Body may defer final determination by referring the matter back to the Executive Committee for further consideration or, if applicable, submitting the matter to Joint Conference Committee pursuant to Section 5.2-13. Any referral back shall state the reasons therefore, shall set a time limit within which a subsequent recommendation to the Governing Body shall be made, and may

include a directive that an additional hearing be conducted to clarify issues which are in doubt. At its next regular meeting after receipt of such subsequent recommendation and consideration of new evidence in the matter, if any, the Governing Body shall make a decision either to appoint the Practitioner to the Medical Staff or to reject him/her for membership. All decisions to appoint shall include a delineation of the clinical privileges which the Practitioner may exercise.

5.2-13 Joint Conference Recommendation. Once the Practitioner has been deemed to have exercised or waived his/her rights under the Fair Hearing Plan Addendum, and the Governing Body's proposed final action remains contrary to the recommendation of the Medical Staff, the Governing Body shall submit the matter to a Joint Conference Committee for review and recommendation, and shall consider its recommendation before making its decision final.

5.2-14 Governing Body Action Final. When the Governing Body's decision is final, it shall send notice of the decision through the Chief Executive Officer to the Secretary of the Medical Staff, to the chairperson of the Executive Committee, and by Special Notice to the Practitioner. If the final decision is adverse as to membership or privileges, as identified in the Fair Hearing Plan, a report will be filed within 15 days of the date of final action with the appropriate licensing body for filing with the National Practitioner Data Bank.

5.3 REAPPOINTMENT PROCESS

5.3-1 Reappointment Prior to Expiration of Current Appointment. The Chief Executive Officer will provide each Staff member with a reappointment application form at least 90 days prior to the expiration of the member's current appointment. Each Staff member who desires reappointment shall submit his/her completed reappointment form to the Chief Executive Officer at least 60 days prior to expiration of his/her appointment. Failure without good cause to return the form shall be deemed a voluntary resignation from the staff and shall result in automatic termination of membership at the expiration of the member's current term. A Practitioner whose membership is so terminated shall be entitled to the procedural rights provided in the Fair Hearing Plan for the sole purpose of determining the issue of good cause. Upon receipt of any completed application form, the Hospital's designated representative will file an inquiry on the applicant with the National Practitioner Data Bank.

5.3-2 Credentials Committee Recommendation. At least 60 days prior to the expiration of each member's current appointment, the Credentials Committee shall review all pertinent information available on each Practitioner scheduled for periodic appraisal for the purpose of determining its recommendations for reappointments to the Executive Committee and for the granting of clinical privileges for the ensuing period, and shall transmit its recommendations, in writing, to the Executive Committee. If the National Practitioner Data Bank report has not yet been received, any favorable recommendation shall be conditioned upon

subsequent receipt of a Data Bank report that does not contradict the information known at the time. When non-reappointment or a change in clinical privileges is recommended, the reason for the recommendation shall be stated and documented.

5.3-3 Recommendations to Governing Body. At least 30 days prior to the expiration of each member's current appointment, the Executive Committee shall make written recommendations to the Governing Body, through the Chief Executive Officer, concerning the reappointment, non-reappointment, and/or clinical privileges of each Practitioner scheduled for periodic appraisal. If the National Practitioner Data Bank report has not yet been received, any favorable recommendation shall be conditioned upon subsequent receipt of a Data Bank report that does not contradict the information known at the time. When non-reappointment, a change in staff status or a change in clinical privileges is recommended, the reasons for the recommendation shall be stated and documented.

5.3-4 Non-reappointment Procedure. Thereafter, the procedure provided in Section 5.2 relating to recommendations on applications for initial appointment shall be followed.

5.3-5 Temporary Extension for Completion of Processing. If the reappointment process has not been fully completed by the end of the current appointment, applicants who have applied for reappointment shall maintain their former appointment status until the process is completed unless corrective action is taken which alters such status or unless the delay is due to the applicant's failure to timely submit a reappointment application form. Any temporary extension of appointment shall not create a right for automatic reappointment for the subsequent term.

5.3-6 Time Periods for Processing. Applications for appointment or reappointment shall be considered in a timely and good faith manner by all individuals and groups who are required by these Bylaws to act on applications and, except for good cause, shall be processed within the time periods specified in Sections 5.2 and 5.3. However, the time periods specified are to assist those named in accomplishing their tasks and shall not be deemed to create any right for the Practitioner to have his/her application processed within those periods nor to create a right for a Staff member to be automatically reappointed for the coming term.

5.3-7 Reapplication After Adverse Action.

a. An applicant who has received a final adverse action regarding appointment or clinical privileges or both and who did not exercise any of the hearing rights provided in the Fair Hearing Plan Addendum to these Bylaws shall not be eligible to reapply for the membership status or privileges that were the subject of the adverse action for a period of six months from the date of final adverse action or until he or she completes training identified by the Medical Staff as a prerequisite for the privileges.

b. An applicant who has received a final adverse action regarding appointment or clinical privileges or both and who exercised some or all of the hearing rights provided in the Fair Hearing Plan Addendum to these Bylaws shall not be eligible to reapply for the membership status or privileges that were the subject of the adverse action for a period of two years from the date of final adverse action.

c. An applicant who received a final adverse action regarding appointment due to misrepresentations in connection with his or her application or for conduct involving sexual harassment, assault, abuse, or additional terminal offenses shall never be eligible to reapply for membership and shall not be entitled to any hearing rights based on a refusal to process his or her application.

d. Any reapplication under this Section shall be processed as an initial application, but the applicant shall submit additional information as the Medical Staff or Governing Body may require in demonstration that the basis for the earlier adverse action no longer exists and that the basis will not reoccur.

e. If the recommendation of the Medical Staff or the action proposed by the Governing Body upon reapplication under Section 5.3-7b continues to be adverse, the scope of the hearing to which the Practitioner is entitled shall be limited to consideration of the additional information submitted in demonstration that the basis for the earlier adverse action no longer exists.

5.3-8 Administrative Denial. The Medical Staff Office may withhold application materials from an applicant or reject an application for appointment or reappointment to the Medical Staff or for clinical privileges without forwarding the application to the Credentials Committee, if it determines that the applicant does not hold a valid Wisconsin license, does not have adequate professional liability insurance, is not eligible to receive payment from the Medicare or Medical Assistance Program or is barred from providing services under Chapter HFS 12 of the Wisconsin Administrative Code. Applicants who are administratively denied under this Section do not have a right to a fair hearing under the Fair Hearing Plan but may submit evidence to the Medical Staff Office to refute the basis for the administrative denial.

5.4 CREDENTIALS POLICY

The contents of the application for Medical Staff appointment and reappointment, the elements considered in making recommendations for appointment and reappointment and certain procedures related to appointment and reappointment are set forth in the Hospital's Credentials Policy.

ARTICLE VI - CLINICAL PRIVILEGES

6.1 CLINICAL PRIVILEGES

Every individual with clinical privileges will have their privileges recommended and the quality of their care reviewed following the procedures of Article V above. The criteria considered in granting clinical privileges is set forth in the Credentials Policy.

6.2 TEMPORARY PRIVILEGES

6.2-1 Temporary Privileges Available. Upon receipt of an application for Medical Staff membership from an appropriately licensed and insured Practitioner, the Chief Executive Officer may, upon the basis of information then available which may reasonably be relied upon as to the competence and ethical standing of the applicant and with the written concurrence of the chairperson of the Executive Committee, grant temporary admitting and clinical privileges to the applicant; but in exercising these privileges, the applicant shall act under the supervision of a member of the Active Staff.

6.2-2 Temporary Privileges for Specific Patients. Temporary clinical privileges may be granted by the Chief Executive Officer, with approval of the Medical Staff President, for the care of a specific patient, to a Practitioner who is not an applicant for membership in the same manner and upon the same conditions as set forth in Section 6.2-1, provided that there shall first be obtained the Practitioner's signed acknowledgement that he/she has received and read copies of the Medical Staff Bylaws, Rules and Regulations, and applicable policies and agrees to be bound by their terms in all matters relating to temporary clinical privileges. Temporary privileges shall be restricted to the treatment of not more than five patients in any one year by any Practitioner, after which the Practitioner shall be required to apply for membership on the Medical Staff before being allowed to attend additional patients.

6.2-3 Privileges for Locum Tenens. The Chief Executive Officer, with approval of the Medical Staff President, may permit a physician serving as a "Locum Tenens" for a member of the Medical Staff to attend patients without applying for membership on the Medical Staff for a period not to exceed 45 days, providing all credentials have first been approved by the President of the Medical Staff.

6.2-4 May Have Specific Requirement. Special requirements of supervision and reporting may be imposed by the President of the Medical Staff on any Practitioner granted temporary privileges. Temporary privileges may be immediately terminated by the Chief Executive Officer, with approval of the Medical Staff President, upon notice of any failure by the Practitioner to comply with the special conditions.

6.2-5 Termination of Temporary Privileges. The Chief Executive Officer may at any time, upon the recommendation of the chairperson of the clinical committee

concerned or the President of the Medical Staff, terminate a Practitioner's temporary privileges effective as of the discharge of the Practitioner's patient(s) then under his/her care in the Hospital. However, when it is determined that the life or health of the patient(s) would be endangered by continued treatment by the Practitioner, the termination may be imposed by any person entitled to impose a suspension pursuant to the Fair Hearing Plan Addendum to these Bylaws, and the same shall be effective immediately. The appropriate committee chairperson or, in his/her absence, the President of the Medical Staff, shall assign a member of the Medical Staff to assume responsibility for the care of the terminated Practitioner's patient(s) until they are discharged from the Hospital. The wishes of the patient(s) shall be considered when feasible in selection of a substitute Practitioner. The termination or modification of temporary privileges shall not entitle the Practitioner involved to the procedural rights set forth in the Fair Hearing Plan.

6.2-6 Available Information Must Be Favorable. Temporary privileges shall be granted only when the information available reasonably supports a favorable determination regarding the requesting Practitioner's qualifications, ability and judgment to exercise the privileges requested. Before temporary privileges are granted, the Practitioner must acknowledge in writing that he/she has received and read the Medical Staff Bylaws, Rules and Regulations and applicable policies, and that he/she agrees to be bound by the terms thereof in all matters relating to his/her temporary privileges.

6.2-7 No Right to Temporary Privileges. No Practitioner is entitled to temporary privileges as a matter of right. A Practitioner shall not be entitled to the procedural rights afforded by the Fair Hearing Plan Addendum to these Bylaws because of his or her inability to obtain temporary privileges or because of any termination, modification or suspension of temporary privileges.

6.3 EMERGENCY PRIVILEGES

In the case of emergency, any Practitioner, to the degree permitted by his/her license and regardless of staff status or lack of it, shall be permitted and assisted to do everything possible to save the life of a patient using every facility of the Hospital necessary, including the calling for any consultation necessary or desirable. When an emergency situation no longer exists, the Practitioner must request the privileges necessary to continue to treat the patient. In the event the privileges are denied or the Practitioner does not desire to request privileges, the patient shall be assigned to an appropriate member of the Medical Staff. For the purpose of this Section, an "emergency" is defined as a condition in which serious permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

6.4 TELEMEDICINE PRIVILEGES

Any physician who diagnoses or treats hospital patients through a telemedicine link, must be privileged and credentialed at Shawano Medical Center as a Courtesy Physician. Credentialing material received from an accredited JCAHO facility will be taken under consideration as part of the physician's request to be credentialed and privileged at Shawano Medical Center. All requests will be forwarded to the CEO or their designee to be processed through Section 5.1 Application for Appointment process (Article V – Procedures for Appointment and Reappointment).

ARTICLE VII - CORRECTIVE ACTION AND HEARING RIGHTS

7.1 PROCEDURE

7.1-1 Hearing Rights. Whenever privileges are denied, suspended, reduced or terminated; staff membership is denied, suspended, or revoked; admitting prerogatives are limited; consultation is required, or terms of probation/preceptorship which limit a Practitioner's practice are imposed or staff category is denied or reduced, the Practitioner affected shall have the right to have a hearing in the manner and according to the limits set forth in the Fair Hearing Plan Addendum.

7.1-2 Corrective Action. All Medical Staff members shall be subject to corrective action. The grounds for requesting action, actions that may be taken in response to the request, when the action is deemed adverse and when the Practitioner is entitled to a fair hearing, are set forth in the Fair Hearing Plan Addendum to these Bylaws.

ARTICLE VIII - OFFICERS

8.1 OFFICERS OF THE MEDICAL STAFF

8.1-1 The officers of the Medical Staff shall be:

a. President

b. Vice-President

c. Secretary-Treasurer

8.2 QUALIFICATIONS OF OFFICERS

Officers must be members of the Active Medical Staff at the time of nomination and election, and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved. The officers shall be Practitioners with demonstrated competence in their fields of practice and demonstrated qualifications on the basis of experience and ability to direct the medico-administrative aspects of Hospital and Medical Staff activities.

8.3 ELECTION OF OFFICERS

8.3-1 Election at Annual Meeting. Officers shall be elected at the Annual Meeting of the Medical Staff. Only members of the Active Medical Staff and Courtesy Medical Staff members identified in Section 4.1-3d shall be eligible to vote.

8.3-2 Nominating Committee. The Nominating Committee shall consist of three members of the Active Medical Staff appointed by the President of the Medical Staff. All nominees must be members in good standing of the Active Medical Staff. The Nominating Committee shall present one or more nominees for each office to the Medical Staff to the Governing Body for approval prior to submission of the nominee to the Medical Staff at the annual meeting.

8.3-3 Nominations From Floor. Nominations may also be made from the floor at the time of the Annual Meeting or be made by petition signed by at least four members of the Active Staff and filed with the Secretary of the Medical Staff at least seven days prior to the Annual Meeting. Nominations from the floor shall require at least three seconds, and the individual nominated must affirmatively signify his/her willingness to serve if elected.

8.3-4 Election Procedure. Officers shall be elected at the annual meeting. Only members of the Active Medical Staff and Courtesy Medical Staff members identified in Section 4.1-3d shall be eligible to vote. Voting will be by voice vote and voting by written proxy will be permitted. Office holders shall be selected by majority vote of those present (either in person or by proxy) and entitled to vote, and their selection shall be confirmed by the Governing Body. If there are more than two candidates for an office and none receives a majority on the first vote, a runoff election will immediately be held between the two candidates receiving the highest number of votes.

8.4 TERM OF OFFICE

All officers shall serve a two year term from the election date or until a successor is elected. Officers shall take office on the first day of the Medical Staff Year.

8.5 VACANCIES IN OFFICE

Vacancies in office during the Medical Staff Year, except for the presidency, shall be filled by the Executive Committee. If there is a vacancy in the office of the president, the Vice-President shall serve out the remaining term.

8.6 DUTIES OF OFFICERS

8.6-1 President. The President shall serve as the chief administrative officer of the Medical Staff to:

a. act in coordination and cooperation with the Chief Executive Officer in all matters of mutual concern within the Hospital;

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

c. serve on the Executive Committee as its Chairperson, with voting privileges;

d. serve as "ex-officio" member of all other Medical Staff committees (without vote);

e. be responsible for the enforcement of Medical Staff Bylaws, Rules and Regulations, and policies, for implementation of sanctions where these are indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a Practitioner;

f. appoint, unless otherwise expressly provided, committee members and chairpersons to all standing, special, and multi-disciplinary Medical Staff committees except the Executive Committee;

g. represent the views, policies, needs, and grievances of the Medical Staff to the Governing Body and to the Chief Executive Officer of the Hospital;

h. serve as the responsible representative for the Medical Staff, receive and interpret the policies of the Governing Body to the Medical Staff and report to the Governing Body on the performance and maintenance of quality and efficiency with respect to the Medical Staff's designated responsibility to provide medical care;

i. be responsible for the educational activities of the Medical Staff;

j. be the spokesperson for the Medical Staff in its external professional and public relations, or designate another Practitioner to act in that capacity;

k. perform such other functions as may from time to time be delegated by the Medical Staff or the Governing Body; and

l. serve as medico-administrative liaison with the Governing Body and the Chief Executive Officer, through monthly reports presented to the Governing Body and the Medical Staff by the President of the Medical Staff who, by virtue of his/her office, is a voting member of the Governing Body , in conjunction with the Chief Executive Officer who meets regularly with the Executive Committee (or Medical Staff as a whole) and the Governing Body.

8.6-2 Vice-President. In the absence of the President, the Vice-President shall assume all the duties and have the authority of the President. The Vice-President shall be a member of the Executive Committee and other committees as assigned. The Vice-President shall automatically succeed the President when the latter fails to serve for any reason. The Vice-President shall perform such additional duties as may be assigned by the President of the Medical Staff, the Executive Committee or the Governing Body.

8.6-3 Secretary-Treasurer. The Secretary-Treasurer shall be a member of the Executive Committee. The Secretary-Treasurer shall be responsible for ensuring accurate and complete minutes of all Medical Staff meetings are kept that reflect the general nature of the business conducted, the decisions reached, and the findings and recommendations of the Medical Staff, and perform such other duties as ordinarily pertain to the office. In the absence of the President and the Vice President, the Secretary-Treasurer shall assume all the duties and have the authority of the President.

8.7 REMOVAL OF OFFICERS

8.7-1 An officer of the Medical Staff may be removed from office by a two-thirds (2/3) majority of the Governing Body or of the members of the Active Medical Staff eligible to vote. Permissible bases for removal include, without limitation:

a. failure to continuously meet the qualifications for office;

b. failure to timely and appropriately perform the duties of the office held;

c. if the officer is under corrective action proceedings under the Corrective Action Procedures and Fair Hearing Plan; and

d. absence from four consecutive staff meeting without excuse.

ARTICLE IX - COMMITTEES

9.1 ORGANIZATION OF COMMITTEES

Committees shall be "standing" and "special." Each standing committee will be organized as a division of the staff as a whole, except as otherwise specified in this Bylaws or by policy. Each will have a chairperson. The members and chairperson of each committee shall be appointed by the Medical Staff President, except the Executive Committee, to serve two-year terms. Each committee shall have a minimum of three members.

9.2 FUNCTIONS OF COMMITTEES

9.2-1 The committees shall be responsible to the Medical Staff as a whole and shall have the general supervision over the clinical work falling within their clinical committee area.

9.2-2 Each committee shall meet regularly as indicated in this Article IX or by Medical Staff policy.

9.2-3 Each committee shall prepare a report on its proceedings to be presented at the monthly Medical Staff meeting.

9.3 EXECUTIVE COMMITTEE

9.3-1 Composition

a. The Executive Committee shall be a standing committee and shall consist of the officers of the Medical Staff and the past President, who shall be eligible to vote. Further, the Chief Executive Officer shall be an ex-officio, non-voting member of the Executive Committee. The majority of Executive Committee members must be fully licensed physicians who are members of the Active Medical Staff.

b. The Executive Committee is a major component in the Hospital's program organized and operated to help improve the quality of health care in the Hospital and its activities will be conducted in a manner consistent with the provisions of §§ 146.37 and 146.38 of the Wisconsin Statutes. The peer review protections of these statutes, including the protection of the confidentiality of committee records and proceedings are intended to apply to all activities of the committee relating to improving the quality of health care and include activities of the individual members of the committee as well as other individuals designated by the committee to assist in carrying out the duties and responsibilities of the committee including but not limited to participating in monitoring plans.

9.3-2 Duties. The duties of the Executive Committee shall be:

a. to represent and to act on behalf of the Medical Staff subject to such limitations as may be imposed by these Bylaws;

b. to coordinate the activities and general policies of the various committees;

c. to receive and act upon committee reports and recommendations from the clinical committee and officers of the staff;

d. to implement policies of the Medical Staff not otherwise the responsibility of the committees;

e. to provide liaison between the Medical Staff, the Chief Executive Officer, and the Governing Body;

f. to recommend action to the Chief Executive Officer on matters of a medico-administrative nature;

g. to make recommendations on Hospital management matters (for example, long-range planning) to the Governing Body through the Chief Executive Officer;

h. to fulfill the Medical Staff's accountability to the Governing Body for the medical care rendered to patients in the Hospital. The committee shall monitor all medical care quality assessment and improvement activities, make recommendations to the Governing Body on the organization of such activities and be responsible for taking any necessary and appropriate action or delegating the responsibility for such action to the appropriate committee or group;

i. to ensure that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the Hospital;

j. to provide for the preparation of all meeting programs, either directly or through delegation to a program committee or other suitable agent;

k. to investigate and review the credentials of all applicants and to make recommendations for Medical Staff membership and Affiliate status and delineation of clinical privileges;

l. to review periodically all information available regarding the performance and clinical competence of staff members and others with clinical privileges, and as a result of such reviews, to make recommendations for reappointments and renewal or changes in clinical privileges;

m. to take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all members of the Medical

Staff and Affiliates, including the initiation of, and/or participation in, Medical Staff corrective actions, appeals or review measures when warranted;

n. to be regularly involved in Medical Staff management, including the enforcement of Medical Staff Rules and Regulations, and committee affairs;

o. to be responsible for making recommendations to the Governing Body relating to the structure of the Medical Staff; the mechanisms used to review credentials and delineate individual clinical privileges; the mechanisms by which membership on the Medical Staff may be terminated; the mechanism for fair hearing procedures; and the mechanism used to conduct, work at and revise the quality assessment and improvement activities of the Medical Staff;

p. to report at each general staff meeting or any special business meeting;

q. to review, approve, and recommend to the Governing Body rules of all clinical committees; and

r. to perform such other functions as may from time to time be delegated by the Medical Staff or Governing Body.

9.3-3 Meetings. The Executive Committee shall meet monthly (except for the months of July and September) and maintain a permanent record of its proceedings and actions. This committee meets as a committee of the whole at monthly Medical Staff meetings and will hold other meetings as necessary.

9.4 STANDING COMMITTEES

The President of the Medical Staff in conjunction with the Executive Committee shall establish, by policy, such standing committees as required for the effective and efficient operation of the Hospital and for the proper discharge of the Medical Staff's responsibility for assuring quality patient care.

9.5 COMMITTEES FOR SPECIAL SERVICES AND/OR FUNCTIONS

9.5-1 Special Committees.

a. Special Committees shall be established by the President of the Medical Staff as required for the effective and efficient operation of the Hospital and for the proper discharge of the Medical Staff's responsibility for assuring quality patient care.

b. Each special committee's membership, chairman, and purpose shall be clearly stated in a written charge for the committee prepared by the President of the Medical Staff at the time the committee is established.

c. Special committees shall serve for the term designated upon appointment, but in no case shall the term exceed that of the President who established the committee. The succeeding President, however, may reinstate the committee at the first regularly scheduled meeting following the annual meeting of the Medical Staff.

d. A special committee shall have no power of action except that specifically stated and recorded at its establishment.

e. Special committees shall prepare minutes of their deliberations and activities and reports and recommendations to the Executive Committee at regular meetings.

9.5-2 Committee of the Whole. A committee of the whole, consisting of all members of the Active Medical Staff and Courtesy Staff serving pursuant to Section 4.1-3d in good standing shall perform those functions and responsibilities delegated to the Medical Staff that are not assigned to a particular standing or special committee and those functions and responsibilities assigned to a named Medical Staff committee where no such committee exists. The Medical Staff shall appropriately participate in the maintenance and improvement of appropriate professional standards throughout the Hospital by participation on the committee of the whole, as part of the Hospital's program organized and operated to help improve the quality of health care. Their activities will be conducted in a manner consistent with the provisions of §§ 146.37 and 146.38 of the Wisconsin Statutes. The peer review protections of these statutes, including the protection of the confidentiality of committee records and proceedings, are intended to apply to all activities of the committee and include activities of the individual members of the committee as well as other individuals designated by the committee to assist in carrying out the duties and responsibilities of the committee including but not limited to participating in monitoring plans. The President of the Medical Staff shall serve as chairman of the committee of the whole.

9.6 COMBINATION OF COMMITTEE FUNCTIONS

9.6-1 Should the Medical Staff determine that certain functions of the committees can be appropriately provided by combining meetings, such can be done so long as:

a. necessary support personnel are able to participate;

b. separate minutes and reports are kept; and

c. Medical Staff members retain separate responsibility for performing the necessary review, research, and recommendation functions.

ARTICLE X - MEDICAL STAFF MEETINGS

10.1 ANNUAL AND REGULAR MEETINGS

An annual staff meeting shall be held before the end of the Medical Staff Year. The agenda of such meetings shall include the election of officers and reports of review and evaluation of the work done in the clinical areas and the performance of the required Medical Staff functions. Monthly staff meetings will be held the fourth Tuesday of each month, except in July and December when there shall be no meeting.

10.2 SPECIAL MEETINGS

10.2-1 Who Shall Call Meeting. The President or the Executive Committee may call a special meeting of the Medical Staff at any time. In addition, The President shall call a special meeting within 30 days after receipt of a written request for same, signed by not less than ten percent of the Active Staff, and stating the purpose for the meeting. The Executive Committee shall designate the time and place of any special meeting.

10.2-2 Methods of Notification. Written or printed notice stating the place, day, and hour of any special meeting of the Medical Staff shall be delivered, either personally or by mail, to each member of the Active Staff and Courtesy Staff identified in Section 4.1-3d not less than four nor more than 30 days before the date of the meeting by, or at the direction of, the President or the Secretary of the Medical Staff. If mailed, the notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail addressed to each staff member at his/her address as it appears on the records of the Hospital. Notice may also be sent to members of other Medical Staff groups who have so requested. The attendance of a member of the Medical Staff at a meeting shall constitute a waiver of notice of the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

10.3 QUORUM

The presence of fifty percent of the total membership of the Active Medical Staff and Courtesy Staff identified in Section 4.1-3d at any regular, annual, or special meeting shall constitute a quorum for purposes of these Bylaws.

10.4 MEDICAL STAFF ATTENDANCE REQUIREMENTS

Each member of the Active Medical Staff and of the Provisional Medical Staff seeking advancement to the Active Medical Staff shall be expected to attend the regular annual meeting of the Medical Staff and at least fifty percent or more of all Medical Staff meetings each year. Unless excused for cause by the Executive Committee, failure to meet the annual attendance requirements shall be grounds for corrective action leading to possible revocation of Medical Staff membership. Reinstatement of staff members whose membership has been revoked because of absence from staff meetings shall be

made only upon application, and the applications shall be processed in the same manner as applications for initial appointment. Absence from three consecutive meetings without prior excuse shall constitute a resignation from the Medical Staff.

ARTICLE XI - COMMITTEE MEETINGS

11.1 REGULAR MEETINGS

Committees may, by resolution, provide the time for holding regular meetings without notice other than the resolution.

11.2 SPECIAL MEETINGS

A special meeting of any committee may be called by, or at the request of, the chairperson, by the President of the Medical Staff, or by one-third of the group's members, but not less than two members.

11.3 NOTICE OF MEETINGS

With the exception of the Executive Committee, written or oral notice stating the place, day, and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be given to each member of the committee not less than two days before the time of the meeting by the person or persons calling the meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited in the United States mail addressed to the member at his/her address as it appears on the records of the Hospital, with postage prepaid. The attendance of a member at a meeting shall constitute a waiver of notice of the meeting.

11.4 QUORUM

Fifty percent of the Active Medical Staff members and the Courtesy Staff members identified in Section 4.1-3d on the committee, but not less than two members, shall constitute a quorum at any meeting.

11.5 MANNER OF ACTION

The action of a majority of the members present at a meeting at which a quorum is present shall be the action of the committee. Action may be taken without a meeting by unanimous consent in writing, setting forth the action taken, signed by each member entitled to vote. No business shall be transacted at any special meeting except that stated in the meeting notice.

11.6 RIGHTS OF EX-OFFICIO MEMBERS

Persons serving under these Bylaws as "ex-officio" members of a committee shall have all rights and privileges of regular members except they shall not be counted in determining the existence of a quorum, nor shall they vote.

11.7 MINUTES

Minutes of each regular and special meeting of a committee shall be prepared, and shall include a record of the attendance of members and the vote taken on each matter. Each committee shall maintain a permanent file of the minutes of each meeting.

11.8 ATTENDANCE REQUIREMENTS

11.8-1 Fifty Percent Attendance.

a. Each member of the Active Medical Staff and of the Provisional Medical Staff seeking advancement to the Active Medical Staff shall be required to attend not less than fifty percent of all meetings of each committee of which he/she may be a member in each year. Failure to meet the annual attendance requirements, unless excused by the chairperson for good cause, shall be grounds for corrective action leading to the removal from committee, and to possible revocation of Medical Staff membership in the same manner, and to the same effect, as provided in Section 10.4, of these Bylaws. Committee chairpersons shall report all attendance requirement failures to the Executive Committee for action.

b. If a member fails to attend the required number of meetings, the member shall be first sent a letter so stating. If within the following six months the member does not meet required attendance (without adequate excuse), the matter shall be referred to the Credentials Committee for recommendation then brought before the Executive Committee for action.

11.8-2 Executive Committee Action.

a. Failure by a Practitioner to attend any meeting with respect to which he/she was given notice that attendance was mandatory, unless excused by the Executive Committee upon a showing of good cause, shall be brought to the attention of the Executive Committee, which shall proceed to take whatever action is deemed advisable.

b. In all other cases, if the Practitioner shall make a timely request for postponement, supported by an adequate showing that his/her absence will be unavoidable, the presentation may be postponed by the chairperson of the committee, or by the Executive Committee if the chairperson is the Practitioner involved, until not later than the next regular committee meeting; otherwise, the pertinent clinical information shall be presented and discussed as scheduled.

ARTICLE XII - IMMUNITY FROM LIABILITY

12.1 CONDITIONS FOR MEDICAL STAFF PREROGATIVES

As a part of the evaluation and education function of the Medical Staff, the following shall constitute express conditions for application for, reapplication to, or exercise of clinical privileges and/or Medical Staff membership by any individual at the Hospital.

12.1-1 Disclosure Privileged. Any act, communication, recommendation, report or disclosure with respect to the individual, performed or made at the request for an authorized representative of this or any other health care facility for the purpose of achieving or maintaining quality patient care at this Hospital or any other health care facility, shall be privileged to the fullest extent permitted by law.

12.1-2 Privilege Extended to Non-Staff. This privilege shall extend to members of the Hospital Medical Staff and its Governing Body, its other Practitioners and personnel, including the administrative staff and its designated representatives, and to third parties who supply information to any at this Hospital authorized to receive, release, or act upon such information. For the purpose of this Article XII, the term "third parties" means both individuals and organizations from whom information has been requested by or who have received information from an authorized representative of the Hospital (including the Governing Body and the Medical Staff), and includes individuals, health care institutions, governmental bodies, quality improvement organizations and any other person or entity with relevant information.

12.1-3 Immunity From Liability. To the fullest extent permitted by law, there shall be absolute immunity from civil liability arising from any such act, communication report, recommendation, or disclosure, even when the information involved would otherwise be deemed privileged.

12.1-4 Applies to All Patient Care. The immunity and privileges referred to above shall apply to any activities, reports, recommendations, disclosures, or communications performed or made in connection with this Hospital's or any other health care institution's activities related, but not limited to:

a. Applications for appointment or clinical privileges;

b. Periodic reappraisals for reappointment or clinical privileges;

c. Corrective action, including suspension;

d. Hearings and appellate reviews;

e. Medical care evaluations;

f. Utilization reviews;

g. Profiles and profile analyses;

h. Malpractice loss prevention; and

i. Other Hospital or committee activities related to maintaining quality and efficient patient care and appropriate professional conduct including but not limited to monitoring of members of the Medical Staff, any other Practitioner, or of a Medical Staff Affiliate under a monitoring protocol established by the Medical Staff.

12.1-5 Scope of Coverage. The acts, communications, reports, recommendations, and disclosures referred to in this Article XII may relate to an individual's professional qualifications, clinical competence, character, judgment, Health Status, ethics, or any other matter that might directly or indirectly have an effect on patient care.

12.1-6 Indemnification. Each individual who exercises clinical privileges or performs any service that is monitored under the monitoring protocols established under these Bylaws, as a condition of exercising the clinical privileges or performing the service, shall indemnify and hold harmless all members of the Medical Staff and the Governing Body, the Chief Executive Officer and their designated representatives from any liability arising from or out of the services performed by the individual being monitored, including but not limited to claims of malpractice, negligent supervision, and any other basis. The exercise of clinical privileges or performance of any service that is monitored constitutes the individual's acceptance of the terms of this indemnification agreement.

12.1-7 Releases. In furtherance of the foregoing, each individual shall, upon request of the Hospital, execute releases in accordance with the tenor and import of this Article XII in favor of the individuals and organizations specified in Section 12.1-2. However, execution of releases is not a prerequisite to the effectiveness of this Article.

12.1-8 Not a Limitation. The consents, authorizations, releases, rights, privileges and immunities provided by the Credentials Policy for the protection of this Hospital's Practitioners, other appropriate Hospital officials and personnel and third parties, in connection with applications for initial appointment, shall also be fully applicable to the activities and procedures covered by this Article XII. All provisions in these Bylaws and in other forms used in the credentials process relating to authorizations, confidentiality of information and immunity from liability are in addition to other immunities provided by law and not in limitation of such immunities.

ARTICLE XIII - GENERAL PROVISIONS

13.1 MISCELLANEOUS

13.1-1 Medical Staff Rules and Regulations. The Medical Staff shall adopt rules and regulations as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Governing Body. These shall relate to the proper conduct of Medical Staff organizational activities, as well as embody the level of practice that is to be required of each Practitioner and Affiliate in the Hospital. The rules and regulations shall be a part of these Bylaws, except that they may be amended or repealed at any regular meeting at which a quorum is present and without previous notice or at any special meeting on notice, by a two-thirds vote of the Active Medical Staff present, provided a quorum is present at the time of the vote. The changes shall become effective when approved by the Governing Body.

13.1-2 Adherence to Rules and Regulations. Rules and regulations promulgated by a committee or the Medical Staff as a whole, adopted by the Medical Staff, and approved by the Governing Body shall apply to and are to be observed by all Practitioners, Allied Health Professionals and Hospital staff, unless otherwise stated in such rule or regulation.

13.1-3 Clinical Committee Rules and Regulations. Subject to the approval of the Medical Staff and the Governing Body, each clinical committee shall formulate its own rules and regulations for the conduct of its affairs and the discharge of its responsibilities. Such rules and regulations shall not be inconsistent with these Bylaws, the general rules and regulations and policies of the Medical Staff, or other policies of the Hospital.

13.1-4 Forms. Application forms and any other prescribed forms required by these Bylaws for use in connection with staff appointments, reappointments, delineation of clinical privileges, corrective action, notices, recommendations, reports, and other matters shall be adopted by the Governing Body after considering the advice of the Medical Staff. Such forms shall be periodically reviewed by the Medical Staff. Minor modifications and revisions may be made without prior Governing Body approval, but the Governing Body reserves the right to revoke the change at any time.

13.1-5 Construction of Terms and Readings. Words used in these Bylaws shall be read as the singular or plural, as the context requires. The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope or effect of any provisions of these Bylaws.

13.1-6 Transmittal of Reports. Reports and other information which these Bylaws require the Medical Staff to transmit to the Governing Body shall be deemed so transmitted when delivered, unless otherwise specified, to the Chief Executive Officer.

13.1-7 Governing Body Action. Whenever these Bylaws require or authorize action by the Governing Body, such action may be taken by a committee of the Governing Body to which the Governing Body has delegated the responsibility and authority to act for it on the particular subject matter, activity or function involved.

13.1-8 Substantial Compliance. Technical or insignificant deviations from the procedures set forth in these Bylaws shall not be grounds for invalidating the action taken.

ARTICLE XIV - AMENDMENTS

14.1 MEDICAL STAFF RESPONSIBILITY

The Medical Staff shall have the initial responsibility and delegated authority to formulate, adopt, and recommend to the Governing Body, Medical Staff Bylaws, Rules and Regulations, policies and amendments, which shall be effective when approved by the Governing Body. This responsibility and authority shall be exercised in good faith and in a reasonable, timely and responsible manner, at least every three years, so as to have Bylaws, Rules and Regulations of generally recognized quality, to provide a basis for acceptance by accreditation agencies, to comply with supervising licensing authorities, and to provide a system of ongoing, effective professional review.

14.2 METHODOLOGY

14.2-1 Approval by Medical Staff and Governing Body. Medical Staff Bylaws may be adopted, amended, or repealed by the following combined action:

a. Medical Staff. The proposed amendment must be submitted at any regular or special meeting of the Medical Staff. A proposed amendment shall be referred to a special committee which shall report on it at the next regular meeting of the Medical Staff or at a special meeting called for such purpose. To be adopted, an amendment shall require a two-thirds vote of the Active Medical Staff and Consulting Staff identified in Section 4.1-3d present, provided a quorum is present at the time of such vote.

b. Governing Body. The Governing Body shall take action by either approving or rejecting the proposed change no later than 30 days after the vote of the active Medical Staff on the proposed amendment. The affirmative vote of the majority of the Governing Body shall be final.

c. Review Timeframe. These Bylaws will be reviewed every three years.

14.2-2 No Unilateral Action. Neither the Medical Staff nor the Governing Body may adopt a Bylaw amendment by unilateral action. Unilateral action for these purposes would be the adoption of a proposed amendment without notice to the

Medical Staff and further without providing a reasonable time for response and recommendation. If the Medical Staff fails to exercise its responsibility and authority as required by Section 14.1, and after notice from the Governing Body to this effect and a reasonable period of time for response, the Governing Body may resort to its own initiative in formulating or amending these Bylaws. In this event, Medical Staff recommendations and views shall be carefully considered by the Governing Body during its deliberations and in its actions.

14.2-3 Superseding Effect. These Bylaws, with the appended Rules and Regulations, shall replace any previous Bylaws, Rules and Regulations, and shall become effective when approved by the Governing Body of the Hospital. They shall, when adopted by the Medical Staff and approved by the Governing Body, be equally binding on the Governing Body and the Medical Staff.

ARTICLE XV - ADOPTION

These Bylaws together with the appended Rules and Regulations, shall be adopted at any regular or special meeting of the Active Medical Staff, shall replace any previous Bylaws, Rules and Regulations and shall become effective when approved by the Governing Body of the Hospital.

Adopted by the Active Medical Staff of Shawano Medical Center, Inc.

_____ _____
President of Medical Staff Date

_____ _____
Medical Staff Coordinator Date

Approved by the Governing Body of Shawano Medical Center, Inc.

_____ _____
Secretary of Governing Body Date

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