NATIONWIDE CHILDREN'S HOSPITAL
COLUMBUS, OHIO

MEDICAL STAFF

CREDENTIALS POLICY

Revised: 11/30/2021

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NATIONWIDE CHILDREN'S HOSPITAL
COLUMBUS, OHIO

ARTICLE I
APPLICATION PROCEDURE FOR MEDICAL STAFF APPOINTMENT AND PRIVILEGING

1.1 Responsibility of Producing Information

1.1.1 In connection with all applications for Medical Staff appointment and/or Privileges, the Practitioner shall have the responsibility of producing information for a proper evaluation of the Practitioner's qualifications and for resolving any doubts about his/her qualifications for Medical Staff membership and/or Privileges.

1.2 Application Content

1.2.1 An application and appropriate documents will be sent to interested applicants upon request. The Section and/or Department Chief(s) will be notified by the Medical Staff Office of the applicant's interest in the Hospital.

1.2.2 Application for Clinical Privileges and/or membership on the Medical Staff shall be made in writing, on a prescribed original form, and submitted to the Medical Staff Office.

1.2.3 Unless otherwise provided in the Medical Staff Bylaws or this Policy, a completed application shall document, at a minimum, the following information, as applicable:

A. Professional education and training, with specification as to pediatric training.

B. ECFMG number.

C. Current and prior affiliations with hospitals, surgery centers, ambulatory care centers, faculty/teaching appointments, *etc.*

D. Other affiliations, such as private practice; partnerships; corporations; military assignments; government agencies, *etc.*

E. Current valid license issued by the State of Ohio to independently practice his/her respective profession.

F. Out-of-state licenses.

G. Current, valid, Drug Enforcement Administration registration number as necessary for the Privileges requested.

H. National Practitioner Identification number.

I. Board certification status consistent with the requirements set forth in Section 1.3 of this Policy.

J. Affiliation with all local, state and national professional societies.

K. Documentation of Professional Liability Insurance coverage in an amount not less than $1 million per incident and $3 million per annual aggregate.

L. Designation of alternative coverage arrangements.

M. Completion of the immunization status questionnaire form.

N. Information as required by the Hospital's Tuberculosis Exposure Control Plan. Failure by the Practitioner to comply shall, as applicable, be deemed a voluntary withdrawal of a pending application or result in an automatic suspension of Medical Staff appointment and/or Privileges.

O. The Medical Staff category, Department/Section assignment, the Privileges requested, and completion of the applicable delineation of Privileges form(s).

P. Evidence of having met the continuing medical or other professional education requirements established by the applicable State licensure board as necessary to maintain current licensure.

Q. A statement of the Practitioner's ability to safely and competently exercise the Privileges requested, with or without a reasonable accommodation, according to accepted standards of professional performance as supported by evidence of current competence verifying the Practitioner's ability to perform the Privileges requested and pediatric experience (*e.g.,* surgical/procedure/case logs from hospitals, ambulatory care facilities, and/or office procedures for which the Practitioner was the primary Practitioner, listed separately for each facility.

(1) If the Practitioner requests an accommodation, the procedure outlined in Section 1.5 below will be followed.

(2) Clinical case logs must be for the last two (2) years and are required to include name and signature, patient identifier (not to include patient names), facility name, type of procedures, date of procedures, and age or date of birth).

R. Peer references from three (3) Practitioners in the applicant's same professional discipline who are personally knowledgeable about the applicant's ability to practice (*e.g.,* training, professional competence, and character) and who have known the applicant for at least one (1) year (additional letters may be requested at the discretion of the

Section and/or Department Chief(s). Peer recommendations include information regarding the applicant's clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism.

(1) Peer recommendations are to be in the form of written documentation reflecting informed opinions on each applicant's scope and level of performance, or a written peer evaluation of Practitioner-specific data collected from various sources for the purpose of validating current competence.

(2) Sources for peer recommendations may include the following: an organization performance improvement committee, the majority of whose members are the applicant's peers; reference letter(s)/form(s), written documentation and documented follow-up telephone conversation(s) about the applicant's written peer reference(s); a department or major clinical service chair who is a peer; or an organization's medical executive committee.

S. Information regarding previously successful or currently pending challenges to the applicant's licensure, board certification/eligibility, or DEA registration or the voluntary or involuntary relinquishment of such licensure, board certification/eligibility, or DEA registration.

T. Information regarding voluntary or involuntary limitation, reduction, suspension, or termination of the applicant's medical staff membership and/or clinical privileges at another hospital/healthcare facility or involuntary suspension or removal from a managed care organization's panel as a result of patient harm.

U. Information regarding the applicant's involvement in professional liability actions (pending claims, judgements, or settlements); list all carriers used for the last ten (10) years.

V. Information as to whether the applicant has been the subject of investigation by a Federal Healthcare Program and, if so, the status or outcome of the investigation.

W. A recent photograph of the applicant.

X. Information necessary to complete a criminal background check pursuant to Article VI including, but not limited to, a driver's license.

Y. A valid email address.

Z. The applicant's signature on the completed application.

1.3 Board Certification Requirements

1.3.1 Unless otherwise provided herein, all Practitioners shall at the time of initial application for Medical Staff appointment and/or Privileges be board-eligible or board certified as follows:

A. Physicians: by the American Board of Medical Specialties or American Osteopathic Association board applicable to their primary specialty and/or primary sub-specialty in accordance with the applicable board requirements.

B. Podiatrists: by the American Board of Podiatric Medicine in accordance with board requirements.

C. Dentists: by the American Board of Pediatric Dentistry; the American Board of General Dentistry; the American Board of Oral & Maxillofacial Surgery; or the American Board of Orthodontics in accordance with the applicable board requirements.

D. Psychologists: Psychologists obtaining neuropsychology testing Privileges shall be certified by the American Board of Clinical Neuropsychology in accordance with board requirements. All other Psychologists will not be required to be board eligible or board certified in order to obtain a Medical Staff appointment and/or Privileges. However, all Psychologists must have completed a one-year internship accredited by the Association of Psychology Postdoctoral and Internship Centers and have completed a one-year postdoctoral fellowship unless additional fellowship requirements are set forth in the applicable Privilege set.

1.3.2 A Practitioner, other than a Psychologist, who is a qualified candidate for board certification at the time of initial application for Medical Staff appointment and/or Privileges shall have five (5) years (or such other time period as set by the applicable board) from the date board eligibility was first attained to become board certified unless a waiver is otherwise granted. Psychologists required to obtain board certification pursuant to this section shall have seven (7) years from the date board eligibility was first attained to become board certified unless a waiver is otherwise granted.

1.3.3 Board certification (or eligibility, as applicable) is a baseline qualification for Medical Staff appointment and/or Privileges. Board certification includes attainment of initial certification, maintenance of certification, and recertification as required by the Practitioner's applicable board(s). Upon attainment of board certification, Practitioners shall continuously maintain board certification and, to the extent required by the applicable board(s), satisfy recertification requirements.

1.3.4 Unless a waiver is requested and subsequently granted in accordance with the procedure set forth in the Medical Staff Bylaws:

A. A Practitioner's failure to satisfy the requirement of board certification (or board eligibility, as applicable) at the time of initial application shall result in the Hospital's inability to process the application as a result of the Practitioner's failure to meet baseline qualifications.

B. A Practitioner's failure to continuously satisfy the requirement of board certification (or board eligibility, as applicable) following attainment of Medical Staff appointment and/or Privileges shall result in an automatic termination of Medical Staff appointment and Privileges.

1.3.5 The board certification requirement will not apply to any Practitioner whose initial application for Medical Staff appointment and Privileges was approved on or prior to July 1, 2005, who was not board certified on or prior to July 1, 2005, and who has continuously maintained a Medical Staff appointment and Privileges in Good Standing at the Hospital. In addition, the board certification, internship, and fellowship requirements for Psychologists set forth in this section will not apply to any Psychologist who completed his or her training prior to January 1, 2019.

1.4 Waiver of Board Certification Requirement

1.4.1 A waiver to allow additional time to attain or to waive the board certification requirement may be requested by a Practitioner in the following instances:

A. Any Practitioner who is required to be board certified and who fails to attain or who is ineligible for board certification, but possesses equivalent qualifications, may request that the Board certification requirement be temporarily or permanently waived. The Practitioner requesting the waiver bears the burden of demonstrating exceptional circumstances and that his or her qualifications are equivalent.

B. Any Practitioner who is required to be board certified and who fails to maintain board certification may request a waiver of the Board certification requirement. The Practitioner requesting the waiver bears the burden of demonstrating exceptional circumstances and that the waiver is in the best interest of the Hospital and patient care. A Practitioner's impending retirement within two (2) years of a recertification deadline may be considered as an exceptional circumstance.

1.4.2 A written request for a waiver of the board certification requirement may be submitted by the Practitioner to the Medical Staff Office for consideration in accordance with the waiver procedure set forth in the Medical Staff Bylaws.

1.5 Requests for Accommodation

1.5.1 Requests for a reasonable accommodation from applicants for, or Practitioners with, a Medical Staff appointment and/or Privileges at the

Hospital shall be forwarded to the Hospital's General Counsel/Legal Services for review and resolution. The General Counsel may consult with the Chief Medical Officer, Medical Staff President, and/or other appropriate Medical Staff leaders, as needed, in making a determination with respect to such request.

1.5.2 When the Wellness Committee determines that a Medical Staff Member is suffering from an impairment that may be amenable to a reasonable accommodation, the committee shall forward the matter to the Hospital's General Counsel/Legal Services for review and resolution. The General Counsel may consult with the Wellness Committee, as needed, in deciding how the matter should be handled.

1.6 Effect of Signing/Submitting an Application for Medical Staff Appointment and/or Privileges

1.6.1 If requested, an applicant shall be given the opportunity to go through the qualifications and other requirements for Medical Staff appointment and/or Privileges with a Hospital representative in person, by telephone, or in writing.

1.6.2 Upon receipt of the application and required application fee, a credentials file shall be created and maintained for the applicant.

1.6.3 By signing and submitting an application for Medical Staff appointment and/or Privileges, the applicant:

A. Acknowledges and attests that the application is correct and complete, and further acknowledges that any material misstatement or omission is grounds for a denial or termination of Medical Staff appointment and/or Privileges.

B. Agrees to appear for personal interviews, if requested, in support of his or her application.

C. Acknowledges the scope and extent of those provisions of the Bylaws which relate to authorization to obtain and release information, confidentiality of information, immunity for reviews and actions taken, and the right to obtain releases for obtaining and sharing information.

D. Agrees to fulfill the responsibilities of Medical Staff appointment and Privileges including, but not limited to, practicing in an ethical manner and providing (or arranging for) continuous care of his/her patients.

E. Agrees to notify the Medical Staff Office immediately if any information contained in the application changes. The foregoing obligation shall be a continuing obligation of the applicant so long as he or she is a Member of the Medical Staff and/or has Privileges at the Hospital.

F. Acknowledges that he/she has been provided (or has access to) the Medical Staff Bylaws and Policies; that he or she agrees to be bound by and comply with the terms thereof, as well as by/with the Hospital's Code of Regulations and applicable Hospital policies and procedures including, but not limited to, the Hospital's Corporate Integrity Plan if he or she is granted appointment and/or Privileges; and, to be bound by and comply with the terms thereof in all matters relating to consideration of his or her application without regard to whether the applicant is granted appointment and/or Privileges.

G. Agrees that when an Adverse recommendation or action is made with respect to his or her Medical Staff appointment and/or Privileges, the applicant will exhaust the administrative remedies afforded by the Medical Staff Bylaws and Policies before resorting to formal legal action.

H. Acknowledges that the Hospital and Affiliate Hospital(s) are part of a healthcare system and that information is shared among the Hospital and Affiliate Hospital(s). As a condition of appointment and/or grant of Privileges, the applicant recognizes and understands that any and all information (including peer review information) relative to his/her appointment and/or exercise of Privileges that is maintained, received, and/or generated by the Hospital or Affiliate Hospital(s) may be shared among the Hospital and Affiliate Hospital(s). The applicant further understands that this information may be used as part of the respective Hospital's/Affiliate Hospital's quality assessment and improvement activities and can form the basis for corrective action.

1.7 Application for Medical Staff Appointment without Privileges

1.7.1 Applicants requesting appointment to (i) the active Medical Staff category without Privileges; (ii) the administrative Medical Staff; and (iii) the affiliate Medical Staff shall complete the same application as applicants to Medical Staff categories with Privileges.

1.7.2 Applicants to the retired Medical Staff category and nominees to the emeritus or honorary Medical Staff categories are not required to complete an application.

1.8 Credentials Verification Process

1.8.1 Upon receipt of a completed application, the Medical Staff Office shall obtain the appropriate documents for review. The information on the application will be verified by the primary source whenever possible. The applicant shall be notified of any problems in obtaining the information required and it shall be the applicant's obligation to obtain the required information. Failure to provide the requested documentation within thirty

(30) days after a request therefore will result in the application being incomplete and may be deemed a voluntary withdrawal of the application.

1.8.2 The Medical Staff Office shall also:

A. Query and review the AMA Practitioner Masterfile or the American Osteopathic Association's Profile Report regarding the applicant.

B. Query and review reports from the National Practitioner Data Bank regarding the applicant.

C. Review results of the applicant's criminal background check.

D. Query appropriate sources (*e.g.,* Office of Inspector General, *etc.*) to determine whether the applicant has been convicted of a healthcare related offense or debarred, suspended, excluded, or otherwise made ineligible for participation in a Federal Healthcare Program.

E. When collection and verification of materials is accomplished, the Medical Staff Office shall transmit the application and all accompanying materials to the appropriate Department and/or Section Chief for review.

F. Applications will not be forwarded for review and action until the Medical Staff Office has deemed the application to be properly completed and all verifications have been obtained.

1.9 Procedure for Review and Action on Initial Applications for Medical Staff Appointment and Privileges

1.9.1 Action by Department and/or Section Chiefs; Surgeon-in-Chief; and, Chief Medical Officer

A. All applications and accompanying materials must be referred to the appropriate Department and/or Section Chief(s) for review. Surgical Section and/or Department applications will also be reviewed by the Surgeon-in-Chief. All Department and/or Section applications will be referred from the Department and/or Section Chiefs to the Chief Medical Officer for review and submission to the Credentials Committee.

B. The Section or Department Chief may conduct an interview, clinical in nature, with all new applicants for appointment to the Medical Staff and/or Clinical Privileges. It will be the responsibility of the Section or Department Chief to arrange the interview. A permanent record of the interview, signed by the appropriate Section or Department Chief will be completed and placed in the applicant's credentials file.

C. The Chief Medical Officer may personally interview the applicant before transmitting the written recommendation for acceptance or

rejection to the Credentials Committee. The Chief Medical Officer, Department and/or Section Chief may stop the appointment process if the applicant refuses a personal interview.

1.9.2 Action by Credentials Committee

A. Upon receipt of feedback from the Department and/or Section Chief(s), the Surgeon-in-Chief, as applicable, and the Chief Medical Officer, the Credentials Committee shall, at its next regular meeting, review the completed application, accompanying material, and recommendations.

B. Upon completion of its review, the Credentials Committee shall submit its findings (which may be reflected in meeting minutes) to the Medical Executive Committee for review. The Credentials Committee findings shall include a recommendation that the applicant's request for Medical Staff appointment and/or Privileges be deferred, approved, or denied. A recommendation for approval shall specify the Medical Staff appointment category and Clinical Privileges recommended.

1.9.3 Action by Medical Executive Committee

A. Upon receipt of the report of the Credentials Committee (which may be reflected in meeting minutes), the Medical Executive Committee will, at its next regular meeting, review the application, the accompanying documentation, and the feedback provided by the Department and/or Section Chief(s), the Surgeon-in-Chief, as applicable, the CMO, and the Credentials Committee regarding the applicant. Upon completion of its review, the Medical Executive Committee shall take one of the following actions.

(1) Deferral: A decision by the Medical Executive Committee to defer action regarding the application for further consideration will be considered at the next regular meeting of the Medical Executive Committee. Absent unusual circumstances in which the Medical Executive Committee believes that a request for additional information is appropriate, the MEC will proceed with a recommendation to grant or deny the request for Medical Staff appointment and/or Privileges. The Medical Staff President shall promptly send the applicant written notice of a decision by the Medical Executive Committee to defer action on the application.

(2) Favorable Recommendation: When the recommendation of the Medical Executive Committee is favorable to the applicant, the written recommendation (which may be reflected in meeting minutes) regarding, as applicable, the appointment, Medical Staff category, Department/Section

assignment, Privileges, and/or any special conditions to be attached to the appointment and/or Privileges shall be forwarded to the Board.

(3) Adverse Recommendation: When the recommendation of the Medical Executive Committee is Adverse to the applicant, the Medical Staff President shall so inform the applicant, by Special Notice, and the applicant shall then be entitled to the procedural rights, if applicable, set forth in the Fair Hearing Policy. No such Adverse recommendation shall be required to be forwarded to the Board until after the applicant has exercised, or has been deemed to have waived, his/her right to a hearing, if any, as provided for in the Fair Hearing Policy.

1.9.4 Action by Board of Directors

A. The Board may take any of the following actions with regard to an application for Medical Staff appointment and/or Privileges:

(1) Favorable MEC Recommendation: The Board may adopt or reject, in whole or in part, a favorable recommendation of the MEC or refer the recommendation back to the MEC for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation shall be made.

(a) If the Board's decision is favorable to an applicant, it shall be effective as the final decision of the Board and the applicant shall be so informed as set forth in Section 1.9.6 below.

(b) If the Board's decision following a favorable recommendation by the MEC is Adverse to the applicant (and provided that the applicant has not previously been granted or waived a hearing on the application), the Chief Executive Officer shall so notify the applicant, by Special Notice, and the applicant shall be entitled to the procedural rights, if applicable, set forth in the Fair Hearing Policy.

(2) Without Benefit of MEC Recommendation: If the Medical Executive Committee does not forward a recommendation to the Board within sixty (60) days of the receipt of the Credentials Committee report, the Board may take action on its own initiative following notice to the Medical Executive Committee of the Board's intent to act.

(a) If the Board's decision is favorable to the applicant, it shall be effective as the final decision of the Board and

the applicant shall be so informed as set forth in Section 1.9.6 below.

(b) If the Board's decision is Adverse to the applicant, the Chief Executive Officer shall so inform the applicant, by Special Notice, and the applicant shall be entitled, if applicable, to the procedural rights set forth in the Fair Hearing Policy.

(3) After Exercise or Waiver of Procedural Rights: In the case of an Adverse MEC recommendation or an Adverse Board decision, the Board shall take final action in the matter only after the applicant has exhausted or waived his/her procedural rights, if any, as provided for in the Fair Hearing Policy.

1.9.5 Review by the Joint Conference Committee

A. Whenever the Board's decision is contrary to the recommendation of the MEC, there shall be review of the matter by the Joint Conference Committee prior to final action by the Board.

B. The Joint Conference Committee shall, after due consideration, make its written recommendation (which may be reflected in meeting minutes) to the Board within ten (10) day after referral to the committee.

C. The Board may thereafter take final action. Such action by the Board may include accepting, rejecting, or modifying, in whole or part, the recommendation of the Joint Conference Committee.

1.9.6 Notice of Final Decision

A. Notification of the final decision of the Board of Directors will be sent by the Chief Executive Officer to the Department and/or Section Chief(s), the Surgeon-in-Chief, as applicable, the Chief Medical Officer, to the applicant, by Special Notice, and as otherwise appropriate.

B. A notice to grant Medical Staff appointment and/or Privileges shall include, as applicable:

(1) Confirmation of the Medical Staff category to which the Practitioner is appointed.

(2) The Department/Section to which the Practitioner is assigned.

(3) The Privileges which the Practitioner has been granted.

(4) Information regarding any special conditions attached to the appointment and/or Privileges

1.10 Time Guidelines

1.10.1 The following time periods are considered guidelines and do not create any rights for an applicant to have his/her application processed within these precise periods; provided; however, that this provision shall not apply to the time periods contained in the Fair Hearing Policy. When the Fair Hearing Policy is activated by an Adverse recommendation or action as provided herein, the time requirements set forth therein shall govern the continued processing of the application.

Individual/Group	Time
Medical Staff Office	90 days
Department/Section Chief	15 days
Surgeon-in-Chief	15 days
Chief Medical Officer	15 days
Credentials Committee	Next regular meeting
MEC	Next regular meeting
Board of Directors	Next regular meeting

1.11 Processing Applications for Medical Staff Appointment without Privileges

1.11.1 Applications for appointment to (i) the active Medical Staff category without Privileges; (ii) the administrative Medical Staff; or (iii) the affiliate Medical Staff shall be processed in the same manner as applications for Medical Staff appointment and Privileges in accordance with the procedure set forth in this Article (for initial appointments) or Article II (for reappointments).

1.11.2 Nominations for appointment to the emeritus or honorary Medical Staff may be made by the MEC and acted upon by the Board. A denial or termination of appointment to the emeritus or honorary Medical Staff shall not trigger procedural rights nor shall it create a reportable event for purposes of federal or state law.

1.11.3 A request for a change from the active Medical Staff category to the retired Medical Staff category will be processed in accordance with section 2.5 below.

ARTICLE II
PROCEDURE FOR REAPPOINTMENT AND REGRANT OF PRIVILEGES

2.1 Application for Reappointment/Regrant of Privileges

2.1.1 Unless otherwise provided herein, Practitioners desiring to maintain Clinical Privileges and/or Medical Staff membership are expected to complete an application packet for Medical Staff reappointment and/or regrant of Privileges and submit it to the Medical Staff Office by the date set forth on the Practitioner's reappointment/regrant application. Practitioners appointed to the honorary or emeritus Medical Staff categories are not required to submit an application for reappointment.

2.1.2 Failure to file the completed application packet on or before the date set forth on the Practitioner's reappointment/regrant application may result in the Hospital's inability to process the Practitioner's request for Medical Staff reappointment and/or regrant of Privileges by the end of the Practitioner's current appointment/Privilege period.

2.2 Content of Application for Reappointment/Regrant of Privileges.

2.2.1 Review of requests for Medical Staff reappointment and/or regrant of Privileges shall include, but not be limited to, consideration of the following information with respect to each Practitioner since the time of the last appointment/Privilege period.

A. Continued satisfaction of the qualifications set forth in Section 2.2 of the Medical Staff Bylaws, the qualifications set forth in the applicable Medical Staff category, and additional information with respect to Section 1.2.3 of this Policy as necessary to update the Practitioner's Medical Staff credentials file subject to the following:

(1) Peer recommendations in accordance with the requirements set forth in Section 1.2.3 (R) of this Policy when insufficient Practitioner-specific data is available.

B. Satisfaction and evidence of continued willingness to satisfy, the responsibilities of Medical Staff appointment and/or Privileges set forth in the Medical Staff Bylaws and the additional duties/responsibilities set forth in the applicable Medical Staff category.

C. The Medical Staff category requested and the reason for any changes thereto.

D. The Privileges requested and the reason for any changes thereto. Completion of the applicable delineation of Privileges form(s).

E. Data contained in each Practitioner's Quality Improvement Profile including, but not limited to, focused and ongoing professional practice evaluation data.

F. Timely return of completed information forms when required.

G. Any other criteria which, in the opinion of the Department and/or Section Chief(s) is information necessary for the Surgeon-in-Chief (if applicable), CMO, Credentials Committee, MEC, or Board to be able to evaluate the request for reappointment/regrant of Privileges.

2.3 Processing Applications for Reappointment and Regrant of Privileges

2.3.1 Information with respect to applications for Medical Staff reappointment and/or regrant of Privileges shall be collected and verified by the Medical Staff Office in accordance with the procedure set forth in Section 1.8 of this Policy

2.3.2 The applicable Department/Section Chief, Surgeon-in-Chief, as applicable, the Chief Medical Officer, the Credentials Committee, the MEC, and the Board shall review and act upon applications for Medical Staff reappointment and/or regrant of Privileges in accordance with the procedure set forth in Section 1.9 of this Policy.

2.3.3 For purposes of reappointment and/or regrant of Privileges, the terms "applicant" and "appointment" and "Privileges" as used in Section 1.9 of this Policy shall be read, as "Practitioner" and "reappointment" and "regrant of Privileges," respectively.

2.4 Time Periods for Processing Applications for Medical Staff Reappointment and Regrant of Privileges

2.4.1 All individuals and groups required to act on an application for Medical Staff reappointment and/or regrant of Privileges must do so in a timely and good faith manner.

2.4.2 If an application for reappointment/regrant of Privileges has not been fully processed by the expiration date of the Practitioner's current appointment and/or Privilege period, the Practitioner's appointment and Privileges shall terminate as of the last date of his/her current appointment/Privilege period. A Practitioner whose appointment and Privileges are so terminated shall not be entitled to the procedural rights provided in Fair Hearing Policy.

2.4.3 If a Practitioner submits an application within ninety (90) days after termination of his/her appointment/Privileges, the application will be treated as an application for reappointment/regrant of Privileges. If a Practitioner submits an application thereafter, such application shall be treated as an initial application for Medical Staff appointment and Privileges.

2.5 Changes in Medical Staff Category and/or Privileges

2.5.1 A Practitioner may, either in connection with reappointment/regrant of Privileges or at any other time, request modification of his/her Medical Staff category or Clinical Privileges by submitting a written request (to include the reasons for such request) to the Medical Staff Office.

2.5.2 A modification request shall be processed in substantially the same manner as an application for reappointment and/or regrant of Privileges.

2.6 Medical-Administrative Officers

2.6.1 Practitioners employed by the Hospital to provide medical-administrative duties must be Members of the Medical Staff and are subject to the same credentialing and appointment/reappointment procedures as are other applicants for Medical Staff appointment.

ARTICLE III
PRIVILEGES WITHOUT MEDICAL STAFF APPOINTMENT; HOUSE STAFF; POSTGRADUATE STAFF; ETC.

3.1 Emergency Privileges

3.1.1 In the case of emergency, any Member of the Medical Staff with Clinical Privileges, to the degree permitted by his/her license and regardless of his/her Medical Staff status or Clinical Privileges, shall be expected to do everything possible to save the life of a patient, using every facility of the Hospital necessary, including calling for any consultation necessary. Emergency Privileges automatically terminate upon alleviation of the emergency situation. When an emergency situation no longer exists, such Member must request the Privileges necessary to continue to treat the patient. In the event such Privileges are denied or he/she does not desire to request the applicable Privileges, the patient shall be assigned to a Member of the Medical Staff with appropriate Privileges. A Practitioner who exercises emergency Privileges is not entitled to the procedural rights set forth in the Fair Hearing Policy.

3.1.2 For the purpose of this section, an "emergency" is defined as a condition in which serious permanent harm would result to a patient absent action; or, in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

3.1.3 Any use of emergency Privileges must be reported to the Medical Staff Office within three (3) business days by the responsible Practitioner and will be subject to automatic review by the Medical Staff officers and the Credentials Committee.

3.2 Disaster Privileges

3.2.1 Disaster Privileges may be granted to a licensed, volunteer Practitioner who does not otherwise have Privileges at the Hospital when the Hospital's emergency management plan has been activated in response to a disaster and the Hospital is unable to handle immediate patient needs. For purposes of this section, a "disaster" is an emergency that, due to its complexity, scope, or duration, threatens the Hospital's capabilities and requires outside assistance to sustain patient care, safety, or security functions.

3.2.2 Disaster Privileges may be granted, on a case-by-case basis, for up to thirty (30) days at the discretion of the Chief Executive Officer, Chief Medical Officer, Medical Staff President, or the Incident Commander in collaboration with the Chief Executive Officer or Chief Medical Officer. Verification of a current, valid government-issued picture identification in addition to presentation of at least one (1) of the following will be acceptable identification to obtain disaster Privileges:

A. Current pocket license to practice medicine/other applicable profession.

B. A current photo identification card from a healthcare organization that clearly identifies professional designation.

C. Confirmation by a Practitioner with current Medical Staff appointment and/or Privileges at the Hospital with personal knowledge regarding the volunteer Practitioner's identity and ability to act as a Practitioner during a disaster.

D. Identification indicating that the Practitioner is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group.

E. Identification indicating that the Practitioner has been granted authority by a government entity to render patient care, treatment, or services in disaster circumstances.

F. Primary source verification of licensure.

3.2.3 The Medical Administrative Specialist, or designee, is required to present to the Medical Staff Office a list of volunteer Practitioner names and copies of the documents listed above (or documentation of the volunteer Practitioner's presentation thereof). A primary source verification of licensure (*i.e.,* an attempt to contact the applicable state licensing board to verify licensure) shall be conducted as soon as the immediate situation is under control or within seventy-two (72) hours from the time the volunteer Practitioner presents to the Hospital, whichever comes first. If primary source verification of licensure cannot be completed within seventy-two (72) hours of the Practitioner's arrival at the Hospital (due to, for example, no means of communication or lack of resources), the Hospital will document all of the following:

A. Reason(s) primary source verification of licensure could not be performed within 72 hours of the Practitioner's arrival at the Hospital.

B. Evidence of the Practitioner's demonstrated ability to continue to provide adequate care, treatment, and services.

C. Evidence of the Hospital's attempt to perform primary source verification of licensure as soon as possible.

3.2.4 In addition to the primary source verification of licensure, the Medical Administrative Specialist will also attempt to:

A. Obtain copies of the volunteer Practitioner's current medical/other professional license, a photo identification card from a facility at

which the volunteer Practitioner currently practices, and the volunteer Practitioner's driver's license if such copies were not otherwise initially provided by the volunteer Practitioner pursuant to Section 3.2.2 above.

B. Contact the primary facility at which the volunteer Practitioner practices to verify that he/she is in good standing.

C. Verify the volunteer Practitioner's professional liability insurance coverage.

3.2.5 All volunteer Practitioners who receive disaster Privileges must, at all times while at the Hospital, wear an identification badge, with photograph, from the facility at which they otherwise hold Privileges. If the volunteer Practitioner does not have such identification, he or she will be issued a badge identifying him or her and designating the Practitioner as an emergency provider.

3.2.6 The activities of volunteer Practitioners who receive disaster Privileges shall be managed by and under the supervision of the Chief Medical Officer. Based upon oversight of each volunteer Practitioner, a reassessment must be made within seventy-two (72) hours of the volunteer Practitioner's arrival at the Hospital to determine if granted disaster Privileges should continue.

3.2.7 The disaster Privileges shall cease upon alleviation of the circumstances of disaster as determined by the Chief Executive Officer.

3.3 Temporary Privileges

Temporary Privileges may be granted on a case by case basis by the appropriate Hospital leadership as set forth in this section. Temporary Privileges may be granted to Practitioners under the following circumstances:

3.3.1 Important Patient Care Need

A. To fulfill an important patient care need (without appointment to the Medical Staff) that mandates an immediate authorization to practice, for a limited period of time, not to exceed ninety (90) days. Temporary privileges for an important patient care need may not exceed two (2) requests during any 12-month period. After two (2) requests for temporary Privileges to meet an important patient care need in a twelve (12) month period of time, the Practitioner must make application to the Medical Staff. Temporary Privileges to meet an important patient care need shall be explicitly curtailed by a date of expiration.

B. Temporary Privileges may be granted for an important patient care need upon receipt and verification of:

(1) Current letter of reference from the Practitioner's primary hospital attesting to his/her character, qualifications, professional standing, and current competence. The letter is required to be from appropriate medical leadership and include the date of appointment and grant of privileges at the primary hospital.

(2) Copy of current valid Ohio license or if from out of state/out of country, a special certificate from the Ohio State Medical Board (or other appropriate licensing entity) authorizing the Practitioner to practice in Ohio.

(3) Copy of current valid DEA certificate, if applicable.

(4) Documentation of current Professional Liability Insurance coverage.

(5) Completion of a query and evaluation of the National Practitioner Data Bank information and such other queries as required by Section 1.8.2 (D).

(6) Information as required by the Hospital's Tuberculosis Exposure Control Plan.

(7) Completion of immunization documentation form.

(8) Board certification status.

(9) Criminal background check.

(10) Copy of current curriculum vitae.

C. If an important patient care need requires that temporary Privileges be granted before all of the items set forth in this section can be received and verified, temporary Privileges may be granted upon verification of (i) the Practitioner's license, (ii) completion of a query and evaluation of the National Practitioner Data Bank information, and (iii) current competence, which may be obtained verbally and documented.

D. Examples of situations in which temporary Privileges to meet an important patient care need would not be granted include, but are not limited to, the following:

(1) The Practitioner fails to submit the application packet in a timely manner for processing of his/her application.

(2) An applicant that is scheduled to be on-call prior to grant of appointment and Privileges.

(3) Failure or inability of Medical Staff Office personnel to verify performance data and information on the application in a timely manner.

3.3.2 Pendency of a Completed Application

A. Temporary Privileges may be granted to an applicant for new Privileges while awaiting review and action on the Practitioner's application by the Medical Executive Committee and Board provided the:

(1) Practitioner has submitted a completed application consistent with the requirements set forth in Section 1.2 of this Policy.

(2) Application raises no concerns upon completion of the verification by The Medical Staff Office set forth in Section 1.8 of this Policy and following review by the Department/Section Chief(s), Surgeon-in-Chief, if applicable, Chief Medical Officer, and Credentials Committee pursuant to Sections 1.9.1 and 1.9.2 of this Policy.

(3) Practitioner has no current or previously successful challenge to licensure or registration; has not been subject to the involuntary termination of medical staff appointment at another organization; and, has not been subject to the involuntary limitation, reduction, denial, or loss of clinical privileges.

B. Temporary Privileges for applicants for new Privileges may be granted for a limited period of time not to exceed the pendency of the application or one hundred and twenty (120) days, whichever is less. For purposes of this section an "applicant for new Privileges" includes a Practitioner applying for Privileges at the Hospital for the first time, a Practitioner currently holding Privileges who is requesting one or more additional Privileges; and a Practitioner who is in the reappointment/reprivileging process and is requesting one or more additional privileges.

C. Temporary Privileges should be granted only when the information available reasonably supports a favorable determination regarding the applicant's request for new Privileges. Under no circumstances may temporary Privileges be granted if the application is still pending because the Practitioner has not responded in a satisfactory manner to a request for clarification of a matter or for additional information.

3.3.3 Approval Process:

A. Upon request, temporary Privileges to meet an important patient care need may be granted by the Chief Executive Officer or Chief

Medical Officer, upon recommendation of the Medical Staff President.

B. Upon written request by a Practitioner for temporary Privileges while the Practitioner's completed application is pending review by the MEC and Board, the applicable Section and/or Department Chief(s) will be responsible for initiating and completing the required form and documentation before recommending temporary Privileges. Appropriate forms may be obtained from the Medical Staff Office. The completed form and required documentation shall be forwarded to the Medical Staff Office for processing. The Credentials Committee chair shall review all temporary Privileges before they are recommended to the Surgeon-in-Chief, when applicable, and Chief Medical Officer. Temporary Privileges may be granted by the Chief Executive Officer or Chief Medical Officer, upon recommendation by the Surgeon-in-Chief, if applicable, the Chief Medical Officer (if the temporary Privileges are being granted by the Chief Executive Officer), and the Medical Staff President. .

C. Written notification of temporary Privileges will be sent by the Medical Staff Office to the Practitioner, the appropriate Department and/or Section Chief(s), and other Hospital departments, as appropriate.

D. The Practitioner will be restricted to the specific delineations for which the temporary Privileges are granted. The Practitioner will be under the supervision of the applicable Section and/or Department Chief(s) while exercising temporary Privileges.

E. Practitioners exercising temporary Privileges must agree to abide by the Medical Staff Bylaws, Policies, and Rules & Regulations, and applicable Hospital policies.

3.4 CME PARTICIPANTS FOR DIRECT PATIENT CARE

3.4.1 Shall consist of Practitioners or APPs who have been accepted into a Nationwide Children's Hospital ("Hospital") approved outreach educational program, continuing medical education ("CME") or continuing dental education program (collectively "CME Participant Program for Direct Patient Care ("CME-PC")).

3.4.2 Application for acceptance into a CME-PC will be made to the CME office. Applicants must provide a completed application for the CME outreach program and may be granted acceptance in the program upon receipt and verification of:

A. Copy of current valid Ohio license or if from out of state/out of country, a special certificate from the Ohio State Medical Board (or other appropriate licensing entity) authorizing the Practitioner/APP to practice in Ohio.

B. Copy of current valid DEA certificate, if applicable.

C. Board certification status.

D. Detailed course description of the CME-PC accompanied by approval of the Hospital's Chief Medical Education Officer.

E. Letter from the Hospital program director attesting to the applicant's character, qualifications, and professional standing.

F. Letter from an authorized leader at the applicant's primary hospital confirming, as applicable, the date of the applicant's medical staff appointment and/or clinical privileges at the primary hospital and attesting to the applicant's character, qualifications, clinical competence, and professional standing.

G. Two (2) professional reference letters from individuals who are not related to the applicant and who are not associated with the applicant's practice.

H. Current curriculum vitae including all of the applicant's education, training, and healthcare affiliations.

I. Documentation of Professional Liability Insurance coverage in an amount not less than $1 million per incident and $3 million per annual aggregate and confirming coverage during participation in the CME-PC.

J. Letter from applicant's Professional Liability Insurance carrier verifying current and/or prior malpractice claims history for the past 10 years.

K. Information as required by the Hospital's Tuberculosis Exposure Control Plan.

L. Completion of the immunization status questionnaire form.

M. Information necessary to complete a criminal background check including, but not limited to, a valid driver's license.

3.4.3 Practitioners may be approved to participate in CME-PC by the Medical Staff President, upon written recommendation by the applicable Section/Department Chief, the Surgeon-in-Chief, if applicable, the Chief Medical Officer, and the Credentials Committee chairperson. APPs may be approved to participate in CME-PC by the Medical Staff President, upon recommendation of the APP Nursing Director, the Chief Nursing Officer, the Unit/Program Medical Director, the Section/Department Chief, the APP Credentials Committee chairperson, and the Medical Staff Credentials Committee chairperson.

3.4.4 CME-PC participants shall provide patient care only under the supervision of Practitioners who are credentialed and privileged by the Hospital to perform the services and who are designated by the applicable CME program director as faculty who may supervise the CME-PC participants in accordance with the CME and other applicable Hospital policies. CME-PC participants shall perform their duties in accordance with the written education program approved by the Chief Medical Education Officer and the Chief Medical Officer, or Physician-In-Chief, or Surgeon-In-Chief, or Chief Nursing Officer, as applicable.

3.4.5 CME-PC participants may only provide clinical services outside of their respective CME program if they have requested and been granted Clinical Privileges at the Hospital.

3.5 HOUSE STAFF

3.5.1 Shall consist of Practitioners who (1) have been accepted to a Hospital approved graduate medical education ("GME") or dental education program; or (2) are enrolled in a GME approved program at another institution recognized by the Hospital ("GME Program")and who are on their pediatric rotations at the Hospital (collectively referred to as "House Staff").

3.5.2 House Staff in a fellowship that is a GME Program will not be able to apply for appointment to the Medical Staff or Clinical Privileges except as Postgraduate Staff and as specifically set forth in Section 3.6.

3.5.3 GME Programs referred to in this section include education programs that are ACGME accredited and also non-ACGME accredited programs which have been approved by the Hospital.

3.5.4 Practitioners enrolled in a fellowship program at another institution that has not been recognized or approved by the Hospital are not eligible for enrollment as House Staff.

3.5.5 Application for enrollment to House Staff will be made to the applicable program director with approval by the Chief of the applicable Department and/or Section.

3.5.6 House Staff shall provide patient care only under the supervision of Practitioners who are credentialed and privileged by the Hospital to perform the services and who are designated by the program director as faculty who may supervise the House Staff in accordance with the GME policies. House Staff are permitted to function clinically as outlined in applicable GME policies. The House Staff shall perform their duties in accordance with written job responsibilities developed by the program directors according to the applicable policy set forth by the Graduate Medical Education Committee (GMEC). Each GME Program also describes the mechanisms through which program directors and attending faculty make decisions about a House Staff member's progressive involvement and autonomy in

delivering patient care. House Staff may not provide clinical services outside their respective GME Program.

3.5.7 The ACGME Designated Institutional Official (DIO) communicates as needed, but at least annually, with the MEC and the Hospital's Board of Directors about House Staff supervision, responsibilities, evaluation, compliance with duty-hour standards, and participation in patient safety and quality of care education. The DIO also coordinates with the MEC to ensure that all supervising Practitioners possess Clinical Privileges commensurate with their supervising activities.

3.5.8 Members of the House Staff may admit patients in accordance with their respective GME Program and may only admit a patient to the service of their supervising Medical Staff Member.

3.5.9 House Staff are eligible to attend meetings, to serve on committees as designated by the Chief Medical Officer, and to function in the clinical areas of the Hospital within the limitations of their GME Program.

3.5.10 Concerns regarding House Staff performance shall be addressed in accordance with the procedures (*e.g.*, for disciplinary/corrective action, procedural rights, *etc.*) set forth in the applicable GME Program policies.

3.6 POSTGRADUATE STAFF

3.6.1 The Postgraduate Staff shall consist of House Staff who:

A. Are Fellows or are advanced training residents in the Hospital GME Program.

B. Have been granted approval to work outside of the fellowship or residency program by the applicable program director and approved by the applicable Department and/or Section Chief(s). Without approval of the applicable program director and Department and/or Section Chief(s), the resident/fellow is not eligible to apply for Privileges and such denial shall not give rise to any fair hearing rights pursuant to the Medical Staff Fair Hearing Policy.

C. Meet the basic requirements for credentialing and privileging set forth in the Medical Staff Bylaws and Credentials Policy.

D. Are board certified or are qualified candidates for board certification at the time of initial request for Privileges and must meet the board certification requirements outlined in the Credentials Policy.

E. Are actively enrolled in a GME Program.

F. Meet all of the Hospital's GME requirements and policies and be in good standing in their training program. If this status changes, the program director must notify the Department and/or Section Chief(s).

3.6.2 The Postgraduate Staff:

A. Shall not be eligible for a Medical Staff appointment.

B. Shall only be eligible to apply for Clinical Privileges and engage in patient care activities in an outpatient care setting within the assigned clinical department with appropriate clinical supervision. A limited exception for inpatient coverage may be granted in order to meet an exigent patient care need in accordance with the temporary Privileges section.

C. Shall exercise only those Clinical Privileges as are granted to him/her pursuant to the applicable delineation of privileges.

D. May attend meetings of the Medical Staff Department/Section in which they are privileged without vote.

E. Shall be eligible to serve on a Medical Staff committee as a designate of the Department and/or Section Chief(s) of the Department/Section in which the Postgraduate Staff member is training.

F. Shall pay application fees.

3.6.3 Notwithstanding the foregoing, upon completion of a fellowship program, a Practitioner shall be eligible to request Medical Staff appointment and Clinical Privileges at the Hospital with respect to the fellowship that was completed while the Practitioner participates in an additional sub-specialty fellowship. Such Practitioner shall be subject to all of the requirements set forth in Sections 3.6.1 and 3.6.2 with respect to his/her participation in the additional sub-specialty fellowship program.

3.6.4 Notwithstanding the foregoing, a Practitioner who currently holds Medical Staff appointment and Clinical Privileges at the Hospital and who seeks to engage in an additional fellowship program may retain his/her existing Medical Staff appointment and Clinical Privileges at the Hospital while participating in the additional fellowship program. Such Practitioner shall be subject to all of the requirements set forth in Sections 3.6.1 and 3.6.2 with respect to his/her participation in the additional fellowship program.

3.7 TERMINATION OF TEMPORARY, DISASTER, OR POSTGRADUATE PRIVILEGES

3.7.1 Termination

A. The Chief Executive Officer, the Chief Medical Officer, or the Medical Staff President may, at any time, terminate all, or any portion, of a Practitioner's temporary, disaster, or Postgraduate Privileges.

B. Where the life or well-being of a patient is determined to be endangered, the Practitioner’s temporary, disaster, or Postgraduate

Privileges may be terminated by any person entitled to impose a summary suspension pursuant to the Medical Staff Bylaws.

3.7.2 Procedural Due Process Rights

A. A Practitioner who has been granted temporary, disaster, or Postgraduate Privileges is not a Member of the Medical Staff and is not entitled to the procedural due process rights afforded to Medical Staff Members.

B. A Practitioner shall not be entitled to the procedural due process rights set forth in the Fair Hearing Policy because the Practitioner's request for temporary, disaster, or Postgraduate Privileges are refused, in whole or in part, or because all or any portion of such Privileges are terminated, not renewed, restricted, suspended or otherwise limited, modified or monitored in any way.

3.7.3 Patient Care

A. In the event a Practitioner's temporary, disaster, or Postgraduate Privileges are revoked, the Practitioner's patients then in the Hospital shall be assigned to another Practitioner by the Medical Staff President and/or CMO. The wishes of the patient will be considered, where feasible, in choosing a substitute Practitioner.

ARTICLE IV
LEAVE OF ABSENCE

4.1 Requests for LOA

4.1.1 Requests for leave of absence (LOA), and extensions thereto, shall be submitted in writing to the Credentials Committee. A LOA may be granted to Medical Staff Members for any reason deemed appropriate by the Credentials Committee, for a specified period of time. Upon an LOA exceeding 365 days, the Credentials Committee will review the LOA for continued appropriateness. If the LOA will extend past the last date of the Medical Staff Member's current appointment/Privilege period, the Medical Staff Member may apply for reappointment during the LOA and the Medical Staff Member's clinical Privileges will be held in abeyance after the last date of the current appointment/Privilege period until the Medical Staff Member's LOA ends and the Medical Staff Member's competency for such Privileges can be confirmed.

4.1.2 The Credentials Committee may recommend placing a Medical Staff Member on LOA when said Member is under medical care or convalescence.

4.1.3 Prerogatives During LOA

A. A Medical Staff Member on LOA shall not exercise Privileges in the Hospital during the LOA and membership rights and responsibilities shall be inactive.

B. He/she shall be excused from all meetings and from paying Medical Staff dues during the period of the LOA.

C. Notwithstanding the foregoing, a request from a Medical Staff Member on a LOA to maintain access to the Hospital's EMR and email may be approved by the applicable Department/Section Chief.

4.1.4 Request for Reinstatement Following Leave of Absence

A. At least thirty (30) days prior to termination of the LOA, a Member wishing to return from the LOA and have his/her Medical Staff appointment and Privileges reinstated shall submit a summary of relevant activities during the LOA to the Credentials Committee.

(1) Members returning from a military LOA will be required to submit proof of military status.

(2) A Member returning from medical LOA will be required to submit his/her Practitioner's report on the Member's ability to resume practice and competently exercise the Privileges requested, with or without a reasonable accommodation,

according to accepted standards of professional performance .

(3) Members returning from an academic LOA shall be required to submit a summary of the educational activities undertaken and evidence of completed training from the appropriate program director.

B. In order to qualify for reinstatement following a LOA, the Member must maintain Professional Liability Insurance coverage during the leave or purchase tail coverage for all periods during which the Member held Privileges at the Hospital. The Member shall provide information to demonstrate satisfaction of continuing Professional Liability Insurance coverage or tail coverage as required by this provision upon request for reinstatement.

C. Requests for and return from an LOA must be approved by the Practitioner's Section and/or Department Chief(s), the Surgeon-in-Chief, if applicable, the Chief Medical Officer, the Credentials Committee, Medical Executive Committee, and the Board of Directors.

4.2 Failure to Request Reinstatement following a LOA

4.2.1 If a Medical Staff Member fails to request reinstatement of his/her appointment and Privileges upon termination of the LOA and is not then under investigation by the Medical Staff, such failure will be deemed a voluntary resignation of the Member's Medical Staff appointment and Privileges and shall not give rise to any procedural rights pursuant to the Fair Hearing Policy.

ARTICLE V
RESIGNATION, TERMINATION, AND REAPPLICATION

5.1 Resignation

5.1.1 Resignation of Medical Staff appointment and Privileges shall be submitted in writing at least thirty (30) days in advance of departure to the respective Department Chief (or designated Section Chief) and copies made available to the Chief Medical Officer, Medical Staff Office and Health Information Management Department.

5.1.2 It is the responsibility of the Practitioner to complete all medical records prior to his/her departure. In the event a Practitioner is deceased, the responsibility of medical record completion will be assumed by the Department Chief (or designated Section Chief).

5.1.3 The name of the Practitioner will be removed from the central mailing system. For purpose of information, the resignation will be forwarded to the Credentials Committee, the Medical Executive Committee, and the Board of Directors.

5.1.4 The President of the Medical Staff will notify the former Practitioner and all appropriate Hospital personnel of the Board's acceptance of the resignation.

5.2 Termination

5.2.1 In those cases where a Practitioner moves away from the Hospital's service area without submitting a forwarding address, within sixty (60) days of moving, or his/her written intentions with regard to his/her Medical Staff appointment and/or Privileges, the Practitioner's appointment and Privileges shall be terminated upon review by the Credentials Committee, recommendation of the Medical Executive Committee, and approval by the Board of Directors.

5.2.2 If a forwarding address is known, the Practitioner will be asked his/her intentions with regard to his/her Medical Staff appointment and Privileges; and, if he/she does not respond within thirty (30) days, his/her name will be submitted to the appropriate committees for approval of termination.

5.2.3 The President of the Medical Staff will send the former Practitioner written notification of the approved termination.

5.3 Report to State Licensing Board

5.3.1 When appropriate, consideration may be given by the Hospital, after consultation with one (1) or more Medical Staff officers, to notifying the applicable State licensing board regarding a Practitioner's actions (*e.g.,* for failure to complete patient records, abandonment, *etc*.).

5.4 Nature of Resignation/Termination

5.4.1 Provided a resignation or termination pursuant to Section 5.1 or Section 5.2 is determined by the Board, following a recommendation of the MEC, to be voluntary, such resignation or termination shall not give rise to any procedural rights set forth in the Fair Hearing Policy.

5.5 Reapplication and Waiting Periods

5.5.1 Except as otherwise provided in the Medical Staff Bylaws or this Policy, or as otherwise determined by the Board upon recommendation of the MEC in light of exceptional circumstances, a Practitioner:

A. Whose Medical Staff appointment and Privileges are automatically terminated pursuant to Section 6.5-1(a)-(e) of the Bylaws may not reapply for Medical Staff appointment and/or Privileges for a period of at least one (1) year from the effective date of the automatic termination.

B. Who has received a final Adverse decision regarding appointment/reappointment and/or Privileges/regrant of Privileges may not reapply for Medical Staff appointment and/or for Privileges for a period of at least two (2) years from the latter of the date of the notice of the final Adverse decision or final court decision.

C. Who has resigned his/her Medical Staff appointment and/or Privileges or withdrawn an application for appointment/reappointment and/or Privileges/regrant of Privileges while under investigation or to avoid an investigation for professional conduct or clinical competency concerns may not reapply for Medical Staff appointment and/or Privileges for a period of at least two (2) years from the effective date of the resignation or application withdrawal.

5.5.2 Any such reapplication shall be processed as an initial application in accordance with the procedures set forth in Article I of this Credentials Policy, and the Practitioner must submit such additional information as the applicable authorities of the Medical Staff and the Board may reasonably require in demonstrating that the basis of the automatic termination, Adverse decision, or resignation/withdrawal has been resolved or no longer exists. If such information is not provided, the reapplication will be considered incomplete and voluntarily withdrawn and will not be further processed.

5.5.3 No Practitioner may submit or have in process at any given time more than one application for Medical Staff appointment and/or the same Privileges.

ARTICLE VI
CRIMINAL BACKGROUND CHECKS; INTERNAL CONFLICTS OF INTEREST

6.1 Criminal Background Checks

6.1.1 Purpose

A. To promote a safe environment for patients, employees, visitors and the general public by conducting criminal background checks (hereafter "background check") as part of the credentialing process for all Practitioners.

6.1.2 Procedure

A. A criminal background check shall be performed on Practitioners applying for initial appointment/Privileges and at the time of each reappointment/regrant of Privileges. No Practitioner may provide care, treatment, and/or services for patients at the Hospital until all credentialing requirements have been met, including results of a criminal background check, and the Practitioner has been granted Privileges to provide such care, treatment, and/or services.

B. Practitioners will be required to sign a waiver/consent for a background check. Refusal to provide adequate information on the initial application or reappointment/regrant form, or to provide consent/waiver for the background check, will result in the Hospital's inability to process the Practitioner's application or termination of Medical Staff appointment and Privileges for failure to meet baseline qualifications.

C. The background check process will be initiated by the Medical Staff Office and will not be performed until the signed consent/waiver is received by the Medical Staff Office.

D. Background checks will be conducted by a third party vendor who will be instructed to provide results to Medical Staff Office personnel only.

E. If the background check identifies any criminal activity not disclosed on the initial application or reappointment/regrant form, the Practitioner will be notified and additional information from the Practitioner will be requested. Failure to disclose all previous convictions will be considered falsification of records and will be grounds for immediate termination from the credentialing process. If the Medical Staff becomes aware that a Practitioner with current appointment and/or Privileges has not completed the application truthfully, he/she will be subject to corrective action.

F. Background check results will be evaluated and processed in accordance with the Medical Staff procedure for credentialing and

will be used for initial credentialing and recredentialing purposes. The following information will be evaluated to determine what action should be taken:

(1) Whether the criminal activity occurred recently.

(2) Number of offenses.

(3) Nature of each offense.

(4) Rehabilitation efforts.

(5) Seriousness of the matter.

(6) Relevance of the matter to the practice of medicine.

G. The Practitioner may be asked to provide a written response regarding the report, meet with the applicable Section/Department Chief(s), meet with the Credentials Committee, and/or may be required to have a fingerprint check. Failure to cooperate may result in the Hospital's inability to process the Practitioner's application or termination of Medical Staff appointment and Privileges for failure to meet baseline criteria.

H. Reasonable efforts will be made to ensure that results of criminal background checks are kept as confidential as possible with a limited number of individuals authorized to review the results.

I. The Practitioner may review the results of his/her own background check by contacting the Medical Staff Office in writing. A copy of the report shall be provided to the Practitioner upon his/her written request directed to the Medical Staff Office.

6.2 Internal Conflicts of Interest

6.2.1 In any instance where a Practitioner has or reasonably could be perceived to have a conflict of interest in any matter that comes before the Medical Staff, a Department/Section, or Medical Staff committee, the Practitioner is expected to disclose the conflict to the individual in charge of the meeting. The Practitioner may be asked and is expected to answer any questions concerning the conflict. The committee (or, in the absence of a committee, the individual in charge of the meeting) is responsible for determining whether a conflict exists and, if so, whether the conflict rises to the level of precluding the Practitioner from participating in the pending matter

6.2.2 A Department/Section Chief shall have the duty to delegate review of applications for appointment, reappointment, or Privileges/regrant of Privileges to another member of the Department/Section if the Department/Section could reasonably be perceived as not being able to review such application objectively.

6.2.3 For purposes of this section, the fact that Practitioners are competitors, partners, or employed in the same group shall not, in and of itself, automatically disqualify such Practitioners from participating in the review of applications or other Medical Staff matters with respect to their colleagues.

ARTICLE VII
RECOGNITION OF A NEW SERVICE, PROCEDURE, OR TECHNIQUE

7.1 Considerations and Privilege Criteria

7.1.1 The Board shall determine the Hospital's scope of patient care services based upon recommendations from Hospital administration, in consultation with the MEC, and thereafter delegates to the MEC the responsibility of developing the appropriate Privilege set for such services.

7.1.2 Overall considerations for establishing new services and procedures (and for recognizing new techniques with respect to existing procedures) include, but are not limited to:

A. The Hospital's available resources and staff (*e.g.,* equipment required, staff skills/training required, *etc.*).

B. The Hospital's ability to appropriately monitor and review the competence of the performing Practitioner(s) (*e.g.,* risks to patients *etc.*).

C. The availability of another qualified Practitioner(s) with Privileges at the Hospital to provide coverage for the procedure when needed and/or to provide coverage for the care of patients after the procedure.

D. The quality and availability of training programs.

E. Whether such service or procedure currently, or in the future, would be more appropriately provided through a contractual arrangement with the Hospital.

F. Whether there is a community need for the service or procedure.

7.2 Procedure for Practitioner Request for Recognition of a New Service, Procedure, or Technique

7.2.1 Requests by Practitioners for recognition of a new service, procedure, or technique that has not yet been recognized by the Board shall be processed as follows:

A. The Practitioner must submit a written request for recognition of a new service, procedure, or technique to the Medical Staff Office. The request should include the new service, procedure, or technique being requested, the reason why the Practitioner believes the Hospital should recognize such service, procedure, or technique, and any additional information that the Practitioner believes may be of assistance to the Hospital in evaluating the request.

B. The applicable Department Chief, with involvement of the Section Chief as appropriate, the Chief Medical Officer, and the Surgeon-in-Chief (as applicable) will review requests for new services, procedures, and techniques taking into account the considerations set forth in Section 7.1.2 as well as what specialties are likely to request such services, procedures, or techniques, positions of specialty societies/certifying boards, and criteria with respect to the services, procedures, or techniques by other hospitals with similar resources and staffing (*e.g.,* indications when use of the new service, procedure, or technique is appropriate, *etc.*). An *ad hoc* committee may be convened to assist with this review.

(1) If the Department Chief, the Chief Medical Officer, and the Surgeon-in-Chief (as applicable) recommend that the requested service, procedure, or technique be recognized at the Hospital, the Department Chief will prepare a written report including the recommended standards to be met with respect to the following: education, training; fellowship/board certification status; experience; and type of professional practice evaluation (*e.g.* whether proctoring/monitoring should be required; and, if so, the number of cases/procedures to be included/performed during an appointment/Privilege period to establish current competency) required to perform the new service, procedure, or technique.

(2) If the Department Chief, the Chief Medical Officer, and the Surgeon-in-Chief (as applicable) recommend that the new service, procedure, or technique be included in an existing Privilege set, the Department Chief will provide the basis for such determination.

(3) If the Department Chief, the Chief Medical Officer, and the Surgeon-in-Chief (as applicable) recommend that the new service, procedure, or technique not be offered at the Hospital, the Department Chief will prepare a written report detailing the findings.

C. The Department Chief shall forward a report containing the input of the Department Chief, the Chief Medical Officer, and the Surgeon-in-Chief (as applicable) to the Credentials Committee. Upon receipt of the Department Chief's report, the Credentials Committee will act. The opinion of the Credentials Committee, whether favorable or not favorable, will be forwarded to the MEC for review and action.

7.3 Amendment of Existing Privilege Sets

7.3.1 Proposed amendments to existing Privilege sets shall be reviewed by the applicable Department/Section Chief, the Chief Medical Officer, the

Surgeon-in-Chief (as applicable) and the Credentials Committee and approved by the MEC.

7.3.2 A decision not to approve proposed amendments to an existing Privilege set does not constitute an appealable event for purposes of the Fair Hearing Policy.

ARTICLE VIII
PEER REVIEW FILES

8.1 Peer Review Files

8.1.1 This section applies to peer review files maintained by the Medical Staff Services Office and documentation generated by or on behalf of a peer review committee.

8.1.2 It is the expectation of the Hospital that appropriate documentation will be maintained in peer review files and/or committee minutes with respect to all actions involving Practitioners. In the event that peer review files in addition to the standard credentials and quality files are generated (*e.g.,* corrective action investigations, fair hearings, *etc.*), a memo should be placed in the standard credentials or quality file (as appropriate) referencing the fact of the other file and providing a summary of the facts of the matter, nature of the concern, and conclusions reached.

8.1.3 Information with respect to any Practitioner that is submitted, collected, or prepared by any representative of the Hospital or any other health care facility, organization, or medical staff for the purpose of achieving and maintaining the quality of patient care and provided to the Credentials Committee or such other committee whose purpose it is to review and access quality information or otherwise perform quality improvement functions shall, to the fullest extent permitted by law, be held in confidence and not be disseminated except as provided herein or except as otherwise required by law.

8.1.4 Any committee as described above shall be considered a peer review committee as described in Ohio Revised Code Section 2305.25 *et seq*.

8.1.5 A breach of confidentiality by any Medical Staff representative would include, but not be limited to, the unauthorized release or exchange of any oral or written peer review protected information to any person/group/agency and may violate provisions of the Ohio Revised Code, imposing civil liability. If it is determined that such a breach has occurred, the Medical Staff Member may be subject to corrective action as deemed appropriate by the Medical Staff leadership.

8.1.6 Subject to Section 8.2., a request for dissemination of information contained in peer review files and committee minutes shall be presumed to require a subpoena. All subpoenas shall be referred to the Legal Services Department. The Legal Services Department will advise and consult with the Medical Staff President and the Chief Medical Officer regarding the particular situation.

8.2 Access to Peer Review Files

8.2.1 The following individuals shall be authorized representatives with access to Medical Staff peer review files, to the extent necessary to perform official functions, subject to the requirement that confidentiality be maintained:

A. Medical Staff Services Office Personnel

B. Respective Section Chiefs and/or Department Chiefs(s)

C. Officers of the Medical Staff

D. Chief Medical Officer

E. Credentials Committee chair and committee members

F. Legal Counsel for Hospital

G. Credential committee chair of related organizations which have contracted with Nationwide Children's Hospital for credentialing and peer review related services

H. Peer review committee members appointed and consultants retained by the CMO and/or Medical Staff President for credentialing and peer review purposes

I. Chief Executive Officer of Hospital

8.2.2 The authorized representatives shall have viewing access only in the presence of Medical Staff Services Office personnel and will not be allowed to remove the peer review files from Hospital premises.

8.2.3 A Practitioner will be permitted access to all information in the Practitioner's peer review file submitted by the Practitioner. Subject to Section 8.2-4, a Practitioner shall not have access to any other information in the Practitioner's peer review file. A Practitioner shall be given access to such information during the course of a fair hearing if an Adverse action or recommendation is based on such information.

8.2.4 Subject to the access rights described hereinabove, information contained in the peer review files of any Practitioner may be disclosed only with the written consent of the Practitioner and only after approval by the CMO and President of Medical Staff in consultation with Hospital legal counsel.

8.2.5 Requests for credentialing information from external organizations shall be in writing, include the reasons for the information, and a statement signed by the Practitioner releasing from liability all those providing the information.

8.2.6 Requests for information from third parties regarding clinical evaluation, restriction of Privileges, or Adverse actions will be referred to the respective

Section Chief and/or Department Chief(s) for completion along with a signed release of liability from the Practitioner. The applicable Chief will return a copy of completed requests to the Medical Staff Services Office.

8.2.7 No information will be released to third parties by telephone except for confirmation of the Practitioner's name and respective Department Chief(s) and/or Section Chief(s).

8.2.8 Accreditation surveyors shall be entitled to inspect Medical Staff credential files on the Hospital premises in the presence of Medical Staff Services Office personnel.

8.2.9 Individuals representing managed care organizations shall have limited access to the Medical Staff peer review files, in the presence of Medical Staff Services Office personnel, with a signed release of liability from the Practitioner. Documents contained in the files are viewable only and cannot be copied.

8.3 Location and Security Precautions

8.3.1 All Medical Staff peer review files shall be maintained in the Medical Staff Services Office. Such files shall be secured and under the supervision of the Medical Staff Services Office Manager. The files shall be secured except during such times as the Medical Staff Services Office personnel are physically present and able to monitor access.

8.3.2 Medical Staff peer review files will not be removed from the Medical Staff Services Office unless under the supervision of Medical Staff Services Office personnel.

8.4 Medical Staff Peer Review Committee and Department/Section Minutes

8.4.1 Dissemination to third parties of Medical Staff peer review committee minutes or the peer review portion of Department and/or Section minutes, related documents, and appendages shall only be made where expressly required by law.

8.4.2 Access to minutes by persons performing official Hospital or Medical Staff functions shall be permitted only to the extent necessary to perform said functions upon approval of the Medical Staff President, CMO, and Hospital legal counsel.

8.4.3 Provisions shall be taken to protect all peer review minutes from disclosure as follows:

A. Minutes shall be restricted to those actually involved in the peer review process.

B. Minutes distributed at a meeting may be collected at the conclusion of a meeting. Otherwise, it is the committee member's responsibility to maintain confidentiality of all minutes.

C. Minutes shall be stamped "Confidential Peer Review Information Protected by Law" under Ohio Revised Code 2305.25, *et seq*.

8.4.4 Accreditation surveyors shall be entitled to inspect Medical Staff committee minutes or Department and/or Section minutes in the presence of Medical Staff Services Office personnel.

ADOPTION & APPROVAL

Adopted by the Medical Executive Committee on November 23, 2021

Approved by the Hospital Board on November 30, 2021