ALLIED HEALTH

POLICY AND PROCEDURE

ORLANDO HEALTH®

1414 KUHL AVENUE

ORLANDO, FL 32806

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SECTION I: GENERAL

A. DEFINITIONS

1. **Allied Health Professional (also "AHP") –** A licensed or certified health professional who is not a physician, podiatrist, dentist or psychologist and who shares in the responsibility of delivering healthcare services in the hospital pursuant to the granting of clinical privileges or authorization to practice, under the scope of an Orlando Health clinical privilege description or job description, respectively.

2. **Advanced Practice Professional (also "APP") –** Includes Physician Assistant (PA), Advanced Registered Nurse Practitioner (ARNP), Certified Nurse Midwife (CNM), and Certified Registered Nurse Anesthetist (CRNA) who are granted clinical privileges under the scope of an Orlando Health clinical privilege description and function under the supervision of an applicable medical staff member in accordance with Florida law.

3. **Dependent Practitioner (also "DP") –** Includes Anatomic Pathologists Assistant (APA), Anesthesiologist Assistant (AA), Anesthesia Technologist (AT), Clinical Perfusionist (CP), Clinical Research Assistant (CRA), Dental Assistant (DA), Dental Perioperativc Support Associate (DPSA), Diabetes Educator (DE), Discharge Summary-Clinical Resume Dictation (DSCRD), Echosonographer (ES), Echo Technologist (ET), EKG Technician (EKGT), Exercise Physiologist (EP), Genetic Counselor (GNTC), Licensed Clinical Social Worker (LCSW), Licensed Practical Nurse (LPN), Medical Assistant (MA), Registered Nurse First Assist (RNFA), Research Nurse, Rounding Nurse (RN), Respiratory Therapist (RT), Surgical Tech (ST), Surgical Tech First Assist (STFA) and such other categories of Dependent Practitioners as are approved by the Orlando Health's Board of Directors who are authorized to practice under the scope of an Orlando Health job description and function under the supervision of a medical staff member but are not employed by Orlando Health.

4. **Supervising Medical Staff Member –** a medical staff member who is permitted under applicable Florida law to supervise an AHP and who assumes responsibility and legal liability for the services rendered by the AHP. The Supervising Medical Staff Member is either the Primary Supervising Medical Staff Member or Alternate Supervising Medical Staff Member as defined below.

5. **Primary Supervising Medical Staff Member** – the Supervising Medical Staff Member who assumes responsibility and legal liability for the services rendered by an AHP at all times the AHP is not under the supervision and control of an Alternate Supervising Medical Staff Member.

6. **Alternate Supervising Medical Staff Member** – a Supervising Medical Staff Member who assumes responsibility and legal liability for the services rendered by AHP while the AHP is under his or her supervision and control.

B. PRACTITIONER NEED

Except where otherwise required by law, no category of AHP will be permitted to provide services at Orlando Health unless the Board first determines that there is a need for such AHP services at the hospital and there exists a current clinical privilege description or job description. Such clinical privileges or authorization to practice shall be subject to any policy of exclusivity adopted by the Board.

C. NON-DISCRIMINATION

No AHP shall be denied clinical privileges or authorization to practice on the basis of sex, race, creed, color or national origin.

SECTION II: AHP COMMITTEE

A. COMPOSITION AND CHAIRMAN

1. The AHP Committee shall consist of the Vice Chief of Staff who shall serve as chairman, the Chief of Staff, the immediate past Chief of Staff, the Chief Nursing Officer, two (2) members of the Active Staff, and ten (10) APPs. Members shall serve for three (3) year terms which shall, in the initial appointment, be so staggered so that as few members' terms expire in any one year as practicable.

    a. The two (2) Active Staff members shall be appointed by the Chief of Staff and shall consist of one (1) medical specialist and one (1) surgical specialist.

    b. The ten (10) APPs shall be appointed by the Chief of Staff and shall consist of two (2) APPs from each of the following facilities: Arnold Palmer Hospital for Children, Dr. P. Phillips Hospital, Orlando Regional Medical Center, South Seminole Hospital, and Winnie Palmer Hospital for Women & Babies. The APPs appointed to the AHP Committee shall include at least one of each of the following a medical ARNP, a surgical ARNP, a medical PA, a surgical PA, a CRNA and a CNM.

2. The Chief Executive Officer or the Chief Executive Officer's designee may attend the meetings of the AHP committee and participate without vote.

B. VICE CHAIRMAN

1. The Vice Chairman shall be a APP member of the AHP Committee who is elected by majority vote of the membership of the AHP Committee voting in the election.

The Vice Chairman shall serve for a term of three (3) years and shall serve until his or her successor takes office. The Vice Chairman may be re-elected but shall not be re-elected for more than one (1) additional consecutive term unless no one else is eligible or desirous to serve.

2. The Vice Chairman shall be a member of the Credentials Committee.

3. The Vice Chairman may be removed from the position by a two-thirds (2/3) vote of all members of the AHP Committee.

4. If there is a vacancy in the position of Vice Chairman, it shall be filled by election of the AHP Committee within 60 days of such vacancy. The newly elected Vice Chairman shall serve out the remaining term.

C. DUTIES

The duties of the AHP Committee shall be:

1. To review the credentials of all APP applicants, to make such investigations and interview all APP applicants as may be necessary, and to make recommendations for delineation of clinical privileges in compliance with this Policy and Procedure and the Medical Staff Bylaws;

2. To make a report to the Credentials Committee on each APP applicant for clinical privileges, including specific consideration of the recommendations from the departments in which such APP applicant requests privileges;

3. To review the Clinical Privilege Descriptions for APPs and make recommendations thereon to the Credentials Committee.

4. To review periodically on its own motion or as questions arise all information available regarding the professional and clinical competence of APPs, their care and treatment of patients, and, as a result of such review, to make recommendations to the Credentials Committee for the granting, reduction, or withdrawal of privileges;

5. To review reports on specific APPs that are referred by the Credentials Committee, Medical Executive Committee, a Hospital Patient Care/Leadership Committee, any other medical staff committee, and by the Chief of Staff;

6. To review the Position Descriptions for DPs and to make recommendations thereon to the Credentials Committee.

7. To review this Policy and Procedure periodically on its own motion or as questions arise and make recommendations thereon to the Medical Executive Committee.

The Chairman of the AHP Committee, the Chairman's representatives, and such members of the committee as the Chairman deems necessary shall be available to meet with the Credentials Committee and/or the Medical Executive Committee on all recommendations that the AHP Committee may make.

D. MEETINGS, REPORTS, AND RECOMMENDATIONS

1. The AHP Committee shall meet as often as necessary to conduct its business, maintain permanent record of its proceedings and actions, and shall report its recommendations to the Credentials Committee and/or the Medical Executive Committee as indicated above.

2. The provisions of the Medical Staff Bylaws regarding department and committee meetings shall apply to meetings of the AHP Committee.

SECTION III: PROVISIONS APPLICABLE TO ALL AHPs

A. SUPERVISION

1. Except where otherwise required by law, services provided by an AHP shall be at the request of a supervising physician, who shall supervise and be responsible for all activities of the designated AHP at Orlando Health.

2. AHPs shall not admit patients but shall provide specified patient care services under the supervision or direction of a member of the medical staff. The Board of Directors shall adopt standards for each category of AHP which shall govern the minimum qualifications for provision of services, including the extent of supervision required, and the services to be provided by the AHP at Orlando Health. Such standards shall be in writing and made available to all applicants.

3. Orlando Health employed AHPs must be supervised by a medical staff member. Proof of malpractice coverage is not required.

4. AHPs who are employed by a non-employed medical staff member must be supervised by a medical staff member and must provide Orlando Health with the AHP's current malpractice coverage.

5. AHPs who are not employed by Orlando Health or in a medical staff member's practice must be supervised by a medical staff member and must provide Orlando Health with the AHP's current malpractice coverage.

6. An AHP who does not have malpractice coverage must provide a Supervising Medical Staff Member Indemnification agreement and an Alternate Supervising Medical Staff Member Indemnification Agreement signed by each Supervising Medical Staff Member who will be supervising the AHP at Orlando Health.

7. It is the responsibility of the AHP to inform the Medical Staff Services Office within seven (7) days of any changes in Supervising Medical Staff Member(s).

B. CONDITIONS

1. Each AHP shall be assigned to their Primary Supervising Medical Staff Member's clinical department

2. Each AHP shall abide by all bylaws, policies, and directives of the hospital, and all bylaws, rules, and regulations and policies and procedures of the medical staff.

3. Each AHP shall agree to be bound by and comply with the Orlando Health Corporate Compliance Program and Code of Conduct as recognized business and practice patterns that comply with federal, state, and local laws, statutes, regulations, and rules.

4. AHPs shall not be members of the Medical Staff. They may not vote or hold office on the Medical Staff and are not entitled to the procedural rights provided in the Medical Staff Bylaws.

5. AHPs shall be re-evaluated periodically, as described in Section III, Part D and Section IV, Part B of this policy and procedure.

6. AHPs are required to notify Orlando Health Medical Staff Services within seven (7) days of any changes in: contact information (i.e. address, phone, fax email, etc), employment, Supervising Medical Staff Member(s), licensure, certification, and other qualifications (to include, but not limited to, any disciplinary actions or professional liability claims or settlements which have been instituted against the AHP).

7. AHP must undergo drug/alcohol screening during initial credentialing. Any AHP who tests positive on the drug/alcohol screening will not be given approval to practice at Orlando Health and will not be entitled to any procedural rights herein.

8. AHPs must clearly identify themselves as AHPs by wearing their current Orlando Health identification badge. AHPs must ensure that in their day-to-day conduct, they are not mistaken for licensed physicians. AHPs must adhere to Orlando Health Dress & Grooming-Appropriate Appearance & Attire Policy (#5916-1528) and Orlando Health Parking All Downtown Buildings and Property Policy (#5706-0214).

C. AUTOMATIC ACTIONS CONCERNING AHPs

1. Loss or Suspension of Professional License

Action by any appropriate agency which revokes or suspends an individual's professional license or certification, or loss of licensure, shall result in automatic relinquishment of all clinical privileges (in the case of an APP) or authorization to practice (in the case of a DP) as of that date. In the case of an APP, if the license

or certification is restored within a sixty (60) day period, the individual's clinical privileges may be restored upon recommendation by the AHP Committee the Credentials Committee and the Medical Executive Committee and approval by the Board of Directors. In the case of a DP, if the license or certification is restored within a sixty (60) day period, the individual's authorization to practice may be restored upon the recommendation of the department chairman and the Chief of Staff. The AHP is responsible for notifying the hospital that the license or certification has been restored. For matters not resolved in a sixty (60) day period, clinical privileges (in the case of an APP) or authorization to practice (in the case of a DP) will not be restored. Only upon reinstatement of license or certification, may the individual reapply as a new applicant.

2. **Loss or Suspension of Drug Enforcement Administration (DEA) License**

In the case of APPs with a DEA license, revocation, loss or suspension of the individual's DEA license in any state shall result in automatic relinquishment of all applicable clinical privileges as of that date. If the DEA license is restored within a sixty (60) day period, the individual's clinical privileges may be restored upon recommendation by the AHP Committee, the Credentials Committee and Medical Executive Committee and approval by the Board of Directors. The APP is responsible for notifying the hospital that the DEA license has been restored. For matters not resolved within a sixty (60) day period, the individual's applicable clinical privileges may not be restored. Only upon reinstatement of the DEA license, may the individual reapply for those clinical privileges.

3. **Lapse of Professional License and/or DEA license**

Lapse of an individual's professional license and/or DEA license shall result in automatic relinquishment of applicable clinical privileges (in the case of an APP) or authorization to practice (in the case of a DP) as of that date. If the license and/or DEA license is restored in a sixty (60) day period the individual's clinical privileges (in the case of an APP) or authorization to practice (in the case of a DP) will be immediately restored. The AHP is responsible for notifying the hospital that the license and/or DEA license has been restored. For matters not resolved in a sixty (60) day period, clinical privileges (in the case of an APP) or authorization to practice (in the case of a DP) will not be restored. Only upon reinstatement of license and/or DEA license, may the individual reapply as a new applicant.

4. **Loss or Lapse of Malpractice Coverage and/or Indemnification Agreement**

Loss or lapse of an individual's malpractice coverage and/or indemnification agreement for more than thirty (30) days shall result in automatic voluntary relinquishment of all clinical privileges (in the case of an APP) or authorization to practice (in the case of a DP).

5. **Loss or Lapse of Life Support Certification**

Loss or lapse of any individual's required life support certification (e.g. BLS, ACLS, PALS, NRP etc.) for more than thirty (30) days shall result in automatic voluntary relinquishment of all clinical privileges (in the case of an APP) or authorization to practice (in the case of a DP).

6. **AHPs Whose Whereabouts are Unknown**

AHPs are responsible for notifying the hospital of any changes in their office and home address and telephone number(s) and other essential contact information. An AHP whose whereabouts are determined to be unknown will be considered to have voluntarily relinquished privileges (in the case of an APP) or authorization to practice (in the case of a DP).

7. **Automatic Relinquishment for OIG Sanctions**

Action by appropriate agency that excludes, suspends, or debars an individual from participation in federal healthcare programs, the conviction of a criminal offense related to the provision of professional healthcare services, or any other event that otherwise makes the individual ineligible for participation in federal healthcare programs, shall result in automatic relinquishment of privileges (in the case of an APP) or authorization to practice (in the case of a DP) as of that date. Only upon reinstatement may the individual reapply as a new applicant.

8. **Loss of Supervising Medical Staff Member**

An AHP who ceases to have any Supervising Medical Staff Member on the Orlando Health Medical Staff or an AHP whose only Supervising Medical Staff Member's status changes to Active Affiliate or Senior Affiliate, temporary suspension or leave of absence shall be deemed to have automatically relinquished all clinical privileges (in the case of an APP) or authorization to practice (in the case of a DP) as of that date. If within thirty (30) days a new Supervising Medical Staff Member is approved, the AHP's privileges (in the case of an APP) or authorization to practice (in the case of a DP) will be reinstated. After thirty (30) days elapsed, the AHP must reapply.

9. **Failure to Provide Requested Information**

Failure to provide requested information pursuant to a written request by the AHP Committee, Credentials Committee, Medical Executive Committee, the Medical Staff Officers, Medical Staff Services Office or any other medical staff committee authorized to request such information shall result in automatic relinquishment of all clinical privileges until the requested information is provided to the satisfaction of the requesting person or committee. In the case of APPs, this includes, but is not limited to, requests to submit FPPE and/or OPPE evaluation forms. If the requested information is not provided within thirty (30) days of the original deadline, the AHP will be considered to have voluntarily relinquished clinical privileges (in the case of an APP) or authorization to practice (in the case of a DP).

10. **Failure to Attend Mandatory Meeting**

The AHP Committee, Credentials Committee, Medical Executive Committee, the Medical Staff Officers, or investigation committee may require a AHP to attend a mandatory meeting. Written notice of the time and place shall be provided at least five (5) days in advance by certified mail, hand delivery or any other delivery method in which confirmation of receipt is obtained. The written notice shall include a statement of the issue involved and that the AHP's attendance is mandatory. Failure of an AHP to attend a mandatory meeting or to respond to the written notice may result in automatic relinquishment of clinical privileges. If the meeting does not occur within seven (7) days after the scheduled date, the AHP will be considered to have voluntarily relinquished clinical privileges (in the case of an APP) or authorization to practice (in the case of a DP). A mandatory meeting shall not constitute an investigation.

11. **Effect of Above Automatic Actions**

In the event of automatic relinquishment as provided above, the AHP will be deemed to have voluntarily relinquished privileges (in the case of an APP) or authorization to practice (in the case of a DP) and shall have no right to any of the procedural rights provided in Section III, Part H of this Policy and Procedure.

D. LEAVE OF ABSENCE

1. **Procedure for Leave of Absence:**

AHPs may be granted leaves of absence by the Board for a definitely stated period of time not to exceed one (1) year or the remainder of the AHP's current renewal term, whichever is shortest. Written requests for leaves of absence shall be made to the respective department chairman and shall state the beginning and ending dates of the requested leave and the reason leave is requested. In the case of APPs, the department chairman shall transmit the request together with a recommendation to

the Medical Executive Committee which shall make a report and a recommendation, and transmit it to the Board. In the case of DPs, the department chairman shall transmit the request together with a recommendation to the Chief of Staff. No AHP may take more than one consecutive one-year leave of absence. Leaves of absence are a matter of courtesy, not of right. In the event that a requested leave of absence is denied, or a leave of absence is granted for a shorter period of time than requested, the determination is final, with no recourse to any procedural rights. Leaves of absence are typically granted for reasons such as military duty, additional training, family matters, or personal health matters. AHP's who are relocating and who do not anticipate returning to this area are discouraged from requesting a leave of absence and should consider resignation.

2. **Reinstatement Following Leave of Absence:**

An AHP who desires reinstatement following a leave of absence shall submit a written request for reinstatement at least ninety (90) days prior to the termination of the leave of absence. The AHP shall submit a written summary of relevant activities during the leave. In the case of APPs, the department chairman shall make a recommendation to the AHP Committee, the AHP Committee shall make a recommendation to the Credentials Committee, the Credentials Committee shall make a recommendation to the Medical Executive Committee and the Medical Executive Committee shall make a recommendation to the Board concerning the reinstatement of the AHP's privileges. In the case of DPs, the department chairman shall make a recommendation to the Chief of Staff who shall make a determination regarding the reinstatement of the DP's authorization to practice.

3. **Failure to Request Reinstatement:**

Failure to make a timely request for reinstatement or to provide a summary of activities shall be deemed a voluntarily relinquishment of privileges (in the case of an APP) or authorization to practice (in the case of a DP). The individual may apply again in the future as an initial applicant upon completion of a new application and payment of any application fee.

E. RESIGNATION

An AHP who wishes to resign must submit written resignation to the Medical Staff Services Office.

F. APPLICATION

1. **Information:** Applications for delineated privileges (APP's) or authorization to practice (DP's) shall be in writing, and shall be submitted on the prescribed forms, which shall require detailed information about the applicant's professional qualifications, including:

(a) The names of at least three (3) individuals, who have had extensive experience in observing and working with the applicant and who can provide adequate reference pertaining to the applicant's professional competence, ethical character, and ability to perform the privileges requested. One of the individuals must be a physician, and two others must be peers with like credentials unless otherwise approved during the initial application process.

(b) Information as to whether the applicant's privileges or authorization to practice have ever been voluntarily or involuntarily revoked, suspended, reduced or not renewed at any other hospital or health care facility;

(c) Information as to whether the applicant's membership in local, state, or national professional associations or license to practice any profession in any state has ever been denied, suspended, limited, terminated, voluntarily or involuntary relinquished, and whether there is any currently pending challenge to such membership or licensure;

(d) Information concerning the applicant's malpractice experience;

(e) A consent to the release of information;

(f) A request for the specific privileges or authorization to practice desired by the applicant and documentation of compliance with the requirements as set forth in the applicable clinical privilege description or job description;

(h) Proof of compliance with applicable malpractice coverage requirements as set forth herein;

(i) Proof of compliance with applicable state practice requirements, including but not limited to, Physician Assistant Supervision Data form and ARNP Protocol; and

(j) Such other information as may be requested by Medical Staff Services.

2. **Undertakings:**

Every application shall be signed by the applicant and shall contain:

(a) The applicant's specific acknowledgment of the agreement to abide by this policy and procedure, all bylaws, policies and procedures, rules and regulations, and directives of Orlando Health and its Medical Staff in all matters relating to consideration of his or her application;

(b) A statement of the applicant's willingness to appear for personal interviews in regards to his or her application;

3. **Burden of Providing Information:**

The applicant shall have the burden of producing adequate information for a proper evaluation of his or her competence, character, ethics and other qualifications, and of resolving any doubts about such qualifications. The applicant shall have the burden of providing evidence that all the statements made and information given on the application are factual and true.

4. **Statement of Release and Immunity from Liability:**

The following are express conditions applicable to any AHP who applies at Orlando Health. By applying the applicant expressly accepts these conditions during the processing and consideration of his or her application as well as for the duration of his or her clinical privileges or authorization to practice:

(a) To the fullest extent permitted by law, the AHP extends absolute immunity and release from liability to the hospital and its authorized representatives from any and all civil liability arising from any acts, communications, reports, recommendations, or disclosures involving the AHP performed, made, taken, or received by this hospital and its authorized representatives, including but not limited to, members of the Medical Staff, in good faith during the course of the business of the hospital including by or from any third party concerning activities relating to, but not limited to:

i. Applications for clinical privileges or authorization to practice, including temporary clinical privileges, when applicable;

ii. Periodic reappraisals undertaken for renewals or expansion of clinical privileges or authorization to practice;

iii. Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation;

iv. Peer review;

v. Proceedings for disciplinary or corrective action, including but not limited to suspension or revocation of clinical privileges or authorization to practice;

vi. Precautionary summary suspension;

vii. Hearings and appellate reviews, for Advanced Practice Professionals only;

viii. Utilization and quality reviews;

ix. Exclusion from federal or state healthcare programs or conviction of healthcare related crimes;

x. Other hospital, departmental, service, or committee activities relating to the quality of patient care or the professional conduct of an AHP; and concerning matters or inquiries relating to an AHP's professional qualifications, credentials, current clinical competence, character, ability to perform clinical privileges or authorization to practice requested or granted, ethics, or any other matter that might directly or indirectly have an effect on the individual's competence, or on patient care, or on the orderly operation of this or any other hospital or health care facility, including otherwise privileged or confidential information.

(b) Any act, communication, report, recommendation or disclosure, with respect to any such AHP performed or made in good faith and at the request of an authorized representative of this hospital or any other hospital or health care facility, for the purposes set forth in (1) above, shall be privileged to the fullest extent permitted by law. Such privilege shall be extended to the hospital and its authorized representatives, and to any third parties who supply information to any of the foregoing authorized to receive, release, or act upon the same. The applicant to the fullest extent permitted by law extends absolute immunity and release from liability to any third parties who supply information as set forth in this Section.

i. The hospital and its authorized representatives are specifically authorized to consult with management and members of the Medical Staff of other hospitals, health care facilities or institutions with which the AHP has been associated and with others who may have information bearing on his or her competence, character and ethical qualifications.

ii. The hospital and its authorized representatives are specifically authorized to inspect all records and documents that may be material to an evaluation of the AHP's professional qualifications or current competence to perform the clinical privileges or essential functions and permitted tasks the AHP requests or currently possesses, as well as of the AHP's moral and ethical qualifications or stability as they may directly or indirectly affect the individual's current

competence, patient care, or the good operation of this hospital or any other health care facility

iii. The AHP specifically releases from any liability all representatives of the hospital, including its Medical Staff, for statements made or acts performed in good faith in evaluating the AHP for any of the purposes or reasons set forth in this section.

iv. As used in this section, the term "hospital and its authorized representatives" means the hospital, the members of its Board and their appointed representatives, the Chief Executive Officer, the Presidents, and their subordinates or designees, the hospital's attorney and the hospital attorney's partners, assistants or designees, and all members of the Medical Staff and all AHPs who have any direct or indirect responsibility for obtaining or evaluating the AHP's credentials and/or acting upon the AHP's application or conduct in the hospital.

v. As used in this section, the term "third parties" means all individuals or government agencies, organizations, associations, partnerships, corporations, whether hospitals, health care facilities or not, from whom information has been requested by the hospital and its authorized representatives, or who have requested such information from the hospital and its authorized representatives, provided that such request is received in good faith and pertains to the subject matter set forth in this section.

SECTION IV: ADVANCED PRACTICE PROFESSIONALS (APP)

A. INITIAL CLINICAL PRIVILEGES FOR APPs

1. **Description of Initial Clinical Privileges:**

Each APP who has been granted clinical privileges to practice in this hospital shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically approved by the Board, except as provided under Section III, Part C of this Policy and Procedure relating to temporary clinical privileges. Clinical privileges represent authorization granted by the Board to provide specific patient care services in the hospital within defined limits based on an individual's license, education, training, experience, judgment and ability to perform the clinical privileges granted.

2. **Application for Initial Clinical Privileges:**

Every initial application for privileges must contain, as a part thereof, a request for the specific clinical privileges desired by the applicant. The evaluation of such requests shall be based upon the applicant's education, training, experience, demonstrated competence and judgment, ability to perform the clinical privileges requested, references, and other relevant information, including an appraisal by the clinical department in which such privileges are sought.

B. PROCEDURE FOR INITIAL CLINICAL PRIVILEGES FOR APP's:

1. **Submission of Application**:

The completed application for privileges shall be submitted by the APP. The application will be considered active for a period of 180 days from the date the application was signed by the applicant. Failure to submit a complete and accurate application or to provide additional documentation or information necessary for processing the application when requested to do so will result in the application being considered incomplete and the application will not be processed. If any additional documentation or information requested is not provided within (30) days of such request, the application may be considered null and void. Reapplication shall require payment of a new application fee.

2. **Initial Procedure:**

After collecting references and other materials deemed pertinent, the application and all supporting materials shall be transmitted to the applicable department for the Department Chairman's written recommendations prior to the AHP Committee's evaluation.

3. **Department Chairman Procedure:**

(a) The Department Chairman shall provide the AHP Committee with specific written recommendations for approving or disapproving the application and for delineating the applicant's clinical privileges. These recommendations shall be made a part of the AHP Committee's report.

(b) As part of the process of making his or her recommendation, the Department Chairman may meet with the applicant to discuss any aspect of the applicant's application, qualifications and requested clinical privileges.

4. **AHP Committee Procedure:**

(a) The AHP Committee shall examine the evidence of the character, professional competence, ethical standing and other qualifications of the applicant and shall determine, through information contained in references given by the applicant and from other sources available to the committee, including an appraisal from the Chairman of the clinical department in

which privileges are sought, whether the applicant has established and meets all of the necessary qualifications for the privileges requested.

(b) After considering the recommendations of the clinical department chairman the AHP Committee shall recommend department assignments and clinical privileges for the APP applicant.

(c) As part of the process of making its recommendation, the AHP Committee may meet with the applicant to discuss any aspect of the applicant's application, qualifications and requested clinical privileges.

5. **AHP Committee Report:**

(a) Not later than ninety (90) days from its receipt of the completed application and all supporting material, the AHP Committee shall make a written report and recommendation on the applicant to the Credentials Committee.

(b) The AHP Committee shall transmit to the Credentials Committee the complete application and all supporting materials and its recommendation that the APP's application for clinical privileges be granted or denied, or that the application be deferred for further consideration.

6. **Credentials Committee Procedure and Report:**

(a) At the next regular meeting after receipt of the AHP Committee report, the Credentials Committee shall consider the report and such other relevant information as is available and shall make a written report and recommendation on the applicant to the Medical Executive Committee.

(b) The Credentials Committee shall transmit to the Medical Executive Committee the complete application and all supporting materials and its recommendation that the APP's application for clinical privileges be granted or denied.

(c) As part of the process of making its recommendation, the Credentials Committee may meet with the applicant to discuss any aspect of the applicant's application, qualifications and requested clinical privileges.

(d) The Credentials Committee may also defer action on the application. When the recommendation of the Credentials Committee is to defer the application for further consideration, it must be followed within ninety (90) days with a subsequent recommendation to the Medical Executive Committee for granting or denial of privileges.

7. **Subsequent Action on the Application:**

(a) At the next regular meeting after receipt of the Credentials Committee report, the Medical Executive Committee shall consider the report and such other relevant information as is available, and shall forward to the Board a written report and recommendations on the prescribed form. The Medical Executive Committee may also defer action on the application.

(b) When the recommendation of the Medical Executive Committee is favorable to the applicant, the recommendation shall be promptly forwarded to the Board. All recommendations must specifically recommend the clinical privileges to be granted, which may be qualified by any probationary conditions relating to such clinical privileges.

(c) When the recommendation of the Medical Executive Committee is to defer the application for further consideration, it must be followed within ninety (90) days with a subsequent recommendation to the Board for granting or denial of privileges.

(d) When the recommendation of the Medical Executive Committee is adverse to the APP, the APP shall be promptly notified by certified mail, return receipt requested. The application shall then be held until after the applicant has exercised or has been deemed to have waived the right to a hearing as provided in Section III, Part H hereof. At the time the applicant has been deemed to have waived the right to a hearing, the recommendation of the Medical Executive Committee, together with all supporting documentation, shall be forwarded to the Board.

(e) If the APP requests a hearing, the initial report of the Medical Executive Committee, the recommendation and hearing record of the Hearing Panel, together with all supporting documentation, shall be promptly forwarded to the Board.

C. TEMPORARY CLINICAL PRIVILEGES FOR APPs

1. **Temporary Clinical Privileges for Applicant APP's**

Upon receipt of an application for clinical privileges from an appropriately licensed applicant, the Chief of Staff may, upon the basis of information then available which may reasonably be relied upon as to the current competence, character and ethical standing of the applicant, and with the written concurrence of the department Chairman concerned, grant temporary clinical privileges to the applicant. The granting of such clinical privileges shall specify a termination date, which shall be no more than 120 days from the date granted. In exercising such clinical privileges, the applicant shall act under the supervision of the APP's Primary or Alternate Supervising Medical Staff Member.

2. **Temporary Clinical Privileges for Non-Applicants to Fulfill an Important Patient Care, Treatment and/or Service Need:**

(a) **Temporary Clinical Privileges for Care of Specific Patient:**

Temporary clinical privileges for care of a specific patient or patients may be granted by the Chief of Staff with the concurrence of the Primary Supervising Medical Staff Member and Chairman of the department concerned, to an APP who is not an applicant in the same manner and upon the same conditions as set forth in Section III, Part C.1. above, provided that the Chief of Staff shall first obtain such individual's signed acknowledgment that he or she agrees to be bound by the hospital and Medical Staff Rules and Regulations, and Policies and Procedures which are then in force in all matters relating to his or her temporary clinical privileges. Such clinical privileges shall be restricted to the specific patients for which they are granted. The APP shall complete an application and present proof of current licensure, and supply any additional information and documentation requested. In exercising such clinical privileges, the APP shall act under the supervision of his or her Primary or Alternate Supervising Medical Staff Member.

(b) **Locum Tenens:**

An appropriately licensed APP who is serving as a locum tenens may be granted temporary clinical privileges. The APP shall complete an application and present proof of current licensure, and shall supply any additional information and documentation requested. The APP must agree in writing to be bound by the bylaws, rules and regulations, and policies and procedures of the hospital and medical staff. Temporary clinical privileges for locum tenens may be granted for a maximum period of 120 days. In exercising such clinical privileges, the APP shall act under the supervision of his or her Primary or Alternate Supervising Medical Staff Member.

3. **Temporary Increase in Clinical Privileges for APP:**

Upon receipt of an application for increased clinical privileges by an APP pursuant to Section III, Part E. below, the Chief of Staff may, upon the basis of the information provided by the APP which justifies increased privileges, and with the written concurrence of the Primary Supervising Medical Staff Member and Department Chairman concerned, grant temporary increased clinical privileges to an APP. In exercising such privileges, the APP shall act under the supervision of the Primary or Alternate Supervising Medical Staff Member. The granting of temporary increased clinical privileges shall specify a termination date for such temporary increased clinical privileges which shall be no more than 120 days from the date granted.

4. **Special Requirements:**

Special requirements of supervision and reporting may be imposed on any individual granted temporary clinical privileges by the Chief of Staff. Temporary clinical privileges shall be immediately terminated by the Chief of Staff upon notice of any failure by the individual to comply with such special conditions.

5. **Termination of Temporary Clinical Privileges:**

(a) Temporary clinical privileges shall be granted for a specific period of time as warranted by the situation. Temporary clinical privileges shall expire at the end of the time period for which they are granted.

(b) The Chief of Staff may at any time, terminate an APP's temporary clinical privileges.

(c) The granting of any temporary clinical privileges is a courtesy on the part of the hospital and the granting, denial, or termination of such temporary clinical privileges shall not entitle the APP concerned to any of the procedural rights provided herein with respect to hearings or appeals.

6. **Emergency Action:**

(a) In an emergency, any APP to the degree permitted by his or her license and regardless of clinical privileges, shall be permitted to do, and shall be assisted in doing everything possible to save the life of a patient in the hospital, using every facility of the hospital necessary. For the purpose of this section, an "emergency" is defined as a condition which could result in serious permanent harm 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.

7. **Disaster Credentialing:**

(a) APPs who do not currently possess clinical privileges may be processed and accepted to render patient care when the emergency management plan has been activated and the organization has determined that the assistance of additional medical professionals is necessary. Disaster privileges may be granted by the Chief of Staff and/or President/CEO or designees. (Refer to Credentialing Practitioners in a Disaster/Emergency #5873-8009).

D. RENEWALS OF PRIVILEGES FOR APPs

1. When Application is Required:

Any APP, who wishes to be considered for renewal of privileges, including one on leave of absence, shall complete and submit an application on the required form within the required timeframe. Privileges shall be granted for a period of no more than two (2) years and shall automatically expire if not renewed.

2. Factors to be Considered:

Each recommendation concerning the renewal of privileges of an APP shall be based upon:

(a) Such APP's professional ethics, current clinical competence, and clinical judgment in the treatment of patients and the APP's ability to perform the clinical privileges requested;

(b) Such APP's compliance with the Allied Health Policies and Procedures, Corporate Compliance Program, Code of Conduct, and the applicable hospital and Medical Staff Bylaws, Rules and Regulations, and policies and procedures;

(c) Such APP's cooperation with hospital personnel;

(d) Such APP's cooperation and relations with members of the medical staff and other practitioners and general attitude toward patients, the hospital and the public;

(e) All APPs shall be evaluated for renewal of privileges on an individual basis after appropriate review;

(f) No APP shall have privileges renewed if he/she has been excluded from federal or state healthcare programs and/or has been convicted of a healthcare related crime.

3. Burden of Providing Information:

The APP who is applying for renewal of privileges shall have the burden of providing adequate information for a proper evaluation of his or her current clinical competence, clinical judgment, professional ethics, ability to perform the clinical privileges requested, and other qualifications, and of resolving any uncertainty about such qualifications. The APP shall have the burden of providing evidence that all the statements made and information given on the application for renewal of privileges and in support of the application are factual and true.

4. **Department Chairman Procedure:**

(a) The chairman of each department shall be provided with the applications for renewal of privileges of all APPs assigned to that department applying for renewal of privileges together with the clinical privileges each then holds and a completed renewal summary.

(b) The chairman of the department shall give his/her recommendations to the AHP Committee. In addition, the chairman shall submit individual recommendations and the reasons therefor, for any changes recommended in department, in clinical privileges, or for non-renewal of privileges.

(c) Recommendations for renewal of clinical privileges, if any, by the department chairman shall be based upon relevant recent training, observation of patient care provided, review of the appropriate records of patients treated in this or other hospitals, and review of all other appropriate records which evaluate the APP's participation in the delivery of care.

5. **AHP Committee Procedure:**

(a) The AHP Committee, after receiving recommendations from the chairman of each department, shall review all pertinent information available including all information provided from other committees of the medical staff and from hospital management for the purpose of determining its recommendations for renewal of clinical privileges.

(b) The AHP Committee shall prepare a list of APPs recommended for renewal of clinical privileges. Recommendations for non-renewal and for changes in requested clinical privileges, with reasons therefore, shall be reported and considered individually.

(c) The AHP Committee shall transmit its report and recommendations to the Credentials Committee. Where non-renewal of an APP's privileges or a change in requested clinical privileges is recommended, the reason for such recommendation shall be stated, documented and included in the report.

6. **Meeting with Affected APP:**

If, during the processing of an APP's application for renewal of clinical privileges, it becomes apparent to the AHP Committee or its chairman that the committee is considering a recommendation that would deny renewal of clinical privileges, deny a requested change in clinical privileges, or reduce clinical privileges of any APP, the chairman of the AHP Committee shall notify the APP of the general tenor of the possible recommendation, and ask the APP if he or she desires to meet with the AHP Committee prior to any final recommendation by the AHP Committee. At such meeting, the APP shall be informed of the general nature of the evidence supporting the action contemplated and shall be invited to discuss, explain, or refute

it. This interview shall not constitute a hearing, shall be preliminary in nature, and Section III, Part H of this policy with respect to hearings shall not apply. The AHP Committee shall indicate as part of its report to the Credentials Committee whether such a meeting occurred.

7. **Credentials Committee Procedure:**

(a) After reviewing the report and recommendations from the AHP Committee and all other relevant information, the Credentials Committee shall make a written report and recommendation to the Medical Executive Committee.

(b) If, during the processing of an APP's application for renewal of clinical privileges it becomes apparent to the Credentials Committee or its chairman that the committee is considering a recommendation that would deny renewal of clinical privileges, deny a requested change in clinical privileges, or reduce clinical privileges of the APP and:

i. If the AHP Committee met with the APP prior to making a recommendation that would deny renewal of clinical privileges, deny a requested change in clinical privileges, or reduce clinical privileges of any APP, the Credentials Committee may, but is not required to, offer the APP an opportunity to meet with the Credentials Committee prior to making a recommendation;

ii. If the AHP Committee did not meet with the APP prior to making its recommendation, or if the AHP Committee's recommendation was favorable to the APP, the Credentials Committee chairman shall notify the APP of the general tenor of the possible recommendation, and ask the APP if he or she desires to meet with the Credentials Committee prior to any final recommendation by the Credentials Committee. At such meeting, the APP shall be informed of the general nature of the evidence supporting the action contemplated and shall be invited to discuss, explain, or refute it. This interview shall not constitute a hearing, shall be preliminary in nature, and Section III, Part H of this policy with respect to hearings shall not apply.

(c) Where non-renewal of an APP's privileges or a change in requested clinical privileges is recommended, the Credentials Committee's report to the Medical Executive Committee shall include the reason and documentation for such recommendation and shall indicate whether the AHP Committee and/or the Credentials Committee met with the APP in question.

8. **Medical Executive Committee Procedure:**

The Medical Executive Committee, after reviewing the report and recommendations of the Credentials Committee and all other relevant information,

shall forward to the Board its report and recommendation. The Medical Executive Committee may also defer action. The chairman of the Credentials Committee or the chairman's designee shall be available to the Medical Executive Committee to answer any questions that may be raised with respect to the recommendations.

9. **Procedure Thereafter:**

Any recommendation by the Medical Executive Committee denying renewal of privileges or denying any requested clinical privileges shall entitle the affected APP to the Procedural Rights provided herein. The APP shall then be promptly notified of the recommendation by certified mail, return receipt requested. The recommendation shall not be forwarded to the Board until the applicant has exercised or has been deemed to have waived the right to a hearing as provided in Section III, Part H hereof, after which the Board shall be given the Medical Executive Committee's final recommendation and shall act on it.

E. PROCEDURE FOR REQUESTING CHANGE IN CLINICAL PRIVILEGES FOR APPs

1. **Application for Increase in Clinical Privileges:**

Whenever an APP desires to have an increase in his or her clinical privileges considered, the APP shall apply in writing on the appropriate application. The application shall state in detail the specific additional clinical privileges desired and the applicant's relevant recent training and experience which justify increased clinical privileges and include documentation of compliance with the requirements for such clinical privileges as set forth in the applicable clinical privilege description. The application shall be signed by the Primary Supervising Medical Staff Member who will be supervising this specific additional privilege. Thereafter, it will be processed in the same manner as an application for initial clinical privileges.

2. **Factors to Be Considered:**

Increase of clinical privileges shall be based upon compliance with the requirements for such clinical privileges as set forth in the applicable clinical privilege description, as well as relevant recent training, the direct observation of patient care provided, review of the appropriate records of patients treated in this or, where available, other hospitals, and review of all other appropriate records and information from applicable departments of the Medical Staff and hospital which evaluate the APP’s participation in the delivery of medical care that justify increased privileges, as well as the Supervising Physician’s recommendation. An APP may not be considered for increased privileges that exceed the Supervising Medical Staff Member’s delineated clinical privileges.

F. CORRECTIVE ACTION FOR APPs

1. Grounds for Action:

Whenever, on the basis of information and belief, the Chief of Staff, the Chairman of a clinical department, the Chairman of any Medical Staff Committee or a majority of any Medical Staff Committee, a majority of the AHP Committee, the Chairman of the Board or the CEO has cause to question:

(a) The clinical competence of an APP; or,

(b) The care or treatment of a patient accorded by an APP; or,

(c) A known or suspected violation of the Allied Health Policy and Procedure, Policies and Directives of the hospital, or applicable Rules and Regulations or Policies and Procedures of the Medical Staff relating to his or her patient care or professional activity including any aspect of his or her conduct in the hospital; or,

(d) A violation of the hospital Code of Conduct or conduct that is otherwise considered to be lower than the standards of the hospital, or is reasonably probable of being disruptive to hospital operations; or,

(e) An APP's compliance with the ethics of his or her profession; or,

(f) An APP's physical or mental impairment which may adversely affect patient care.

a written request for an investigation shall be addressed to the Medical Executive Committee making specific reference to the activity or conduct which gave rise to the request.

2. Investigation Procedure:

(a) The request shall be considered by the Medical Executive Committee at its next meeting and if, in the opinion of that Committee:

i. The request for investigation contains information sufficient to warrant a recommendation, the Medical Executive Committee shall make one. If the Medical Executive Committee is considering a recommendation that would entitle the APP to Fair Hearing and Appeal Rights pursuant to Section III, part H hereof, the Chief of Staff shall notify the APP of the general tenor of the possible recommendation and ask the APP if he or she desires to meet with the Medical Executive Committee prior to any final recommendation by the Committee. At such meeting, the affected

APP shall be informed of the general nature of the evidence supporting the action contemplated and shall be invited to discuss, explain, or refute it. This interview shall not constitute a hearing, shall be preliminary in nature, and Section III, Part H hereof shall not apply.

ii. The request for investigation does not at that point contain information sufficient to warrant a recommendation, the Medical Executive Committee shall immediately turn the matter over to the Credentials Committee for investigation.

(b) To avoid delay, the Medical Staff Officers may review the request and refer the matter to the Credentials Committee for investigation without consideration of the matter by the Medical Executive Committee as a whole, if in their opinion an investigation is necessary.

(c) If the matter is referred to the Credentials Committee for investigation, the Credentials Committee Chair shall appoint an Investigation Committee.

i. This Investigation Committee shall consist of three (3) persons, one (1) of whom shall be an APP with like credentials, two (2) shall be members of the medical staff. The Investigation Committee shall not include any Supervising Medical Staff Members(s) or practice partners of the APP under investigation or any members of the Medical Executive Committee.

ii. The Investigation Committee shall have available to them the full resources of the medical staff and the hospital to aid in their work, as well as the ability to use outside consultants as required.

iii. The individual with respect to whom an investigation has been requested shall have an opportunity to meet with the Investigation Committee before it makes its report. At this meeting (but not as a matter of right in advance of it), the APP shall be informed of the general nature of the evidence supporting the investigation requested and shall be invited to discuss, explain or refute it. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in Section III, Part H hereof shall apply. A record of such interview shall be made by the Investigation Committee and included with its report to the Credentials Committee.

iv. The investigation shall be completed and the report and recommendation submitted to the Credentials Committee within a reasonable time. If an investigation cannot be completed within 180 days, the Credentials Committee shall be advised of the delay and

the reasons therefor, and shall communicate the same to the Medical Executive Committee.

v. At its next meeting following receipt of the Investigation Committee report and recommendation, the Credentials Committee shall make a report and recommendation to the Medical Executive Committee if it has sufficient information to do so. If the Credentials Committee needs additional information, it may refer the matter back to the Investigation Committee with a request for such additional information.

3. **Procedure Thereafter:**

(a) At its next meeting following receipt of the Credentials Committee report and recommendation, the Medical Executive Committee shall make its recommendation to the Board if it has sufficient information to do so. If the Medical Executive Committee needs additional information, it may refer the matter back to the Credentials Committee for such additional information. It may recommend CEU's or other instructional, non-disciplinary requirements; a written warning; a letter of reprimand; terms of probation; reduction of clinical privileges; a suspension of clinical privileges; revocation of clinical privileges or such other action or combination of actions as it deems appropriate. The Medical Executive Committee may accept, modify, or reject the recommendation it receives from the Credentials Committee.

(b) Any recommendation by the Medical Executive Committee for reduction of clinical privileges, for revocation of clinical privileges, or for suspension of clinical privileges, (other than a precautionary summary suspension), shall entitle the affected APP to the Procedural Rights provided in Section III, Part H hereof. The Chief of Staff shall promptly notify the affected APP by certified mail. The Chief of Staff shall then hold the recommendation until after the APP has exercised or has been deemed to have waived the right to a hearing as provided in Section III, Part H hereof. At the time the APP has been deemed to have waived the right to a hearing, the Chief of Staff shall forward the recommendation of the Medical Executive Committee to the Board. The Chairman of the Credentials Committee and Medical Executive Committee, as applicable, or the Chairman's designee shall be available to the Board or its appropriate committee to answer any questions that may be raised with respect to the recommendation.

G. PRECAUTIONARY SUMMARY SUSPENSION OF CLINICAL PRIVILEGES FOR APPs

1. **Grounds for Precautionary Summary Suspension:**

(a) The Chief of Staff, the CEO or the Chairman of the Board shall each have the authority to summarily suspend all or any portion of the clinical privileges of an APP whenever such action must be taken immediately in the best interest of patient care or safety in the hospital, or for the continued effective operation of the hospital. Such suspension shall be deemed an interim precautionary step in the professional review activity related to any ultimate professional review action and not a complete professional review action. Such suspension shall not imply any final finding of responsibility for the situation that caused the suspension. The APP may be given an opportunity to refrain voluntarily from exercising privileges pending an investigation of the concerns raised.

(b) Such precautionary summary suspension shall become effective immediately upon imposition.

2. **Medical Executive Committee Procedure:**

(a) The individuals who exercise their authority under Section III, Part G of this policy and procedure to summarily suspend an Advanced Practice Professional's privileges shall immediately report their action to the Chief of Staff. The Medical Executive Committee shall then take such further action as is required in the manner specified under Section III, Part F of this policy and procedure. The precautionary summary suspension shall remain in force unless and until modified by the Chief of Staff, Medical Executive Committee, the CEO, or the Board, or until the matter that required the suspension is finally resolved.

H. FAIR HEARING AND APPEAL RIGHTS FOR APPs

1. **Request for Hearing:**

(a) **Notice of Recommendation:**

i. When a recommendation is made which, according to this Policy and Procedure, entitles an individual to request a hearing prior to a final decision of the Board on that recommendation, the APP shall be given notice. The notice shall advise of the action that has been recommended, the reasons for the recommended action, that the APP has the right to request a hearing, the time limit within which a hearing must be requested, and a summary of rights in the hearing pursuant to Section III, Part H.2 below. The APP shall have thirty

(30) days following the date of the receipt of such notice within which to request a hearing. Said request shall be made to the Chief of Staff. In the event the APP does not request a hearing within the time and in the manner set forth above, the APP shall be deemed to have waived the right to such hearing and to have accepted the action involved and such action shall thereupon become effective immediately upon final Board action.

(b) **Grounds for Hearing:**

The only grounds for hearing shall be denial of initial application for clinical privileges, denial of application for renewal of clinical privileges, denial of request for increased clinical privileges, revocation or reduction of clinical privileges, suspension of clinical privileges (other than precautionary summary suspension), and denial of reinstatement from leave of absence. No matter or action other than those specified herein shall constitute grounds for a hearing.

(c) **Time and Place for Hearing:**

The Chief of Staff or designee shall schedule the hearing. The hearing shall commence as soon as practicable. In the event the hearing cannot commence within one hundred twenty (120) days following the receipt of hearing request, the person shall be advised in writing of the reason for the delay.

(d) **Notice of Hearing and Witness Lists:**

i. The Chief of Staff or designee shall give at least thirty (30) days' notice of the date, time and place of the hearing to the person who requested the hearing.

ii. As a part of, or together with, the notice of hearing, MEC shall state in writing, in concise language, the acts or omissions with which the APP is charged, a list of the charts, if any, in question, the recommended course of action that is being challenged by this request for hearing, or the reasons for the denial of the request of the APP, (to the extent this information has not been furnished with the Notice of Recommendation), and a list of the names and addresses of the individuals, so far as is then reasonably known, who will give testimony or evidence in support of its recommendation at the hearing, The names and addresses of additional witnesses shall be provided as soon as procured.

iii. The Medical Executive Committee may, by notice, request the person who requested the hearing to provide a list of witnesses. The

person requesting the hearing shall provide a written list of the names and addresses of the individuals, so far as is then reasonably known, who will give testimony or evidence in support of that person within ten (10) days of such request, and shall provide the names and addresses of additional witnesses as soon as procured.

(e) **APP Hearing Panel:**

i. If a hearing is requested by an APP pursuant to this Policy and Procedure, it shall be conducted before an APP Hearing Panel consisting of three persons. Two of the APP Hearing Panel members shall be medical staff members. The third APP Hearing Panel member shall be an APP, who may have privileges at Orlando Health or who may be selected from outside the hospital. The Chief of Staff shall appoint the APP Hearing Panel members and shall also designate a chairperson of the APP Hearing Panel.

ii. The persons appointed for the APP Hearing Panel shall not have actively participated in the consideration of the matter involved at any previous level, although knowledge of the matter involved will not preclude an individual from serving as a member of the APP Hearing Panel. The APP Hearing Panel shall not include any of the following: the APP's Supervising Physician(s), practice partners or associates of the APP or his/her Supervising Physician(s), and/or anyone who is in direct economic competition with the APP who requested the hearing.

(f) **Failure to Appear:**

Failure without good cause of the person requesting the hearing to appear and proceed at such a hearing, shall be deemed to constitute voluntary acceptance of the recommendations or actions pending which shall then become final and effective immediately.

(g) **Postponements and Extensions:**

Postponements and extensions of time beyond the times expressly permitted herein may be requested by anyone but shall be permitted only by the APP Hearing Panel or its chairman acting upon its behalf on a showing of good cause.

(h) **Recommendation of the Hearing Panel:**

i. Within twenty (20) days after final adjournment of the hearing, the APP Hearing Panel shall render a recommendation and report, which shall be delivered to the Board. The recommendation and

report of the APP Hearing Panel shall contain a concise statement of the reasons justifying the recommendation made. At the same time, a copy of the recommendation and report shall be delivered by registered mail to the person who requested the hearing and to MEC.

ii. The MEC shall have the opportunity to comment on the Hearing Panel's report. Such comments shall be in writing and sent directly to the Board. A copy of such comments shall be provided to the person who requested the hearing.

(i) **The Appeal:**

The recommendation of the APP Hearing Panel shall be considered final, subject only to the right of appeal as provided in Section III , Part H.3 hereof and the approval of the Board.

2. **Hearing Procedure:**

(a) **Personal Presence Mandatory:**

Under no circumstances shall the hearing be conducted without the personal presence of the person requesting the hearing.

(b) **Representation:**

i. The hearing provided for in this Policy and Procedure is for the purpose of internal hospital resolution of matters bearing on professional conduct or competence. Accordingly, neither the APP who requested the hearing, nor the MEC, shall be represented at the hearing by an attorney.

ii. The Medical Executive Committee shall appoint a representative from the medical staff to represent it at the hearing.

(c) **The Presiding Officer:**

i. The Chairman of the APP Hearing Panel shall be the presiding officer, or the Chief of Staff may appoint an attorney (who may be legal counsel to the hospital) as presiding officer. If an attorney is appointed as presiding officer, he or she may participate in the private deliberations of the APP Hearing Panel and may be a legal advisor to the APP Hearing Panel, but may not vote and may not act as an advocate in the hearing.

ii. The presiding officer shall act to ensure that all participants in the hearing have a reasonable opportunity to be heard and that decorum

is maintained throughout the hearing. The presiding officer shall be entitled to determine the order of procedure. The presiding officer shall have the authority and discretion to make rulings on all questions which pertain to matters of procedure and to the admissibility of evidence, upon which the presiding officer may be advised by legal counsel to the hospital.

(d) **Record of Hearing:**

A record shall be made of the hearing by one of the following methods: a court reporter present to make a record of the hearing, a recording, or minutes of the proceedings. The cost of such court reporter, if used, shall be borne by the hospital. The person requesting the hearing shall be entitled to a copy of the record upon payment of any reasonable charges associated with the preparation thereof. The APP Hearing Panel may, but shall not be required to, order that oral evidence shall be taken only by oath or affirmation administered by any person designated by such body and entitled to notarize documents in this State.

(e) **Rights of Both Sides:**

At a hearing, both sides have the following rights: to call and examine witnesses, to introduce exhibits, to cross-examine any witness on any matter relevant to the issues and to rebut any evidence. If the person requesting the hearing does not testify in his or her own behalf, he or she may be called and examined as if under cross-examination.

(f) **Admissibility of Evidence:**

The hearing shall not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. Any evidence determined by the presiding officer to be relevant shall be admitted, regardless of the admissibility of such evidence in a court of law. Each party shall have the right to submit a memorandum of points and authorities, or other written statement in support of its position, and the APP Hearing Panel may request such a memorandum to be filed following the close of the hearing. The APP Hearing Panel may interrogate the witnesses or call additional witnesses if it deems it appropriate.

(g) **Official Notice:**

The presiding officer shall have the discretion to take official notice of any matters, either technical or scientific, relating to the issues under consideration which could have been judicially noticed by the courts of this State. Participants in the hearing shall be informed of the matters to be officially noticed and they shall be noted in the record of hearing. The

person requesting the hearing shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time shall be granted, if requested, to present written rebuttal of any evidence admitted on official notice.

(h) **Basis of Recommendation:**

The recommendation of the APP Hearing Panel shall be based on the evidence produced at the hearing. This evidence may consist of the following:

i. Oral testimony of witnesses;

ii. Memorandum of points and authorities presented in connection with hearing;

iii. Any material contained in the hospital's files regarding the person who requested the hearing so long as this material has been admitted into evidence at the hearing and the person who requested the hearing had the opportunity to comment on and, by other evidence, refute it;

iv. Any and all applications, references, and accompanying documents;

v. All officially noticed matters; and,

vi. Any other admissible evidence.

(i) **Burden of Proof:**

i. It shall be incumbent on the person who requested the hearing initially to come forward with evidence in support of his or her position.

ii. After all the evidence has been submitted by both sides, the Hearing Panel shall recommend against the person who requested the hearing unless it finds that said person has proved that the recommendation of the Medical Executive Committee was unreasonable, not sustained by evidence, or otherwise unfounded.

(j) **Adjournment and Conclusion:**

i. The presiding officer may adjourn the hearing and reconvene the same at the convenience of the participants. Upon conclusion of the presentation of oral and written evidence, the hearing shall be

closed. The APP Hearing Panel shall thereupon, outside of the presence of any other person except the presiding officer (if an attorney was appointed as the presiding officer), conduct its deliberations and render a recommendation and report.

3. **Appeal to the Board:**

(a) **Time for the Appeal:**

i. Within fifteen (15) days after the APP is notified of either (a) a recommendation adverse to him or her made by the APP Hearing Panel or (b) an action by the Board which reverses a favorable recommendation of the APP Hearing Panel, the applicant or APP may request an appellate review by the Board. Should the recommendation of the APP Hearing Panel or action by the Board be contra to the recommendation of MEC, the MEC may request an appellate review by the Board within fifteen (15) days after notification. Said written request shall be delivered to the Chief Executive Office either in person, or by certified or registered mail. If such appellate review is not requested within fifteen (15) days as provided above, both sides shall be deemed to have accepted the recommendation involved and it shall thereupon become final and shall be effective upon final Board approval. The written request for appeal shall also include a brief statement as to the reasons for appeal.

(b) **Grounds for Appeal:**

i. The only grounds for appeal from the hearing shall be:

a. Substantial failure to comply with this Policy and Procedure in the conduct of hearings and decisions upon hearings so as to deny due process or a fair hearing; or

b. Action taken arbitrarily, capriciously or with prejudice; or,

c. The recommendation of the APP Hearing Panel, or Board action was not supported by the evidence.

(c) **Time, Place and Notice:**

In the event of any appeal to the Board as set forth in the preceding section, the CEO, on behalf of the Board shall schedule and arrange for an appellate review. The CEO shall cause the APP to be given notice of the time, place and date of the appellate review. The date of appellate review shall be not less than thirty (30) days, nor more than ninety (90) days from

the date of receipt of the request for appellate review. The time for appellate review may be extended by the Chairman of the Board or designee for good cause.

(d) **Nature of Appellate Review:**

i. The CEO, after considering the recommendations of the Chairman of the Board, shall appoint a Review Panel composed of not less than three (3) persons, either Board members, reputable persons outside the hospital, or a combination of the two, none of whom are in direct economic competition with the APP, to consider all records providing that basis upon which the recommendation before it was made.

ii. The Review Panel may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the hearing. Each party shall have the right to present a written statement in support of the position on appeal, and in its sole discretion, the Review Panel may allow each party to appear personally and make oral argument. The Review Panel shall recommend final action to the Board.

(e) **Final Decision of the Board:**

At its next meeting after receipt of the recommendation of the Review Panel, such recommendation to be served not later than twenty (20) days after the conclusion of the proceedings before the Review Panel, the Board shall render a decision in writing. The Board may affirm, modify, or reverse the recommendation of the Review Panel or, in its discretion, may refer the matter for further review and recommendation. The Board's decision shall include a statement of the basis for the decision. Copies thereof shall be delivered to the APP and to the MEC in person or by certified mail.

(f) **Further Review:**

Except where the matter is referred for further action and recommendation, the final decision of the Board following the appeal shall be effective immediately and shall not be subject to further review. If the matter is referred for further action and recommendation, such recommendations shall be promptly made to the Board in accordance with the instructions given by the Board no later than the next meeting of the Board. Thereafter the Board shall render a final decision, including a statement of the basis for the decision, and shall deliver copies thereof to the APP and the MEC in person or by certified mail.

(g) **Right to One Appeal Only:**

No APP shall be entitled to more than one (1) appellate review on any single matter which may be the subject of an appeal, without regard to whether such subject is the result of action by the MEC, or the Board, or recommendation of a Hearing Panel, or a combination of acts of such bodies. However, nothing herein shall restrict the right of an APP to reapply or restrict the right to apply for an increase in clinical privileges after the expiration of two (2) years from the date of such denial of application unless the Board provides otherwise in the formal written denial.

SECTION V: DEPENDENT PRACTITIONERS

A. PROCEDURE FOR INITIAL AUTHORIZATION TO PRACTICE FOR DPs:

1. **Application for Initial Authorization to Practice:**

Each DP who has been given authorization to practice in this hospital shall be entitled to perform only those essential functions and permitted tasks granted by the Chief of Staff. Authorization granted by the Chief of Staff to provide specific patient care services in the hospital within defined limits including any and all supervision requirements, shall be based on an individual's license or certification, as applicable, education, training, experience, judgment and ability to perform the essential functions and permitted tasks granted. Evaluation of the applicant shall be based upon the education, training, experience, demonstrated competence and judgment, ability to perform the essential functions and permitted tasks, requested references and other relevant information, including an appraisal by the applicable clinical department chairman. The DP shall have the burden of establishing his or her qualifications for and competence to perform the essential functions and permitted tasks.

2. **Submission of Application:**

The completed application for authorization to practice shall be submitted by the DP. Failure to submit a completed application or to provide additional documentation or information necessary for processing the application when requested to do so will result in the application being considered incomplete and the application will not be processed. If any additional documentation or information requested is not provided within thirty (30) days of such request, the application will be considered null and void. Reapplication shall require payment of a new application fee.

3. **Initial Procedures:**

After collecting references and other materials deemed pertinent, the

application and all supporting materials shall be presented to the applicable department for Department Chairman's written recommendation prior to the Chief of Staff evaluation.

4. **Department Chairman Procedure:**

(a) The Department Chairman shall provide the Chief of Staff with specific written recommendations for granting or denying the application for authorization to practice.

(b) As part of the process of making his or her recommendation, the Department Chairman may interview the applicant to discuss any aspect of the applicant's application, qualifications and authorization to practice.

5. **Chief of Staff Review Process:**

(a) The Chief of Staff shall review the recommendation of the Department Chairman and shall determine whether the DP has established and meets all of the necessary qualifications for the requested authorization to practice.

(b) If granted, the DP will be informed of his/her authorization to practice in writing. The documentation of such approval shall be placed in each individual DP's credentials file.

(c) If denied, the DP will be notified in writing.

B. ANNUAL EVALUATION FOR RENEWAL OF AUTHORIZATION TO PRACTICE FOR DPs:

DPs will be evaluated annually for renewal of authorization to practice. Failure to provide complete information on the prescribed form and any other information requested in the time specified will result in automatic expiration of authorization to practice.

1. **Factors to be Considered:**

Each annual evaluation shall be based upon:

(a) Such DP's professional ethics, current clinical competence and clinical judgment in the care of patients and the DP's ability to perform the essential functions and permitted tasks;

(b) Such DP's compliance with the Allied Health Policies and Procedures, Corporate Compliance Program, Code of Conduct, and the applicable hospital and medical staff bylaws, rules and regulations and policies and procedures;

(c) Such DP's cooperation with hospital personnel; and

(d) Such DP's cooperation and relations with medical staff members and other practitioners and general attitude toward patients, the hospital and the public

(e) All DPs shall be evaluated for renewal of authorization to practice on an individual basis after appropriate review

(f) No DP shall be granted renewal of authorization to practice if he/she has been excluded from federal or state healthcare programs and/or has been convicted of a healthcare related crime.

(g) All annual evaluations must include a nurse manager review. If authorized by the Medical Staff Services Office, two peer evaluations may substitute for the nurse manager review.

(h) All annual evaluations must include a Primary Supervising Medical Staff Member review.

2. **Burden of Providing Information:**

The DP who is undergoing an annual evaluation for renewal of authorization to practice shall have the burden of providing adequate information for a proper evaluation of his or her current competence, judgment, professional ethics, ability to perform the essential functions and permitted tasks requested, and other qualifications, and of resolving any doubts about such qualifications. The DP shall have the burden of providing evidence that all the statements made and information given on the application for renewal of authorization to practice and in support of the application are factual and true.

3. **Department Chairman Procedure:**

(a) The Department Chairman shall provide the Chief of Staff with specific written recommendations for granting or denying the renewal of authorization to practice.

(b) As part of the process of making his or her recommendation, the Department Chairman may interview the applicant to discuss any aspect of the applicant's renewal application, qualifications and authorization to practice.

4. **Chief of Staff Procedure:**

(a) The Chief of Staff shall review the recommendation of the Department Chairman and shall determine whether the DP has established and meets

all of the necessary qualifications for the requested renewal of the authorization to practice.

(b) If granted, the DP will be informed of his/her authorization to practice in writing. The documentation of such approval shall be placed in each individual DP's credentials file.

(c) If denied, the DP will be notified in writing.

C. CORRECTIVE ACTION FOR DPs:

1. Grounds for Action:

Whenever, on the basis of information and belief, the Chief of Staff, the Chairman of a clinical department, the Chairman of any Medical Staff Committee or a majority of any Medical Staff Committee, a majority of the AHP Committee, the Chairman of the Board or the CEO has cause to question:

(a) The clinical competence of a DP; or,

(b) The care or treatment of a patient accorded by a DP; or,

(c) A known or suspected violation of the Allied Health Policy and Procedure, Policies and Directives of the hospital, or applicable Rules and Regulations or Policies and Procedures of the Medical Staff relating to his or her patient care or professional activity including any aspect of his or her conduct in the hospital; or,

(d) A violation of the hospital Code of Conduct or conduct that is otherwise considered to be lower than the standards of the hospital, or is reasonably probable of being disruptive to hospital operations; or,

(e) A DP's compliance with the ethics of his or her profession; or,

(f) A DP's physical or mental impairment which may adversely affect patient care.

a written request for an investigation shall be addressed to the Chief of Staff making specific reference to the activity or conduct which gave rise to the request.

2. Investigation Procedure:

(a) The matter shall be reviewed by the Medical Staff Officers who will make a determination. If a Medical Staff Officer is one of the DP's Supervising

Medical Staff Members, the Medical Staff Officer shall not participate in the review and shall appoint a designee in his or her stead.

(b) The Medical Staff Officers will determine whether corrective action is needed, and if so, will determine the specific corrective action to be taken. In making this determination, the Medical Staff Officers may conduct such investigation as they believe appropriate, including interviewing employees, medical staff members, and others who may have knowledge of the matter(s) in question and obtaining records and information from various departments of the hospital. The Medical Staff Officers shall interview the DP and may interview the DP's Supervising Medical Staff Member(s) prior to reaching a determination.

(c) Corrective action may include, but is not limited to, the following:

i. CEU's or other instructional, non-disciplinary requirements

ii. Written warning

iii. Letter of reprimand

iv. Terms of probation

v. Suspension of authorization for a period of time

vi. Termination of authorization

vii. Any other action or combination of actions as determined to be appropriate.

(d) The Medical Staff Officers decision will take effect immediately and the DP will be notified by certified mail.

(e) The DP is not entitled to any of the hearing and appeal rights provided in Section III Part H hereof.

D. PRECAUTIONARY SUMMARY SUSPENSION FOR DPs

1. The Chief of Staff, the CEO or the Chairman of the Board shall each have the authority to summarily suspend the DP's authorization to practice whenever such action must be taken immediately in the best interest of patient care or safety in the hospital, or for the continued effective operation of the hospital. Such suspension shall not imply any final finding of responsibility for the situation that caused the suspension. The DP may be given an opportunity to refrain voluntarily from practicing pending an investigation of the concerns raised.

2. Such precautionary summary suspension shall become effective immediately upon imposition and remain in effect until a determination is made by the Medical Staff Officers as provided under Section IV Part C hereof, or until the matter that required the suspension is finally resolved.

SECTION VI: AMENDMENTS

Amendments to this policy and procedure shall follow the process outlined in Article XII in the Medical Staff Bylaws for amendment of policies and procedures, with the following modifications:

A. Any amendment proposed by the Medical Executive Committee shall first be distributed to all medical staff members and to all AHPs with clinical privileges or authorization to practice at Orlando Health for review and comment. The proposed amendment shall be distributed by mail, facsimile transmission, email, or posting on the medical staff pages of the hospital website at least fourteen (14) days prior to the Medical Executive Committee vote, together with instructions on how interested persons may communicate comments. All comments shall be summarized and provided to the Medical Executive Committee prior to Medical Executive Committee action on the proposed amendment.

B. If an amendment is proposed by a petition of medical staff members pursuant to Article XII, Section 2 (b), before the proposed amendment is voted on by the medical staff members qualified to vote, the amendment shall first be submitted to the Medical Executive Committee for review and comment. The Medical Executive Committee shall cause the proposed amendment to be distributed to all medical staff members and all AHPs with clinical privileges or authorization to practice at Orlando Health for review and comment. The proposed amendment shall be distributed by mail, facsimile transmission, email, or posting on the medical staff pages of the hospital website at least fourteen (14) days prior to the Medical Executive Committee meeting at which the proposed amendment is to be discussed, together with instructions on how interested persons may communicate comments. All comments shall be summarized and provided to the Medical Executive Committee prior to Medical Executive Committee review and comment on the proposed amendment. The Medical Executive Committee's recommendation with respect to the proposed amendment may accompany the ballot.

C. Any amendment proposed by the AHP Committee shall be submitted to the Medical Executive Committee.