MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS OF ST. MARY'S HOSPITAL

POLICY ON ALLIED HEALTH PROFESSIONALS

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ARTICLE 1

GENERAL

1.1. Definitions:

The following definitions apply to terms used in this Policy:

(a) "ALLIED HEALTH PROFESSIONALS" ("AHPs") means individuals other than Medical Staff members who are authorized by law and by the Hospital to provide patient care services within the Hospital.

(b) "BOARD" means the Board of Directors of the Hospital, which has the overall responsibility for the Hospital, or its designated committee.

(c) "CATEGORY I PRACTITIONER" means a Licensed Independent Practitioner, a type of Allied Health Professional who is permitted by law and by the Hospital to provide patient care services without direction or supervision, within the scope of his or her license and consistent with the clinical privileges granted.

(d) "CATEGORY II PRACTITIONER" means an Advanced Dependent Practitioner, a type of Allied Health Professional who provides a medical level of care or performs surgical tasks consistent with granted clinical privileges, but who is required by law and/or the Hospital to exercise those clinical privileges under the direction of, or in collaboration with, a Supervising Practitioner pursuant to a written supervision or collaborative agreement (i.e., Advanced Practice Registered Nurses ("APRN"), Physician Assistants ("PA")).

(e) "CATEGORY III PRACTITIONER" means a type of Allied Health Professional who is permitted by law or the Hospital to function only under the direction of, or in collaboration with, a Supervising Practitioner, pursuant to a written supervision agreement and consistent with the scope of practice granted. Except as specifically indicated in Article 6 of this Policy, all aspects of the clinical practice of Category III practitioners at the Hospital shall be handled by the Medical Staff Office in accordance with Medical Staff Office policies and procedures, and the provisions of this Policy shall specifically not apply. Hereafter, as used in this Policy, the term "Allied Health Professional" shall mean Category I and Category II practitioners only (except for Article 6).

(f) "CHIEF EXECUTIVE OFFICER" or "CEO" means the individual appointed by the Board to act on its behalf in the overall management of the Hospital.

(g) "CHIEF MEDICAL OFFICER" ("CMO") means the individual appointed to act as the chief medical officer of the Hospital. The Chief Medical Officer shall work in cooperation with the President of the Medical Staff.
"CLINICAL PRIVILEGES" means the authorization granted by the Board to render specific patient care services, for which the Medical Staff leaders and Board have developed eligibility and other credentialing criteria and focused and ongoing professional practice evaluation standards.

"DAYS" means calendar days.

"DENTIST" means a doctor of dental surgery ("D.D.S.") or doctor of dental medicine ("D.M.D.").

"HOSPITAL" means St. Mary's Hospital.

"MEDICAL EXECUTIVE COMMITTEE" or "MEC" means the Executive Committee of the Medical Staff.

"MEDICAL STAFF" means all physicians, dentists, and podiatrists who have been appointed to the Medical Staff by the Board.

"MEDICAL STAFF LEADER" means any Medical Staff Officer, department chief, and committee chair.

"MEMBER" means any physician, dentist, and podiatrist who has been granted Medical Staff appointment and clinical privileges by the Board to practice at the Hospital.

"NOTICE" means written communication by regular U.S. mail, e-mail, facsimile, Hospital mail, hand delivery, or posting on the Medical Staff website or bulletin board.

"PHYSICIAN" includes both doctors of medicine ("M.D.s") and doctors of osteopathic medicine ("D.O.s").

"PODIATRIST" means a doctor of podiatric medicine ("D.P.M.").

"SPECIAL NOTICE" means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.

"SUPERVISING PRACTITIONER" means a member of the Medical Staff with clinical privileges, who has agreed in writing to supervise a Category II or Category III practitioner while he or she is practicing in the Hospital.

"SUPERVISION" means the oversight of, or collaboration with, a Category II or Category III practitioner by a Supervising Practitioner that may or may not require the actual presence of the Supervising Practitioner, but that does require, at a minimum, that the Supervising Practitioner be readily available for
consultation. The requisite level of supervision (general, direct, or personal) shall be determined at the time each Category II or Category III practitioner is credentialed and shall be consistent with any applicable written supervision agreement that may exist. ("General" supervision means that the physician is immediately available by phone, "direct" supervision means that the physician is on the Hospital's campus, and "personal" supervision means that the physician is in the same room.)

1.2. Time Limits:

Time limits referred to in this Policy are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

1.3. Delegation of Functions:

(a) When a function is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one or more qualified designees.

(b) When a Medical Staff member is unavailable to perform a necessary function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.
ARTICLE 2

SCOPE AND OVERVIEW OF POLICY

2.1. Scope of Policy:

This Policy addresses those Allied Health Professionals who are permitted to provide services at the Hospital. It sets forth the credentialing process and the general practice parameters for these individuals, as well as guidelines for determining the need for additional categories of Allied Health Professionals at the Hospital.

2.2. Categories of Allied Health Professionals:

(a) Only those specific categories of Allied Health Professionals that have been approved by the Board of Directors shall be permitted to practice at the Hospital. All Allied Health Professionals shall be classified as either Category I, Category II, or Category III practitioners.

(b) Current listings of the specific categories of Allied Health Professionals functioning in the Hospital as Category I and Category II practitioners are attached to this Policy as Appendices A and B, respectively. The Appendices may be modified or supplemented by action of the Board, after receiving the recommendation of the MEC, without the necessity of further amendment of this Policy.
ARTICLE 3

GUIDELINES FOR DETERMINING THE NEED FOR NEW CATEGORIES OF ALLIED HEALTH PROFESSIONALS

3.1. Determination of Need:

Whenever an Allied Health Professional in a category that has not been approved by the Board requests permission to practice at the Hospital, the Board shall appoint an ad hoc committee to evaluate the need for that particular category of Allied Health Professional and to make a recommendation to the Board. As part of the process, the Allied Health Professional shall be invited to submit information about the nature of the proposed practice, why Hospital access is sought, and the potential benefits to the community by having such services available at the Hospital. If the Allied Health Professional is a dependent practitioner, the ad hoc committee may also obtain information from the supervising physician. The ad hoc committee may also consult with other experts, including those on the Medical Staff and those outside the Hospital, and may consider the following factors when making a recommendation to the Board as to the need for the services of this category of Allied Health Professionals:

(a) the nature of the services that could be offered;

(b) any state license or regulation which outlines the scope of practice for the Allied Health Professional;

(c) any state "non-discrimination" or "any willing provider" laws that would apply to the Allied Health Professional;

(d) the patient care objectives of the Hospital, including patient convenience;

(e) how well the community’s needs are currently being met and whether they could be better met if the services offered by the Allied Health Professional were provided by the Hospital or as part of its facilities;

(f) the type of training that is necessary to perform the services that could be offered and whether there are individuals with more training currently providing those services;

(g) the availability of supplies, equipment, and other necessary Hospital resources;

(h) the need for and availability of trained staff to support the services that would be offered; and

(i) the ability to appropriately supervise performance.
3.2. Development of Policy:

(a) If the ad hoc committee recommends that there is a need for the particular category of Allied Health Professional at the Hospital, the committee shall recommend:

1. any specific qualifications and/or training that they must possess beyond those set forth in this Policy;

2. a detailed description of their authorized scope of practice or clinical privileges;

3. any specific conditions that apply to their functioning within the Hospital; and

4. any supervision requirements, if applicable.

(b) In developing such policies, the ad hoc committee shall consult the appropriate department chief(s) and applicable state law and may contact applicable professional societies or associations. The ad hoc committee may also recommend to the Board the number of Allied Health Professionals that are needed in a particular category.
ARTICLE 4

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

4.1. Threshold Eligibility Qualifications:

To be eligible to apply for initial and continued permission to practice at the Hospital, Allied Health Professionals must, where applicable:

(a) have a current, unrestricted license or certification to practice in Georgia and have never had a license or certification to practice revoked or suspended by any state licensing agency;

(b) where applicable to their practice, have a current, unrestricted DEA registration;

(c) be located close enough to fulfill their responsibilities as an Allied Health Professional and to provide timely and continuous care for their patients in the Hospital;

(d) possess current, valid professional liability insurance coverage in such form and in amounts satisfactory to the Hospital;

(e) have never been convicted of, or entered a plea of guilty or no contest to, Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse;

(f) have never been, and are not currently, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program;

(g) have never had clinical privileges or scope of practice denied, revoked, suspended, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct;

(h) have never resigned or relinquished clinical privileges or scope of practice during an investigation or in exchange for not conducting an investigation;

(i) have never been convicted of, or entered a plea of guilty or no contest to, any felony; or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, or violence;

(j) provide evidence of a negative purified protein derivative (PPD) test, or, for applicants who have had positive PPD skin tests, provide evidence of a current chest x-ray showing no active disease;
(k) satisfy all additional eligibility qualifications relating to their specific area of practice that may be established by the Hospital;

(l) if seeking to practice as a Category II or Category III practitioner, have a supervision agreement with a Supervising Practitioner; and

(m) be able to document their:

(1) relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, and clinical judgment, and an understanding of the contexts and systems within which care is provided;

(2) adherence to the ethics of their profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients and their profession;

(3) good reputation and character;

(4) ability to perform, safely and competently, the clinical privileges or scope of practice requested;

(5) ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families and other members of health care teams; and

(6) recognition of the importance of, and willingness to support, the Hospital's commitment to quality care and a recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

4.2. Waiver of Threshold Eligibility Criteria:

(a) Any individual who does not satisfy a threshold eligibility criterion may request that it be waived. The individual requesting the waiver bears the burden of demonstrating exceptional circumstances and that his or her qualifications are equivalent to, or exceed, the criterion in question.

(b) The Board may grant waivers in exceptional cases after considering the findings of the Credentials Committee and the MEC, the specific qualifications of the individual in question, and the best interests of the Hospital and the community it serves. The granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals.

(c) No individual is entitled to a waiver or to a hearing if the Board determinates not to grant a waiver.
(d) A determination that an individual is not entitled to a waiver is not a "denial" of clinical privileges or scope of practice. Rather, that individual is ineligible to request clinical privileges or scope of practice.

4.3. No Entitlement to Medical Staff Appointment:

Allied Health Professionals shall not be appointed to the Medical Staff or entitled to the rights, privileges, and/or prerogatives of Medical Staff appointment.

4.4. Non-Discrimination Policy:

No individual shall be denied permission to practice at the Hospital on the basis of gender, race, creed, or national origin.

4.5. Ethical and Religious Directives:

All Allied Health Professionals shall abide by the terms of the Ethical and Religious Directives for Catholic Health Care Services promulgated by the National Conference of Catholic Bishops with respect to their practice at the Hospital. No activity prohibited by said directives shall be engaged in at the Hospital by any Allied Health Professional.

4.6. Assumption of Duties and Responsibilities:

As a condition of permission to practice at the Hospital, all Allied Health Professionals shall specifically agree to the following:

(a) to provide continuous and timely care to all patients in the Hospital for whom the individual has responsibility;

(b) to abide by all applicable bylaws, policies, rules and regulations of the Medical Staff and Hospital;

(c) to accept committee assignments, participation in performance improvement and professional practice evaluation activities, and such other reasonable duties and responsibilities as may be assigned;

(d) to constructively participate in the development, review, and revision of clinical protocols and pathways pertinent to his or her specialty, including those related to national patient safety initiatives and core measures;

(e) to comply with adopted protocols and pathways or clearly document the clinical reasons for variance;

(f) to inform the CMO or President of the Medical Staff of any change in the individual's status or any change in the information provided on the individual's
application form. This information shall be provided with or without request, at the time the change occurs, and shall include, but not be limited to:

- changes in licensure status or professional liability insurance coverage;
- the filing of a professional liability lawsuit against the practitioner;
- changes in the individual's status at any other hospital;
- arrest, charge, indictment, conviction, or a plea of guilty or no contest in any criminal matter;
- exclusion or preclusion from participation in Medicare or any sanctions imposed; and
- any changes in the individual's ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment because of health status issue including impairment due to addiction, and any charge of, or arrest for, driving under the influence (DUI);

(g) to immediately submit to a blood, hair, and/or urine test, or to a complete physical and/or mental evaluation, if at least two Medical Staff Leaders (or one Medical Staff Leader and one member of Hospital Administration) are concerned with the individual's ability to safely and competently care for patients and request such testing and/or evaluation. The health care professional(s) to perform the testing and/or evaluations shall be determined by the Medical Staff leadership;

(h) to maintain a current e-mail address with the Medical Staff Office, which shall be the official mechanism used to communicate all Medical Staff information to the member other than peer review information pertaining to the member and/or protected health information of patients;

(i) to acknowledge that the individual has had an opportunity to read a copy of this Policy and any other applicable bylaws, policies, rules and regulations and agrees to be bound by them;

(j) to appear for personal or phone interviews in regard to an application for permission to practice as may be requested;

(k) to refrain from illegal fee splitting or other illegal inducements relating to patient referral;

(l) to refrain from assuming responsibility for diagnosis or care of hospitalized patients for which he or she is not qualified or without adequate supervision;
(m) to refrain from deceiving patients as to the individual's status as an Allied Health Professional;

(n) to seek consultation whenever required or as needed;

(o) to participate in the performance improvement and quality monitoring activities of the Hospital;

(p) to complete, in a timely manner, the medical and other required records, containing all information required by the Hospital;

(q) to perform all services and conduct himself/herself at all times in a cooperative and professional manner;

(r) to satisfy applicable continuing education requirements;

(s) to pay any applicable dues and assessments;

(t) to complete a Tuberculosis Health Questionnaire annually; and

(u) that, if there is any misstatement in, or omission from, the application, the Hospital may stop processing the application (or, if permission to practice has been granted prior to the discovery of a misstatement or omission, the permission may be deemed to be automatically relinquished). In either situation, there shall be no entitlement to the procedural rights provided in this Policy.

4.7. Burden of Providing Information:

(a) Allied Health Professionals seeking permission to practice shall have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications, and for resolving any doubts about such qualifications.

(b) Allied Health Professionals seeking appointment have the burden of providing evidence that all the statements made and information given on the application are accurate and complete.

(c) An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information verified from primary sources. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time. Any application that continues to be incomplete 30 days after the individual has been notified of the additional information required shall be deemed to be withdrawn.
(d) It is the responsibility of the individual seeking permission to practice to provide a complete application, including adequate responses from references. An incomplete application will not be processed.

4.8. Application Form:

(a) The application forms for both initial and renewed permission to practice as an Allied Health Professional shall require detailed information concerning the applicant's professional qualifications. The Allied Health Professional applications existing now and as may be revised are incorporated by reference and made a part of this Policy.

(b) In addition to other information, the applications shall seek the following:

(1) information as to whether the applicant's clinical privileges, scope of practice, permission to practice, and/or affiliation has ever been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, reduced, subjected to probationary or other conditions, limited, terminated, or not renewed at any hospital or health care facility, or is currently being investigated or challenged;

(2) information as to whether the applicant's license or certification to practice any profession in any state, Drug Enforcement Administration, or any state controlled substance license (if applicable) is or has ever been voluntarily or involuntarily relinquished, suspended, modified, terminated, restricted, or is currently being investigated or challenged;

(3) information concerning the applicant's professional liability litigation experience and/or any professional misconduct proceedings involving the applicant, in this state or any other state, whether such proceedings are closed or still pending, including the substance of the allegations of such proceedings or actions, the substance of the findings of such proceedings or actions, the ultimate disposition of any such proceedings or actions that have been closed, and any additional information concerning such proceedings or actions as the Credentials Committee, MEC or Board may deem appropriate;

(4) current information regarding the applicant's ability to perform, safely and competently, the scope of practice or clinical privileges requested and the duties of Allied Health Professionals; and

(5) a copy of government-issued photo identification.

(c) The applicant shall sign the application and certify that he or she is able to perform the scope of practice or clinical privileges requested and the responsibilities of Allied Health Professionals.
4.9. Grant of Immunity and Authorization to Obtain/Release Information:

By applying for permission to practice at the Hospital, Allied Health Professionals expressly accept the following conditions (i) during the processing and consideration of the application, whether or not permission to practice is granted, (ii) as a condition of continued permission to practice, if granted, (iii) should permission to practice be revoked, reduced, suspended, and/or otherwise affected for reasons related to clinical competence or professional conduct, and (iv) with regard to any third-party inquiries received after the individual leaves about his or her tenure at the Hospital:

(a) **Immunity:**

To the fullest extent permitted by law, the Allied Health Professional releases from any and all liability, extends absolute immunity to, and agrees not to sue the Hospital or Board, any member of the Medical Staff or the Board, their authorized representatives, and third parties who provide information for any matter relating to permission to practice, clinical privileges, or the individual's qualifications for the same. This immunity covers any actions, recommendations, reports, statements, communications, or disclosures involving the individual which are made, taken, or received by the Hospital, its authorized agents, or third parties in the course of credentialing and peer review activities.

(b) **Authorization to Obtain Information from Third Parties:**

The Allied Health Professional specifically authorizes the Hospital, Medical Staff leaders, and their authorized representatives (1) to consult with any third party who may have information bearing on the Allied Health Professional's professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on his or her qualifications for permission to practice at the Hospital, and (2) to obtain any and all communications, reports, records, statements, documents, recommendations, or disclosures of third parties that may be relevant to such questions. The Allied Health Professional specifically authorizes third parties to release this information to the Hospital and its authorized representatives upon request. The Allied Health Professional also agrees to sign any necessary authorizations to permit a consumer reporting agency to conduct a criminal background check and report the results to the Hospital.

(c) **Authorization to Release Information to Third Parties:**

The Allied Health Professional also authorizes Hospital representatives to release information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their agents when information is requested in order to evaluate his or her professional qualifications for appointment, privileges, permission to practice, scope of practice, and/or
participation status at the requesting organization/facility, and any license or regulatory matter.

(d) **Procedural Rights:**

The Allied Health Professional agrees that the procedural rights set forth in this Policy shall be the sole and exclusive remedy with respect to any professional review action taken by the Hospital.

(e) **Legal Actions:**

If, notwithstanding the provisions in this Section, an Allied Health Professional institutes legal action and does not prevail, he or she shall reimburse the Hospital and any member of the Medical Staff or Board involved in the action for all costs incurred in defending such legal action, including reasonable attorney's fees and lost revenues.
ARTICLE 5

CREDENTIALING PROCEDURE

5.1. Request for Application:

(a) Applications for permission to practice at the Hospital shall be in writing and shall be on forms approved by the Board upon recommendation by the MEC and Credentials Committee.

(b) Any individual requesting an application for permission to practice at the Hospital shall be sent a letter that outlines the eligibility criteria for permission to practice, as well as any eligibility requirements that relate to the Allied Health Professional's specific area of practice, and the application form.

(c) Allied Health Professionals who are in a category of practitioners that has not been approved by the Board for access to the Hospital shall be ineligible to receive an application. A determination of ineligibility does not entitle an Allied Health Professional to the procedural rights outlined in Article 8 of this Policy.

5.2. Initial Review of Application:

(a) A completed application, with copies of all required documents, must be submitted to the Medical Staff Office within 30 days after receipt of the application if the Allied Health Professional desires further consideration. The application must be accompanied by the application processing fee, if one is required.

(b) As a preliminary step, the application will be reviewed by the Medical Staff Office and the CMO (if necessary) to determine that all questions have been answered and that the individual satisfies all threshold criteria. Individuals who fail to return completed applications or fail to meet the eligibility criteria set forth in Section 4.1(a-l) of this Policy will be notified that they are not eligible for permission to practice at the Hospital and that their application will not be processed. A determination of ineligibility does not entitle an Allied Health Professional to the procedural rights outlined in Article 8 of this Policy.

(c) The Medical Staff Services Office shall also review the application to determine if all questions have been answered, all references and other information or materials have been received, and pertinent information provided on the application has been verified with primary sources. If an application is complete, it shall be transmitted, along with all supporting documentation, to the applicable department chief.
5.3. Department Chief Procedure:

(a) The Medical Staff Office shall transmit the complete application and all
supporting materials to the appropriate department chief or the individual to
whom the department chief has assigned this responsibility. Each chief shall
prepare a written report regarding whether the applicant has satisfied all of the
qualifications for permission to practice and the clinical privileges requested.

(b) As part of the process of making this report, the department chief has the right to
meet with the applicant and the supervising physician (if applicable) to discuss
any aspect of the application, qualifications, and requested clinical privileges.
The department chief may also confer with experts within the department and
outside of the department in preparing the report (e.g., other physicians, relevant
Hospital department heads, nurse managers). In the event that the department
chief, or the individual to whom the department chief has assigned this
responsibility, is unavailable or unwilling to prepare a written report, the Chair of
the Credentials Committee or the President of the Medical Staff shall appoint an
individual to prepare the report.

(c) The department chief shall be available to answer any questions that may be
raised with respect to that chair's report and findings.

5.4. AHP Committee and Credentials Committee Procedure:

(a) The AHP and Credentials Committees shall review the report from the
appropriate department chief and the information contained in references given by
the applicant and from other available sources. The Committees shall examine
evidence of the applicant's character, professional competence, qualifications,
prior behavior, and ethical standing and shall determine whether the applicant has
established and satisfied all of the necessary qualifications for the clinical
privileges or scope of practice requested.

(b) The Committees may use the expertise of any individual on the Medical Staff or
in the Hospital, or an outside consultant, if additional information is required
regarding the applicant's qualifications. The Committees may also meet with the
applicant and, when applicable, the supervising physician. The appropriate
department chief may participate in this interview.

(c) After determining that an applicant is otherwise qualified for permission to
practice and the scope of practice or clinical privileges requested, the AHP and
Credentials Committees shall review the applicant's "Health Status Confirmation
Form" to determine if there is any question about the applicant's ability to perform
the scope of practice or privileges requested and the responsibilities of permission
to practice. If so, the Committees may require the applicant to undergo a physical
and/or mental health examination by a physician(s) satisfactory to the
Committees. The results of this examination shall be made available to the
Committees for their consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the Committees shall be considered an incomplete application and all processing of the application shall cease.

(d) The AHP and Credentials Committees may recommend the imposition of specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring). The AHP and Credentials Committees may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of an individual's compliance with any conditions.

5.5. Medical Executive Committee Procedure:

(a) At its next meeting, after receipt of the written findings and recommendation of the AHP and Credentials Committees, the MEC shall:

(1) adopt the findings and recommendations of the Committees as its own; or

(2) refer the matter back to the AHP Committee and/or Credentials Committee for further consideration and responses to specific questions raised by the MEC; or

(3) set forth in its report and recommendation clear and convincing reasons, along with supporting information, for its disagreement with the Credentials Committee's recommendation.

(b) If the MEC's recommendation is favorable to the applicant, the Committee shall forward its recommendation to the Board, through the CEO, including the findings and recommendation of the department chief and the Credentials Committee. The MEC's recommendation must specifically address the clinical privileges requested by the applicant, which may be qualified by any probationary or other conditions or restrictions relating to such clinical privileges.

(c) If the MEC's recommendation would entitle the applicant to the procedural rights set forth in this Policy, the MEC shall forward its recommendation to the CEO, who shall notify the applicant of the recommendation and his or her procedural rights. The CEO shall then hold the MEC's recommendation until after the individual has completed or waived the procedural rights outlined in this Policy.

5.6. Board Action:

(a) The Board may delegate to a committee, consisting of at least two Board members, action on applications if there has been a favorable recommendation from the Credentials Committee and the MEC (or their designees) and there is no evidence of any of the following:
(1) a current or previously successful challenge to any license, certification, or registration;

(2) an involuntary termination, limitation, reduction, denial, or loss of permission to practice, clinical privileges or scope of practice at any other hospital or other entity; or

(3) an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

Any decision reached by the Board Committee to appoint shall be effective immediately and shall be forwarded to the Board for ratification at its next meeting.

(b) When there has been no delegation to the Board Committee, upon receipt of a recommendation that the applicant be granted permission to practice and clinical privileges or scope of practice, the Board may:

(1) grant the applicant permission to practice and clinical privileges or scope of practice as recommended; or

(2) refer the matter back to the Credentials Committee or MEC or to another source inside or outside the Hospital for additional research or information; or

(3) reject or modify the recommendation.

(c) If the Board determines to reject a favorable recommendation, it should first discuss the matter with the Chair of the Credentials Committee and the President of the Medical Staff. If the Board's determination remains unfavorable to the applicant, the CEO shall promptly send special notice to the applicant that the applicant is entitled to request the procedural rights as outlined in this Policy.

5.7. Request for Temporary Clinical Privileges:

(a) Temporary clinical privileges may be granted by the CEO, upon recommendation of the President of the Medical Staff, when an applicant for permission to practice at the Hospital has submitted a completed application and the application is pending review by the MEC and Board, following a favorable recommendation of the AHP and Credentials Committees.

(b) Prior to temporary privileges being granted in this situation, the credentialing process must be complete, including verification of current licensure, relevant training or experience, current competence, ability to exercise the privileges requested and current professional liability coverage; compliance with privileges
criteria; and consideration of information from the Data Bank (as applicable) and from a criminal background check. In order to be eligible for temporary privileges, an individual must also demonstrate that there are no current or previously successful challenges to his or her licensure or registration and that he or she has not been subject to involuntary termination of membership, or involuntary limitation, reduction, denial, or loss of clinical privileges/scope of practice, at another health care facility.

(c) The individual must also agree in writing to be bound by all applicable bylaws, rules and regulations, policies, procedures and protocols prior to temporary privileges being granted.

(d) Temporary privileges in this situation shall be granted for a maximum period of 120 consecutive days, and shall expire at the end of the time period for which they are granted.

5.8. Termination of Temporary Clinical Privileges:

(a) The CEO may terminate temporary privileges for any reason and at any time, after consulting with the President of the Medical Staff, the Credentials Committee Chair, or the department chief.

(b) The granting of temporary clinical privileges is a courtesy. Neither the denial nor termination of temporary privileges shall entitle the individual to the procedural rights set forth in Article 8.

5.9. Provisional Clinical Privileges to Confirm Competence:

(a) All initial clinical privileges, regardless of when granted, will be provisional for a period of 12-24 months, as recommended by the Credentials Committee.

(b) During the provisional period, the individual's exercise of the provisional clinical privileges will be evaluated by the chair of the department in which the individual has clinical privileges and/or another physician designated by the Credentials Committee in order to confirm the individual's competence. The evaluation may include chart review, monitoring of the individual's practice patterns, proctoring, external review, and information obtained from other practitioners.

(c) During the provisional period, the individual must participate in the care of a sufficient number of patients so as to permit the Credentials Committee to evaluate the individual's competence to exercise the newly granted privilege(s), or those clinical privileges will be automatically relinquished.
5.10. Renewal of Permission to Practice:

(a) Permission to practice at the Hospital as an Allied Health Professional is a courtesy extended by the Board and, if granted, shall be for a period not to exceed two years. Renewal of clinical privileges shall be granted only upon submission of a completed renewal application.

(b) Failure to submit an application at least two months prior to the expiration of the individual's current term shall result in automatic expiration of clinical privileges at the end of the then current term.

(c) Once an application for renewal of permission to practice has been completed and submitted to the Medical Staff Office, it shall be evaluated in the same manner and follow the same procedures outlined in this Policy regarding initial applications.

(d) As part of the process for renewal of clinical privileges for Category I and Category II practitioners, the following factors shall be considered:

(1) the competency of the practitioner as assessed by the appropriate department chief and documented on a biennial evaluation form;

(2) a recommendation from a peer, if possible; and

(3) results of the Hospital's professional practice evaluation activities, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty; and

(4) resolution of any verified complaints received from patients or staff.

(e) In addition to the above, for Category II practitioners, the following information shall be considered:

(1) an assessment prepared by the Supervising Practitioner(s); and

(2) an assessment prepared by the applicable Hospital supervisor (i.e., OR Supervisor, Nursing Supervisor).

(f) Applicants seeking renewal of clinical privileges who are the subject of an adverse recommendation shall be entitled to the procedural rights outlined in Article 8 before the Board takes final action.
ARTICLE 6

CONDITIONS OF PRACTICE APPLICABLE TO
CATEGORY II AND CATEGORY III PRACTITIONERS

6.1. Supervision by Supervising Practitioner:

(a) Any activities permitted by the Board to be done at the Hospital by a Category II or Category III practitioner shall be done only under the supervision of the Supervising Practitioner.

(b) Category II or Category III practitioners may function in the Hospital only so long as (i) they are supervised by a Supervising Practitioner, and (ii) they have a current, written supervision agreement with that individual. In addition, should the Medical Staff appointment or clinical privileges of the Supervising Practitioner be revoked or terminated, the individual's permission to practice at the Hospital and clinical privileges or scope of practice shall be automatically relinquished, unless the individual will be supervised by another individual appointed to the Medical Staff.

(c) As a condition for permission to practice at the Hospital, each Category II or Category III practitioner and his/her Supervising Practitioner must submit a copy of their written supervision agreement to the Hospital. This agreement must meet the requirements of all applicable Georgia statutes and regulations, as well as any additional requirements of the Hospital. It is also the responsibility of the Category II or Category III practitioner and his/her Supervising Practitioner to provide the Hospital, in a timely manner, with any revisions or modifications that are made to the agreement.

6.2. Questions Regarding Authority of a Category II or Category III Practitioner:

(a) Should any Medical Staff member or Hospital employee who is licensed or certified by the state have any question regarding the clinical competence or authority of a Category II or Category III practitioner, either to act or to issue instructions outside the physical presence of the Supervising Practitioner in a particular instance, the Medical Staff member or Hospital employee shall have the right to require that the Category II or Category III practitioner's supervisor validate, either at the time or later, the instructions of the Category II or Category III practitioner. Any act or instruction of the Category II or Category III practitioner shall be delayed until such time as the staff member or Hospital employee can be certain that the act is clearly within the scope of the Category II or Category III practitioner's activities as permitted by the Board.

(b) Any question regarding the clinical practice or professional conduct of a Category II or Category III practitioner shall be immediately reported to the
President of the Medical Staff, the Chair of the Credentials Committee, the relevant department chief, or the CEO, who shall undertake such action as may be appropriate under the circumstances. The individual to whom the concern has been reported shall also discuss the matter with the Supervising Practitioner.

6.3. Responsibilities of Supervising Practitioner:

(a) The Supervising Practitioner shall be responsible for the actions of the Category II or Category III practitioner in the Hospital.

(b) The number of Category II or Category III practitioners acting under the supervision of a Supervising Practitioner, as well as the acts they may undertake, shall be consistent with applicable Georgia statutes and regulations, the rules and regulations of the Medical Staff, and the policies of the Board.
ARTICLE 7

PEER REVIEW PROCEDURES FOR QUESTIONS INVOLVING ALLIED HEALTH PROFESSIONALS

7.1. Collegial Intervention:

(a) As part of the Hospital's performance improvement and professional practice evaluation activities, this Policy encourages the use of collegial intervention and progressive steps by Medical Staff leaders and Hospital administration to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised. Collegial intervention efforts are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders.

(b) Collegial efforts may include, but are not limited to, counseling, sharing of comparative data, monitoring, and additional training or education.

7.2. Administrative Suspension:

(a) The President of the Medical Staff, the Chair of the Credentials Committee, the relevant department chief, the CMO, and the CEO shall each have the authority to impose an administrative suspension of all or any portion of the clinical privileges of any Allied Health Professional whenever a concern has been raised about such individual's clinical practice or conduct.

(b) An administrative suspension shall become effective immediately upon imposition, shall immediately be reported in writing to the CEO and the President of the Medical Staff, and shall remain in effect unless or until modified by the CEO or the MEC. The imposition of an administrative suspension does not entitle an Allied Health Professional to the procedural rights set forth in Article 8 of this Policy.

(c) Upon receipt of notice of the imposition of an administrative suspension, the CEO and the President of the Medical Staff shall forward the matter to the full MEC, which shall review and consider the question(s) raised and thereafter make an appropriate recommendation to the Board. If the MEC's recommendation is to restrict or terminate the Allied Health Professional's clinical privileges, the individual and, when applicable, the supervising physician shall be entitled to the procedural rights outlined in Article 8 of this Policy before the MEC's recommendation is considered by the Board.
7.3. Automatic Relinquishment of Clinical Privileges:

An Allied Health Professional's clinical privileges shall be automatically relinquished, without entitlement to the procedural rights outlined in this Policy, in the following circumstances:

(a) the Medical Staff appointment or clinical privileges of a Supervising Practitioner supervising a Category II practitioner are revoked or terminated for any reason, unless the Category II practitioner will be supervised by another practitioner appointed to the Medical Staff;

(b) a Category II practitioner ceases to be supervised by a practitioner currently appointed to the Medical Staff for any reason, unless the Category II practitioner will be supervised by another practitioner appointed to the Medical Staff;

(c) an Allied Health Professional's license or certification expires, is revoked, or is suspended or restricted;

(d) the Allied Health Professional no longer satisfies any of the threshold eligibility criteria set forth in Section 4.1(a-l) or any additional threshold credentialing qualification set forth in the specific Hospital policy relating to his or her discipline;

(e) the Allied Health Professional is indicted, convicted, or enters a plea of guilty or no contest to, any felony; or to any misdemeanor related to (i) the practice of his or her profession or other healthcare related matters; (ii) controlled substances or illegal drugs; (iii) third-party reimbursement; or (iv) violence;

(f) the Allied Health Professional fails to provide information pertaining to his or her qualifications for the scope of practice or clinical privileges in response to a written request from the Credentials Committee, the MEC, the CMO, the CEO, or any other committee authorized to request such information; or

(g) a determination is made that there is no longer a need for the services that are being provided by the Allied Health Professional.

7.4. Leave of Absence:

(a) An Allied Health Professional may request a leave of absence, for a period not to exceed a year, by submitting a written request to the CEO. The CEO will determine whether a request for a leave of absence shall be granted.

(b) Except for maternity leaves, Allied Health Professionals must report to the CEO any time they are away from patient care responsibilities for longer than 30 days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Under such
circumstances, the CEO, in consultation with the President of the Medical Staff, the CMO, may trigger an automatic leave of absence.

(c) Individuals requesting reinstatement shall submit a written summary of their professional activities during the leave, and any other information that may be requested by the Hospital at least 30 days prior to the conclusion of the leave of absence. If the leave of absence was for health reasons (except for maternity leaves), the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges or scope of practice requested.

(d) Requests for reinstatement shall then be reviewed by the relevant department chief, the Chair of the Credentials Committee, the President of the Medical Staff, the CMO, and the CEO. If all these individuals make a favorable recommendation on reinstatement, the Allied Health Professional may immediately resume clinical practice at the Hospital. This determination shall then be forwarded to the Credentials Committee, the Medical Executive Committee, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee, Medical Executive Committee, and the Board for review and recommendation. If a request for reinstatement is not granted, for reasons related to clinical competence or professional conduct, the individual shall be entitled to the procedural rights set forth in Article 8 of this Policy.
ARTICLE 8

PROCEDURAL RIGHTS FOR ALLIED HEALTH PROFESSIONALS

8.1. General:

Allied Health Professionals shall not be entitled to the hearing and appeals procedures set forth in the Medical Staff Credentials Policy. Any and all procedural rights to which these individuals are entitled are set forth in this Article.

8.2. Procedural Rights for Category I and Category II Practitioners:

(a) In the event that a recommendation is made by the MEC that a non-Hospital employed Category I or Category II practitioner not be granted the clinical privileges requested, or that the clinical privileges previously granted be restricted or terminated, the practitioner shall be notified of the recommendation. The notice shall include the specific reasons for the recommendation and shall advise the individual that he or she may request a hearing before the adverse recommendation is transmitted to the Board for final action.

(b) If the Category I or Category II practitioner desires to request a hearing, he or she must make such request in writing and direct it to the CEO within 30 days after receipt of the written notice of the adverse recommendation.

(c) If a request for a hearing is made in a timely manner, the CEO, in conjunction with the President of the Medical Staff, shall appoint an Ad Hoc Committee composed of up to three individuals (including, but not limited to, individuals appointed to the Medical Staff, Allied Health Professionals, Hospital management, individuals not connected to the Hospital, or any combination of these individuals) and a Presiding Officer, who may be legal counsel to the Hospital. The Ad Hoc Committee shall not include anyone who previously participated in the recommendation, any relatives or practice partners of the Category I or Category II practitioner, or any competitors of the affected individual.

(d) As an alternative to the Ad Hoc Committee described in paragraph (c) of this Section, the CEO, in conjunction with the President of the Medical Staff, may instead appoint a Hearing Officer to perform the functions that would otherwise be carried out by the Ad Hoc Committee. The Hearing Officer shall preferably be an attorney at law. The Hearing Officer may not be in direct economic competition with the individual requesting the hearing and shall not act as a prosecuting officer or as an advocate to either side at the hearing. If the Hearing Officer is an attorney, he or she shall not represent clients who are in direct economic competition with the affected individual. In the event a Hearing Officer is appointed instead of an Ad Hoc Committee, all references in this Article to the
Ad Hoc Committee shall be deemed to refer instead to the Hearing Officer, unless the context would clearly otherwise require.

(e) The hearing shall be convened as soon as is practical, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to by the parties.

8.3. Hearing Process for Category I and Category II Practitioners:

(a) At the hearing, a representative of the MEC shall first present the reasons for the recommendation. The Category I or Category II practitioner shall be invited to present information, both orally and in writing, to refute the reasons for the recommendation, subject to a determination by the Presiding Officer (or the Hearing Officer) that the information is relevant. The Presiding Officer (or the Hearing Officer) shall have the discretion to determine the amount of time allotted to the presentation by the representative of the MEC and the Category I or Category II practitioner.

(b) Both parties shall have the right to present witnesses. The Presiding Officer (or Hearing Officer) shall permit reasonable questioning of such witnesses.

(c) The Category I or Category II practitioner and the MEC may be represented at the hearing by legal counsel, provided, however, that while counsel may be present at the hearing, counsel shall not call, examine, and cross-examine witnesses nor present the case.

(d) The affected practitioner shall have the burden of demonstrating that the recommendation of the MEC was arbitrary, capricious, or not supported by substantial evidence. The quality of care provided to patients and the smooth operation of the Hospital shall be the paramount considerations.

(e) Minutes of this proceeding shall be kept and shall be attached to the report and recommendation of the Ad Hoc Committee.

8.4. Ad Hoc Committee or Hearing Officer Report:

(a) The Ad Hoc Committee (or the Hearing Officer) shall prepare a written report and recommendation within 30 days after the conclusion of the proceeding, and shall forward it along with all supporting information to the CEO. The CEO shall send a copy of the written report and recommendation, via certified mail, return receipt requested, to the Category I or Category II practitioner. A copy shall also be provided to the MEC.

(b) Within ten days after receiving notice of the recommendation, either the Category I or Category II practitioner or the MEC may make a request for an appeal. The request must be in writing and must include a statement of the
reasons for appeal, including the specific facts, which justify further review. The request shall be delivered to the CEO either in person or by certified mail.

(c) If a written request for appeal is not submitted within the ten-day time frame specified above, the recommendation and supporting information shall be forwarded by the CEO to the Board for final action. If a timely request for appeal is submitted, the CEO shall forward the report and recommendation, the supporting information, and the request for appeal to the Chair of the Board.

8.5. Appeals Process for Category I and Category II Practitioners:

(a) The grounds for appeal shall be limited to the following assertions: (i) there was substantial failure to comply with this Policy and/or other applicable bylaws or policies of the Hospital or the Medical Staff and/or (ii) the recommendation was arbitrary, capricious, or not supported by evidence.

(b) The Chair of the Board, or a committee of the Board appointed by the Chair, will consider the request for appeal and the record upon which the adverse recommendation was made. This review shall be conducted within 30 days after receiving the request for appeal.

(c) The Category I or Category II practitioner and the MEC shall each have the right to present a written statement in support of its position on appeal.

(d) At the sole discretion of the Chair of the Board or the committee appointed by the Chair, the Category I or Category II practitioner and a representative of the MEC may also appear personally to discuss their position. In that event, however, neither party shall be represented by counsel at the appeal.

(e) Upon completion of the review, the Chair of the Board or the committee appointed by the Chair shall provide a report and recommendation to the full Board for action. The Chair (or the committee) may also refer the matter to any committee or individual deemed appropriate for further review and recommendation to the full Board. The Board shall then make its final decision based upon the Board's ultimate legal responsibility to grant privileges and to authorize the performance of clinical activities at the Hospital.
ARTICLE 9

HOSPITAL EMPLOYEES

(a) A request for clinical privileges, on an initial basis or for renewal, submitted by a Category I or Category II practitioner who is seeking employment or who is employed by the Hospital will be processed in accordance with the terms of Article 5 of this Policy. The findings of the Board regarding each individual's qualifications will be forwarded to Hospital management personnel or Human Resources (as appropriate) to assist the Hospital in making employment decisions.

(b) All Category III practitioners who are seeking employment or who are employed by the Hospital shall be evaluated by Human Resources through Human Resources processes and procedures, but they must meet the qualifications set forth in Section 4.1 of this Policy.

(c) Except as provided in paragraph (d) below, any disciplinary concern or action with respect to an employed Allied Health Professional will be governed by the Hospital's employment policies and manuals and the terms of the individuals employment relationship and/or written contract. If an Allied Health Professional's employment is terminated by the Hospital for any reason, the individual's permission to practice in the Hospital will automatically expire without any procedural rights set forth in this Policy.

(d) If a concern about an employed Allied Health Professional's clinical competence or conduct originates with the Medical Staff, the concern will be reviewed and addressed in accordance with Articles 7 and 8 of this Policy, after which a report will be provided to Human Resources.

(e) Except as otherwise provided above, to the extent that the Hospital's employment policies or manuals, or the terms of any applicable employment contract, conflict with this Policy, the employment policies, manuals, and terms of the individual's employment contract will govern.
ARTICLE 10

AMENDMENTS

This Policy may be amended by a majority vote of the members of the MEC present and voting at any meeting of that Committee where a quorum exists, provided that the written recommendations of the Credentials Committee concerning the proposed amendments shall have first been received and reviewed by the MEC. Notice of all proposed amendments shall be provided to each Active Staff member of the Medical Staff at least 14 days prior to the MEC meeting, and any Active Staff member of the Medical Staff may submit written comments on the amendments to the MEC. In addition, any Active Staff member may personally address the MEC concerning the proposed amendments, provided this individual notifies the President of the Medical Staff of this request at least two days prior to the meeting. No amendment shall be effective unless and until it has been approved by the Board.
ARTICLE 11

ADOPTION

This Policy is adopted and made effective upon approval of the Board, superseding and replacing any and all other Bylaws, Rules and Regulations of the Medical Staff or Hospital policies pertaining to the subject matter thereof.

Originally adopted by the Medical Staff: December 29, 2006
Most recent revisions adopted by the MEC: March 9, 2010
Reviewed & Accepted As Is by the MEC: November 10, 2015
Reviewed & Accepted As Is by the MEC: December 11, 2018
Reviewed & Accepted As Is by the MEC: December 14, 2021

Originally approved by the Board: January 31, 2007
Most recent revisions approved: March 31, 2010
Reviewed & Accepted As Is by the Board: November 19, 2015
Reviewed & Accepted As Is by the MEC: December 21, 2018
Reviewed & Accepted As Is by the MEC: December 21, 2021
APPENDIX A

Those individuals currently practicing as Category I practitioners are as follows:

Audiologists
Psychologists
APPENDIX B

Those individuals currently practicing as Category II practitioners are as follows:

Certified Neonatal Nurse Practitioners
Certified Nurse Midwives
Certified Registered Nurse Anesthetists
Nurse Practitioners
Physician's Assistants
Physician's Assistants in Anesthesia
APPENDIX C

Those individuals currently practicing as Category III practitioners are as follows:

- Dental Operative Assistants
- Licensed Practical Nurses
- Operating Room Technicians
- Registered Nurses
- Surgical Technicians
- Ultrasonographers