

**MEDICAL STAFF BYLAWS, POLICIES, AND
RULES AND REGULATIONS OF
SAINT JOSEPH REGIONAL MEDICAL CENTER**

**POLICY ON ALLIED HEALTH
PROFESSIONALS**

FOR

**SAINT JOSEPH REGIONAL
MEDICAL CENTER MISHAWAKA**

AND

SJRMCM-PLYMOUTH CAMPUS, INC.

**Effective Date
July 22, 2024**

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ARTICLE 1

DEFINITIONS

1.1 Definitions:

The following definitions apply to terms used in this Policy:

- (1) "ALLIED HEALTH PROFESSIONALS" ("AHPs") means individuals other than Medical Staff members who are authorized by law and by the Medical Center to provide patient care services within the Medical Center.
- (2) "BOARD" means the Board of Trustees of Saint Joseph Regional Medical Center or Board of Directors of Saint Joseph Regional Medical Center-Plymouth Campus, Inc., as applicable.
- (3) "CHIEF MEDICAL OFFICER" or "CMO" means the individual appointed by the Board to act as the chief medical officer of the Medical Center, in cooperation with the President of the Medical Staff.
- (4) "CLINICAL PRIVILEGES" means the authorization granted by the Board to render specific patient care services.
- (5) "DAYS" means calendar days.
- (6) "HOSPITAL-TRAINED DENTIST" means a doctor of dental surgery ("D.D.S.") or doctor of dental medicine ("D.M.D.") who is trained and experienced in hospital practice.
- (7) "MEDICAL CENTER" means Saint Joseph Regional Medical Center or Saint Joseph Regional Medical Center-Plymouth Campus, Inc., as applicable.
- (8) "MEDICAL EXECUTIVE COMMITTEE" or "MEC" means the Executive Committee of the respective Medical Staffs.
- (9) "MEDICAL STAFF" means all physicians, hospital-trained dentists, and podiatrists who have been appointed to the respective Medical Staffs by the respective Boards.
- (10) "MEDICAL STAFF LEADER" means any Medical Staff officer, department chairperson, section chairperson, and committee chair.
- (11) "MEMBER" means any physician, hospital-trained dentist, and/or podiatrist who has been granted Medical Staff appointment and clinical privileges by the Board to practice at the Medical Center.

- (12) "NOTICE" means written communication by regular U.S. mail, e-mail, facsimile, hospital mail, or hand delivery.
- (13) "PHYSICIAN" includes both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s").
- (14) "PODIATRIST" means a doctor of podiatric medicine ("D.P.M.").
- (15) "PRESIDENT" means the individual appointed by the Board to act on its behalf in the overall management of the respective Medical Centers.
- (16) "PRESIDENT OF THE MEDICAL STAFF" means the individual elected by the Medical Staff to perform the functions outlined in the Medical Staff documents.
- (17) "SJRMC" means Saint Joseph Regional Medical Center.
- (18) "SPECIAL NOTICE" means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.
- (19) "SUPERVISING PHYSICIAN" means the physician who is responsible for appropriately supervising or collaborating with a Level II or Level III practitioner while he or she is practicing in the Medical Center.

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:

When a function is to be carried out by a member of Medical Center 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.

ARTICLE 2

SCOPE AND OVERVIEW OF POLICY

2.1 Scope of Policy:

- (a) This Policy addresses those Allied Health Professionals not on the Medical Staff who are permitted to provide services at the Medical Center. This Policy 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 Medical Center.
- (b) This Policy shall not apply to Allied Health Professionals who are employed by the Medical Center (except to the extent set forth in Article 9).

2.2 Categories of Allied Health Professionals:

Only those specific categories of Allied Health Professionals that have been approved by the Board shall be permitted to practice at the Medical Center. All such categories shall be classified as either "Licensed Independent Practitioners," "Licensed Advanced Practitioners," or "Dependent Practitioners," each having a slightly different relationship to the Medical Center.

2.3 Licensed Independent Practitioners:

- (a) "Licensed Independent Practitioners" (hereinafter referred to as Level I practitioners) shall include all those Allied Health Professionals who are licensed or certified under state law, authorized to function independently in the Medical Center, and granted clinical privileges. These individuals require no formal or direct supervision by a physician.
- (b) A current listing of the specific categories of Allied Health Professionals functioning in the Medical Center as Level I practitioners is attached to this Policy as Appendix A. This Appendix may be modified or supplemented by action of the Board after receiving the recommendations of the Credentials Committee and MEC, without the necessity of further amendment of this Policy.

2.4 Licensed Advanced Practitioners:

- (a) "Licensed Advanced Practitioners" (hereinafter referred to as Level II practitioners) shall include all those Allied Health Professionals who are licensed or certified under state law, are granted clinical privileges, and function in the Medical Center under the supervision of, or in collaboration with, a physician(s) appointed to the Medical Staff.

- (b) A current listing of the specific categories of Allied Health Professionals functioning in the Medical Center as Level II practitioners is attached to this Policy as Appendix B. This Appendix may be modified or supplemented by action of the Board after receiving the recommendations of the Credentials Committee and MEC, without the necessity of further amendment of this Policy.

2.5 Dependent Practitioners:

- (a) "Dependent Practitioners" (hereinafter referred to as Level III practitioners) shall include all those Allied Health Professionals who are permitted to practice in the Medical Center only under the direct supervision of a physician(s) appointed to the Medical Staff and have a scope of service. The supervising physician(s) is responsible for the actions of the Level III practitioner in the Medical Center.
- (b) A current listing of the specific categories of Allied Health Professionals functioning in the Medical Center as Level III practitioners is attached to this Policy as Appendix C. This Appendix may be modified or supplemented by action of the Board, after receiving the recommendations of the Credentials Committee and MEC, without the necessity of further amendment of this Policy.

2.6 Additional Policies:

The Board shall adopt a separate policy for each category of Allied Health Professional that it approves to practice in the Medical Center. These separate policies shall supplement this Policy and shall address the specific matters set forth in Section 3.2 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 Medical Center, the President 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 Medical Center access is sought, and the potential benefits to the community by having such services available at the Medical Center. The ad hoc committee 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 Medical Center, 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 Medical Center 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 Medical Center 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 Medical Center, the committee shall recommend:
 - (1) any specific qualifications and/or training that they must possess beyond that set forth in this Policy;
 - (2) a detailed description of their authorized clinical privileges;
 - (3) any specific conditions that apply to their functioning within the Medical Center; and
 - (4) any supervision requirements, if applicable.
- (b) In developing such recommendations, the ad hoc committee shall consult the appropriate department chairperson(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 General Qualifications:

To be eligible to apply for initial and continued permission to practice at the Medical Center, an Allied Health Professional must:

- (a) if a license or certification is required, have a current, unrestricted license or certification to practice in Indiana and have never had a license or certification to practice revoked or suspended by any state licensing agency;
- (b) where applicable to his or her practice, have a current, unrestricted DEA registration and Indiana state controlled substance license;
- (c) be located (office and residence) close enough to the Medical Center to fulfill his or her Allied Health Professional responsibilities and to provide timely and continuous care for patients in the Medical Center;
- (d) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Medical Center;
- (e) have never been convicted of Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil monetary penalties as defined in the federal or state statutes and regulations;
- (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, scope of practice, or employment denied, revoked, resigned, relinquished, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct;
- (h) 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, sexual misconduct, or violence;
- (i) satisfy all additional eligibility qualifications relating to his or her specific area of practice that may be established by the Medical Center;

- (j) if seeking to practice as a Level II or III practitioner, have a supervision or collaborative agreement with a physician who is appointed to the Medical Staff; and
- (k) be able to document his or her:
 - (1) relevant training, experience, demonstrated current clinical competence, and judgment;
 - (2) adherence to the ethics of his or her profession;
 - (3) good reputation and character;
 - (4) ability to perform, safely and competently, the clinical privileges requested;
 - (5) ability to utilize medical resources efficiently; and
 - (6) ability to work harmoniously with others sufficiently to convince the Medical Center that all patients treated by him or her will receive quality care and that the Medical Center and its Medical Staff will be able to operate in an orderly manner.

4.2 Waiver of Criteria:

- (a) Any individual who does not satisfy a criterion may request in writing that it be waived. The individual requesting the waiver bears the burden of demonstrating 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, MEC, or other committee designated by the Board, the specific qualifications of the individual in question, and the best interests of the Medical Center 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 determines not to grant a waiver.

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 Medical Center on the basis of gender, race, creed, or national origin.

4.5 Assumption of Duties and Responsibilities:

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

- (a) to provide continuous and timely care to all patients for whom the individual has responsibility;
- (b) to abide by all applicable bylaws, policies, rules and regulations of the Medical Staff and Medical Center;
- (c) to accept committee assignments and such other reasonable duties and responsibilities as may be assigned;
- (d) to provide, with or without request, new or updated information to the President or CMO, as it occurs, pertinent to any question on the application form;
- (e) to immediately submit to a blood 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 the Administrative team) are concerned with the individual's ability to safely and competently care for patients. The health care professional(s) to perform the testing and/or evaluations shall be determined by the Medical Staff leaders;
- (f) 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;
- (g) to appear for personal interviews in regard to an application for permission to practice as may be requested;
- (h) to refrain from illegal fee splitting or other illegal inducements relating to patient referral;
- (i) to refrain from assuming responsibility for diagnosis or care of hospitalized patients for which he or she is not qualified or without adequate supervision;
- (j) to refrain from deceiving patients as to the individual's status as an Allied Health Professional;
- (k) to seek consultation when appropriate;

- (l) to participate in the monitoring and evaluation activities;
- (m) to complete, in a timely manner, all medical and other required records, containing all information required by the Medical Center;
- (n) to perform all services and conduct himself/herself at all times in a cooperative and professional manner;
- (o) to satisfy applicable continuing education requirements;
- (p) to promptly pay any applicable dues and assessments; and
- (q) that, if there is any misstatement in, or omission from, the application, the Medical Center 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.

4.6 Burden of Providing Information:

- (a) Allied Health Professionals seeking permission to practice shall have the burden of producing information deemed adequate by the Medical Center 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.
- (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 60 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.

4.7 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. 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 or Drug Enforcement Administration registration or state controlled substance license 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; and
 - (4) current information regarding the applicant's ability to perform, safely and competently, the clinical privileges requested and the duties of Allied Health Professionals.
- (b) The applicant shall sign the application and certify that he or she is able to perform the clinical privileges requested and the responsibilities of Allied Health Professionals.

4.8 Grant of Immunity and Authorization to Obtain/Release Information:

By applying for permission to practice at the Medical Center, Allied Health Professionals expressly accept the following conditions during the processing and consideration of the application, whether or not permission to practice is granted, and as a condition of continued permission to practice, if granted:

(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 Medical Center, the Medical Staff, their authorized representatives, and appropriate third parties for any matter relating to permission to practice, clinical privileges at the Medical Center, or the individual's qualifications for the same. This includes any actions, recommendations, reports, statements, communications, or disclosures involving the individual which are made, taken, or received by the Medical Center, its authorized agents, or appropriate third parties.

(b) Authorization to Obtain Information from Third Parties:

The Allied Health Professional specifically authorizes the Medical Center, 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 Medical Center, 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 also specifically authorizes third parties to release this information to the Medical Center and its authorized representatives upon request.

(c) Authorization to Release Information to Third Parties:

The Allied Health Professional also authorizes Medical Center representatives to release information to other hospitals, health care facilities, managed care organizations, and their agents when information is requested in order to evaluate his or her professional qualifications for appointment, privileges, permission to practice, and/or participation status at the requesting organization/facility.

(d) Authorization to Share Information among SJRMC Facilities:

The individual specifically authorizes the SJRMC facilities (Saint Joseph Regional Medical Center or Saint Joseph Regional Medical Center-Plymouth Campus, Inc.) to share credentialing and peer review information pertaining to the individual's clinical competence and/or professional conduct. This information may be shared at the time of initial permission to practice and at any other time during the individual's affiliation with the Medical Center.

(e) 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 Medical Center.

(f) 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 Medical Center and any of its authorized representatives named in the action for all costs incurred in defending such legal action, including reasonable attorney's fees.

ARTICLE 5

CREDENTIALING AND PEER REVIEW PROCEDURES

5.1 Request for Application:

- (a) Applications for permission to practice at the Medical Center 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 Medical Center 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 Medical Center 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 Medical Staff Office and the CMO (if necessary) shall review all applications 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-j) of this Policy will be notified that they are not eligible for permission to practice at the Medical Center 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 Office shall 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. Thereafter, the completed application and all supporting materials shall be transmitted to the applicable department chairperson.

5.3 Department Chairperson Procedure:

- (a) The department chairperson shall prepare a written report regarding whether the applicant has satisfied all of the qualifications for permission to practice and the clinical privileges or scope of practice requested. As part of the process of making this report, the department chairperson 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 chairperson 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 chairperson 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.
- (b) The department chairperson may also recommend that an application raises no questions and should be processed in an expedited manner.
- (c) The department chairperson shall be available to the Credentials Committee, MEC, or the Board to answer any questions that may be raised with respect to that chair's report and findings.

5.4 Expedited Process:

- (a) If recommended by the relevant department chairperson, applications for initial permission to practice may be processed as set forth in this Section so long as they meet the following conditions:
 - (1) the applicant has not changed practice locations more than three times in the past 10 years;
 - (2) all reference evaluations are completed and received within a reasonable time of the initial request;
 - (3) all references contain only favorable evaluations, including unqualified recommendations for the scope of practice or clinical privileges requested;
 - (4) the applicant's claims activity (including past malpractice claims and settlements) is reasonable in light of his or her area of practice and there has been no unusual pattern or excessive number of liability actions resulting in a judgment against the applicant;
 - (5) there are no current or previously successful challenges to licensure or registration;

- (6) there has been no involuntary termination, limitation, restriction, reduction, denial or loss of permission to practice, clinical privileges or scope of practice at any hospital or other entity; and
 - (7) there has been no investigation into and no disciplinary action taken relating to permission to practice, clinical privileges, or scope of practice at any hospital or other entity.
- (b) The Chair of the Credentials Committee, acting on behalf of the Committee, shall review the report from the department chairperson. The Chair of the Credentials Committee 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 permission to practice and the scope of practice or clinical privileges requested.
 - (c) The President of the Medical Staff shall review the report and recommendation made by the Chair of the Credentials Committee. If the President of the Medical Staff concurs with the recommendation, the recommendation shall be forwarded to the President.
 - (d) The President may grant the individual temporary clinical privileges or temporary scope of practice, as applicable, for a period not to exceed 120 days.
 - (e) After determining that an applicant is otherwise qualified for permission to practice and the clinical privileges or scope of practice requested, the Chair of the Credentials Committee or the CMO shall review the applicant's "Confirmation of Ability to Perform Privileges Requested" form to determine if there is a question about the applicant's ability to perform the clinical privileges or scope of practice requested and the responsibilities of permission to practice. If there is no question, the temporary clinical privileges or scope of practice shall take effect. If there is a question, the application shall be referred to the full Credentials Committee.
 - (f) In the event the department chairperson, the Chair of the Credentials Committee, the President of the Medical Staff, the CMO, or the President has any questions about the applicant, the questions shall be noted and the matter shall be referred to the entire Credentials Committee for further action.
 - (g) A report regarding all applicants granted temporary clinical privileges or scope of practice shall be forwarded to the Credentials Committee for its information, and the application for clinical privileges or scope of practice shall be forwarded to the MEC for review and recommendation, and to the Board for final action.

5.5 Full Credentials Committee Procedure:

- (a) For all other applications, the Credentials Committee shall review the report from the appropriate department chairperson and the information contained in references given by the applicant and from other available sources. The Credentials Committee 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 Credentials Committee may use the expertise of any individual on the Medical Staff or in the Medical Center, or an outside consultant, if additional information is required regarding the applicant's qualifications. The Credentials Committee may also meet with the applicant and, when applicable, the supervising physician. The appropriate department chairperson may participate in this interview.
- (c) After determining that an applicant is otherwise qualified for permission to practice and the clinical privileges or scope of practice requested, the Credentials Committee shall review the applicant's Confirmation of Ability to Perform Privileges Requested form to determine if there is any question about the applicant's ability to perform the clinical privileges or scope of practice requested and the responsibilities of permission to practice. If so, the Credentials Committee may require the applicant to undergo a physical and/or mental examination by a physician(s) satisfactory to the Credentials Committee. The results of this examination shall be made available to the Committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall be considered an incomplete application and all processing of the application shall cease.
- (d) The Credentials Committee 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 Credentials Committee may also recommend that permission to practice be granted for a period of not more than three years in order to permit closer monitoring of an individual's compliance with any conditions.

5.6 MEC Procedure:

- (a) At its next meeting, after receipt of the written findings and recommendations of the Credentials Committee, the MEC shall:
 - (1) adopt the findings and recommendations of the Credentials Committee as its own; or

- (2) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the MEC prior to its final recommendation; or
 - (3) state its reasons in its report and recommendation, 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 President of the Medical Staff, including the findings and recommendation of the department chairperson and the Credentials Committee. The MEC's recommendation must specifically address the clinical privileges or scope of practice requested by the applicant, which may be qualified by any probationary or other conditions or restrictions relating to such clinical privileges or scope of practice.
- (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 President who shall notify the applicant of the recommendation and his or her procedural rights. The President shall then hold the MEC's recommendation until after the individual has completed or waived the procedural rights outlined in this Policy.

5.7 Board Action:

- (a) Upon receipt of a recommendation from the MEC, 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 Medical Center for additional research or information; or
 - (3) reject or modify the recommendation.
- (b) If the Board determines to reject a favorable recommendation, it will 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, the President shall notify the applicant of its determination and the applicant's procedural rights as outlined in this Policy.

5.8 Renewal of Permission to Practice:

- (a) Renewal of an Allied Health Professional's clinical privileges or scope of practice shall be considered only upon submission of a completed application for renewed permission to practice. Six months prior to the date of expiration of an Allied Health Professional's clinical privileges or scope of practice, the Medical Staff Office shall give the individual special notice of the date of expiration and an application form for renewed clinical privileges or scope of practice.
- (b) Failure to return a completed application to the Medical Staff Office within 30 days will result in the assessment of a reappointment processing fee. In addition, 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 permission to practice and clinical privileges or scope of practice at the end of the then current term, and the individual may not practice until an application is processed.
- (c) Renewed permission to practice, if granted, shall be for a period of not more than three years.
- (d) Once an application for renewed 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 for initial applicants.
- (e) As part of the process for renewal of permission to practice for a Level II practitioner's clinical privileges or Level III practitioner's scope of practice, the competency of the individual shall be assessed by the supervising or collaborating physician(s) and the applicable department chairperson or designee on a biennial evaluation form. The evaluation form along with other reasonable indicators of continuing qualifications shall be factors for the renewal of Level II and Level III practitioners' permissions to practice.
- (f) As part of the process for renewal of clinical privileges for Level I practitioners, the following factors shall be considered:
 - (1) the competency of the Level I practitioner as assessed by the appropriate department chairperson and documented on a biennial evaluation form;
 - (2) a recommendation from a peer; and
 - (3) use of the Medical Center's facilities taking into consideration practitioner-specific information concerning other individuals in the same or similar specialty.

ARTICLE 6

CONDITIONS OF PRACTICE APPLICABLE TO LEVEL II AND LEVEL III PRACTITIONERS

6.1 Supervision by Supervising Physician:

- (a) Any activities permitted by the Board to be done at the Medical Center by a Level II or Level III practitioner shall be done only under the supervision of, or in collaboration with, the physician supervising that individual.
- (b) Level II or Level III practitioners may function in the Medical Center only so long as (i) they are supervised by, or in collaboration with, a physician currently appointed to the Medical Staff, and (ii) if they are an advanced practice nurse or a physician assistant, they have a current, written supervision or collaborative agreement with that physician that meets the requirements of state laws and regulations. In addition, should the Medical Staff appointment or clinical privileges of the staff physician supervising or working in collaboration with a Level II or Level III practitioner be revoked or terminated, the individual's permission to practice at the Medical Center and clinical privileges or scope of practice shall be automatically relinquished (unless the individual will be supervised by or be in collaboration with another physician on the Medical Staff).
- (c) As a condition for permission to practice at the Medical Center, each Level II or Level III practitioner and his/her supervising or collaborating physician must submit a copy of their written supervision or collaborative agreement to the Medical Center. This agreement must meet the requirements of all applicable Indiana statutes and regulations, as well as any additional requirements of the Medical Center. It is also the responsibility of the Level II or Level III practitioner and his/her supervising or collaborating physician to provide the Medical Center, in a timely manner, with any revisions or modifications that are made to the agreement.

6.2 Questions Regarding Authority of a Level II or Level III Practitioner:

- (a) Should any Medical Staff member or Medical Center employee who is licensed or certified by the state have any question regarding the clinical competence or authority of a Level II or Level III practitioner either to act or to issue instructions outside the physical presence of the supervising or collaborating physician in a particular instance, the Medical Staff member or Medical Center employee shall have the right to require that the Level II or Level III practitioner's supervisor validate, either at the time or later, the instructions of the Level II or Level III practitioner. Any act or instruction of the Level II or Level III practitioner shall be delayed until such time as the staff member or Medical Center employee can

be certain that the act is clearly within the scope of the Level II or Level III practitioner's activities as permitted by the Board.

- (b) Any question regarding the clinical practice or professional conduct of a Level II or Level III practitioner shall be immediately reported to the President of the Medical Staff, the Chair of the Credentials Committee, the relevant department chairperson, the CMO, or the President, who shall undertake such action as may be appropriate under the circumstances.

6.3 Responsibilities of Supervising Physician:

- (a) The Supervising Physician shall be responsible for appropriately supervising or collaborating with a Level II or Level III practitioner while he or she is practicing in the Medical Center.
- (b) The number of Level II or Level III practitioners acting under the supervision of one physician, as well as the acts they may undertake, shall be consistent with applicable state statutes and regulations and any other policies adopted by the Medical Center. The Supervising Physician shall make all appropriate filings with the State Board of Medicine regarding the supervision and responsibilities of the Level II or Level III practitioner, to the extent that such filings are required.
- (c) It shall be the responsibility of the Supervising Physician to provide, or to arrange for, professional liability insurance coverage for the Level II or Level III practitioner in amounts required by the Board that covers any activities of the Level II or Level III practitioner at the Medical Center, and to furnish evidence of such coverage to the Medical Center. The Level II or Level III practitioner shall act at the Medical Center only while such coverage is in effect.

ARTICLE 7

PEER REVIEW PROCEDURES FOR QUESTIONS INVOLVING ALLIED HEALTH PRACTITIONERS

7.1. Collegial Intervention:

- (a) As part of the Medical Center's performance improvement and professional and peer review activities, this Policy encourages the use of collegial intervention and progressive steps by Medical Staff leaders and Medical Center 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 relevant department chairperson, the CMO, and the President 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 President and the President of the Medical Staff, and shall remain in effect unless or until modified by the President or the MEC.
- (c) Upon receipt of notice of the imposition of an administrative suspension, the President 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:

The clinical privileges of an Allied Health Professional shall be automatically relinquished, without entitlement to the procedural rights outlined in this Policy, in the following circumstances:

- (a) the Allied Health Professional no longer satisfies all of the threshold eligibility criteria set forth in Section 4.1 (a-j) or any additional threshold credentialing qualifications set forth in the specific Medical Center policy relating to his or her discipline;
- (b) the Medical Staff appointment or clinical privileges of the staff physician supervising a Level II or Level III practitioner is revoked or terminates for any reason (unless the Level II or Level III practitioner will be supervised by another physician on the Medical Staff);
- (c) a Level II or Level III practitioner ceases to be appropriately supervised by or in collaboration with a physician currently appointed to the Medical Staff for any reason (unless the Level II or Level III practitioner will be supervised by or in collaboration with another physician on the Medical Staff);
- (d) the revocation, limitation, suspension, or lapse of an Allied Health Professional's license, certification, DEA registration, Indiana controlled substance license, and/or insurance coverage;
- (e) an Allied Health Professional's termination, exclusion, or preclusion from participation in the Medicare or Medicaid program by action of the government;
- (f) an Allied Health Professional's indictment, conviction, or plea of guilty or no contest to any felony; or to any misdemeanor involving violations of law pertaining to controlled substances, illegal drugs, insurance fraud or abuse, sexual misconduct, or violence; 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 President. The President will determine whether a request for a leave of absence shall be granted. Requests for reinstatement must be made at least 30 days prior to the conclusion of the leave of absence.
- (b) If the leave of absence was for health reasons, 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 requested.
- (c) The request for reinstatement shall be referred to the Credentials Committee for review and recommendation. The recommendation of the Credentials Committee

shall be forwarded to the MEC for recommendation and then to the Board for final action.

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 Credentials Policy. Any and all procedural rights to which these individuals are entitled are set forth in this Article.

8.2 Procedural Rights for Level III Practitioners:

- (a) In the event that a recommendation is made by the MEC that a Level III practitioner not be granted the scope of practice requested, or that the scope of practice previously granted be restricted, terminated, or not renewed, the individual shall be notified of the recommendation. The notice shall include a general statement of the reasons for the recommendation and shall advise the individual that he or she may request a meeting with the MEC before its recommendation is forwarded to the Board.
- (b) If a meeting is requested, the meeting shall be scheduled to take place within a reasonable time frame. The meeting shall be informal and shall not be considered a hearing. The Supervising Physician and the Level III practitioner shall both be permitted to attend this meeting. However, no counsel for either the Level III practitioner or the MEC shall be present.
- (c) Following this meeting, the MEC shall make its final recommendation to the Board.

8.3 Procedural Rights for Level I and Level II Practitioners:

- (a) In the event that a recommendation is made by the MEC that a Level I or Level II practitioner not be granted the clinical privileges requested, or that the clinical privileges previously granted be restricted, terminated, or not renewed, 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 Level I or Level II practitioner desires to request a hearing, he or she must make such request in writing and direct it to the President 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 President, 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, Medical Center management, individuals not connected to the Medical Center, or any combination of these individuals) and a Presiding Officer, who may be legal counsel to the Medical Center. The Ad Hoc Committee shall not include anyone who previously participated in the recommendation, any relatives or practice partners of the Level I or Level 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 President, 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.

8.4 Hearing Process for Level I and Level II Practitioners:

- (a) At the hearing, a representative of the MEC shall first present the reasons for the recommendation. The Level I or Level 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 Level I or Level 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 Level I or Level 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 Medical Center 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.

8.5 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 President. The President shall send a copy of the written report and recommendation, via certified mail, return receipt requested, to the Level I or Level II practitioner. A copy shall also be provided to the MEC.
- (b) Within ten days after receiving notice of the recommendation, either the Level I or Level 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 President 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 President to the Board for final action. If a timely request for appeal is submitted, the President shall forward the report and recommendation, the supporting information, and the request for appeal to the Chairman of the Board.

8.6 Appeals Process for Level I and Level II Practitioners:

- (a) The grounds for appeal shall be limited to the following assertions: (1) there was substantial failure to comply with this Policy and/or other applicable bylaws or policies of the Medical Center or the Medical Staff and/or (2) the recommendation was arbitrary, capricious, or not supported by evidence.
- (b) The Chairman of the Board, or a committee of the Board appointed by the Chairman, will consider the record upon which the adverse recommendation was made. New or additional written information that is relevant and could not have been made available to the Presiding Officer (or Hearing Officer) may be considered at the discretion of the Chairperson or the appellate review committee. This review shall be conducted within 30 days after receiving the request for appeal.

- (c) The Level I or Level 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 Chairman of the Board or the committee appointed by the Chairman, the Level I or Level 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 Chairman of the Board or the committee appointed by the Chairman shall provide a report and recommendation to the full Board for action. The Chairman (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 Medical Center.
- (f) The Level I or Level II practitioner shall receive special notice of the Board's action. A copy of the Board's final action will also be sent to the MEC and to the Credentials Committee for information.

ARTICLE 9

MEDICAL CENTER EMPLOYEES

- (a) The employment of an Allied Health Professional by the Medical Center will be governed by the Medical Center's employment policies and manuals and the terms of the individual's employment relationship and/or written contract.
- (b) Any Allied Health Professional who is in a category listed in Appendices A, B, or C and who is seeking employment by the Medical Center must meet the same qualifications set forth in Section 4.1 of this Policy. In addition, before making an employment decision, the Medical Center's Human Resources Department must obtain an assessment of the Allied Health Professional's qualifications from an appropriate Medical Staff leader or committee (or their designees). This paragraph does not apply to Medical Center employees generally, unless those employees are assigned to a particular physician as part of their employment.
- (c) To the extent that the Medical Center's employment policies or manuals, or the terms of any applicable employment contract, conflict with this Policy, the employment policies, manuals, and descriptions, and terms of the individual's employment relationship and/or written contract will apply.

ARTICLE 10

AMENDMENTS

- (a) All amendments to this Policy must be approved by the MECs for each of the SJRMC facilities (Saint Joseph Regional Medical Center and Saint Joseph Regional Medical Center-Plymouth Campus, Inc.).
- (b) For an amendment to be adopted:
 - (1) Notice of all proposed amendments shall be provided to all voting Medical Staff members in each facility at least 14 days prior to the MEC meeting at which the amendment will be considered, and any member of the Medical Staff may submit written comments to the MEC; and
 - (2) The quorum for the regular or special MEC meeting at which the amendment will be considered must be at least two-thirds (2/3) of all voting members; and
 - (3) The amendment must receive a majority vote of the MEC members present and voting at the meeting.
- (c) If there is any disagreement among or between the MECs for the three facilities concerning a proposed amendment, a joint meeting shall be called for the purpose of discussing and resolving the disagreement.
- (d) 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 Medical Staff bylaws, rules and regulations, or Medical Center policies pertaining to the subject matter thereof.

Saint Joseph Regional Medical Center - Mishawaka

Adopted by the Medical Staff: August 11, 2006
March 5, 2007
December 7, 2009 (MEC)
September 13, 2010
January 14, 2013
May 5, 2014
April 13, 2020
April 12, 2021
May 6, 2024

Approved by the Board: September 19, 2006
March 20, 2007 effective date January 1, 2007
June 24, 2008 (Board Resolution)
December 21, 2009
September 20, 2010
April 29, 2013
May 21, 2014
June 30, 2020
May 19, 2021
July 24, 2023
May 15, 2024

Revised Effective Date: January 1, 2007
July 1, 2008
January 1, 2010
October 1, 2010
May 1, 2013
May 21, 2014
June 30, 2020
May 19, 2021
July 24, 2023
July 22, 2024

Saint Joseph Regional Medical Center-Plymouth Campus, Inc.

Adopted by the Medical Staff: July 28, 2006
August 23, 2010 (MEC)
January 26, 2013 (MEC)
May 9, 2014
April 19, 2021
May 6, 2024

Approved by the Board: September 11, 2006
September 14, 2010
March 12, 2013
May 21, 2014
May 19, 2021
July 24, 2023
May 15, 2024

Revised Effective Date: April 11, 2007
October 1, 2010
May 1, 2013
May 21, 2014
May 19, 2021
July 24, 2023
July 22, 2024

APPENDIX A

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

Saint Joseph Regional Medical Center

Non-Hospital Trained Dentists

Psychologists

Geneticists

Saint Joseph Regional Medical Center-Plymouth Campus, Inc.

Psychologists

Optometrists – Health Center

APPENDIX B

Those individuals currently practicing as Level II practitioners at the Medical Center are as follows:

Saint Joseph Regional Medical Center

Certified Nurse Midwives

Certified Nurse Specialists

Nurse Practitioners

Physician Assistants

CRNA

RNFA

Saint Joseph Regional Medical Center-Plymouth Campus, Inc.

Nurse Practitioners

Physician Assistants

Certified Nurse Midwives

CRNA

RNFA

APPENDIX C

Those individuals currently practicing as Level III practitioners at the Medical Center are as follows:

Saint Joseph Regional Medical Center

Dental Assistants

Medical Assistants

Pathology Assistants

Behavioral Health Assessment Clinician

Ophthalmic Assistant

Surgical Assistants

Medical Nurses Employed by Physicians

Surgical Nurses Employed by Physicians

Saint Joseph Regional Medical Center-Plymouth Campus, Inc.

Medical Assistants

Psychiatric Medical Assistants