RULES AND REGULATIONS
OF
THE MEDICAL STAFF

MINISTRY SAINT JOSEPH'S HOSPITAL
MARSHFIELD, WISCONSIN

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A. ADMISSION AND DISCHARGE OF PATIENTS

1. Ethical and Religious Directives

Subject to the Hospital's policies regarding treatment of individuals with emergency conditions, the Hospital shall not be required to accept patients with non-emergent conditions or cases which do not conform to the current Ethical and Religious Directives for Catholic Health Services.

2. Admitting Privileges

A patient may be admitted to the Hospital only by a member of the Active, Consultant Active or Courtesy Medical Staff with admitting privileges. All Practitioners shall be governed by the official admitting policy of the Hospital.

3. Responsibility for Care

A member of the Active, Consultant Active or Courtesy staff shall be responsible for the medical care and treatment of each patient in the Hospital, for the prompt and accurate completion of the medical record, for necessary special instructions to the patient and for transmitting reports of the condition of the patient to the referring Practitioner and to relatives of the patient. They shall be responsible for the continuous care of their hospitalized patients. Whenever these responsibilities are transferred to another staff member, an order specifying the transfer of responsibility shall be entered on the order sheet of the medical record. A physician shall be designated to be responsible for the medical aspects of care.

4. Provisional Admitting Diagnosis

Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement shall be recorded as soon as possible.

5. Frequency of Attending Physician Visits

All patients in the Hospital must be visited at least once daily by the attending physician or another physician assuming the attending physician's responsibilities.

6. Responsibility for Designating Coverage

A Practitioner, who will be absent, should indicate to each applicable patient care area the name of an alternate Practitioner who will be assuming responsibility for the patient.

7. Admission Priorities

The Admitting Office, based on physician order, will admit patients on the basis of the following order of priorities:

a. Elective - The health of a patient is not endangered by a delayed admission. Such patients are usually scheduled several days to several weeks in advance of admission. In consideration of the patient, the Hospital will make every effort to accommodate this patient's desired date of admission. However, when circumstances dictate, admission of patients in this category can be deferred.

b. Urgent - Delay in admission beyond several days might threaten the patient's life or well-being.

c. Emergent - Immediate threat to the patient's life or well-being exists. This situation warrants the highest admitting priority.

8. Dangerous Patients

The admitting physician shall be responsible for giving such information as may be necessary to assure the protection of the patient from self-harm and to assure the protection of others whenever the patient might be a source of danger.

9. Suicidal Patients

Any patient considered to be suicidal must have consultation by a member of the psychiatric staff within 24 hours of admission or the onset of suicidal indications, whichever is earlier.

10. Critical Care Admissions and Discharges

Questions as to the advisability of admission to or discharge from a Critical Care Unit should be resolved through consultations with the medical director of the appropriate critical care unit.

11. Documenting Length of Stay

The attending Practitioner is required to document the need for admission and continued hospitalization.

12. Discharge Orders

A patient shall be discharged only on a written or telephone order of the attending Practitioner or another Practitioner acting as their designee. Should a patient leave the Hospital against the advice of the attending Practitioner, or without proper discharge order, a notation of the incident shall be made in the patient's medical record, and the patient will be asked to sign an acknowledgement of discharge against medical advice form.

13. Transfer of Patient

a. Patients shall be transferred to another acute care facility when the required medical care cannot be provided at the hospital and the medical benefits of transfer outweigh the risks of transfer, or when transfer is requested by the patient or the patient's legally responsible representative. The attending/transferring Practitioner must facilitate a safe, efficient transfer and is responsible for Practitioner-to-Practitioner communication and for obtaining the receiving hospital's agreement to accept the patient in transfer.

b. No patient shall be transferred to another hospital for the sole reason of inability to pay if the hospital has the facilities to provide the care needed.

c. All patients will receive stabilizing treatment within the Hospital's capacity prior to transfer to another facility so as to minimize the risk to the patient's health. Such stabilization includes medical evaluation by a Practitioner, and initiation of treatment to minimize risk to the patient until the transfer is accomplished. All pertinent medical records that are available at the time of transfer will accompany the patient to the receiving hospital, and the transfer must be affected through qualified personnel and transportation equipment as required, including the use of necessary and medically appropriate life support measures during transfer. Other records not available at the time of transfer will be sent to the receiving hospital as soon as practicable after transfer.

d. Except in emergencies in which the attending/transferring Practitioner certifies in writing that the benefits of transfer outweigh the risk of transfer, the patient will not be transferred without being given an explanation for the transfer.

e. An informed consent should be signed by the patient or patient's legally responsible representative when transfer is arranged. If such consent cannot be obtained, either through refusal or inability to sign, the reason for the lack of consent should be documented in the patient's medical record.

f. If a patient refuses a medically indicated transfer, a statement regarding such shall be placed in the medical record by the attending Practitioner or his/her designee.

g. Transfers governed by the Emergency Medical Treatment and Labor Act ("EMTALA") shall be completed in accordance with the Hospital's EMTALA policy. Additionally, those individuals at the Hospital who are qualified to perform a medical screening examination, as required by EMTALA include the following: [**NOTE: Include categories of health care providers designated as qualified medical professionals for EMTALA purposes**.]

14. Certification of Death

In the event of a hospital death, the deceased shall be certified dead by the attending physician or an appropriate designee within a reasonable time. Policies with respect to dead bodies shall conform to local law.

15. Notification of Death

It is the attending physician's responsibility to relate details of the patient's death to relatives of the deceased patient either by phone or, preferably, in person.

16. Permission for Autopsy

It shall be the duty of staff members to secure permission for autopsies whenever possible. An autopsy may be performed only with a proper consent, and signed in accordance with State law.

B. MEDICAL RECORDS

1. Responsibility for Completing the Medical Record

2. The attending Practitioner shall be responsible for recording the chief complaint, details of the present illness, relevant past history of illness and pertinent social and family histories, review of body systems, pertinent physical assessment, a statement of conclusions or impressions, a plan of care, diagnostic and therapeutic orders, clinical observations of progress, results of therapy, conclusions at the termination of hospitalization, and a discharge summary. The other components of a complete medical record, including laboratory and radiology reports, operative reports, consultations, and autopsy reports, where appropriate, are the responsibility of the appropriate physician, department or service. It shall be the responsibility of the Hospital to provide adequate dictation, transcription and medical record services to ensure efficient completion of the medical record. History and Physical Examination Requirements

A history and physical examination must be completed and documented in the medical record no more than thirty (30) days before or twenty-four (24) hours after admission or registration of each patient, but prior to surgery or a procedure requiring anesthesia services. When the history and physical examination is completed within the thirty (30) days prior to admission or registration, an examination of the patient must be documented in the medical record within twenty four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The History and Physical exam should include the chief complaint, details of the present illness, relevant past history of illness, pertinent social and family histories, inventory of relevant body systems, pertinent physical assessment, a statement of conclusions or impressions, and a plan of care. Recording of histories for obstetrical patients and newborns shall be conducted pursuant to Section B. 12, below.

3. Informed Consent

Documented informed surgical consents are required prior to the operative procedure except in those situations wherein the patient's life is in jeopardy and suitable consent cannot be obtained due to the condition of the patient.

4. Requirement for H&P Before Procedures

A history and physical examination must be recorded prior to surgery or a procedure requiring anesthesia services, as described herein. When the appropriate preoperative assessment is not recorded before the procedure, the procedure shall be cancelled unless the attending Practitioner states in writing that such delay would be detrimental to the patient.

5. Definition of Extreme Emergency

Extreme emergencies may cause surgery to be performed prior to completion of the aforementioned preoperative assessment. An extreme emergency is defined as a situation where delay in the needed surgery may cause an increased chance of death to the patient or a worsened outcome pertaining to the problem requiring surgery. This decision is left to the discretion of the attending physician and surgeon (also note rule B.4 above). Retrospective review of these cases by the Chief of Staff may occur if it is felt that an inappropriate judgment was made.

6. Countersignatures for House Staff

Resident Staff shall be authorized to write reports, progress notes, and orders for treatment with the knowledge and consent of the supervising physician. All Resident Staff H & P's, consults, discharge notes, discharge summaries and operative reports shall be authenticated within 30 days following discharge, or death by the supervising staff physician or dentist. Authentication may be obtained through electronic dictation on those items as described above and will be accepted as final authentication. Orders written by non-licensed House staff shall be authenticated by a licensed supervising physician before such orders are carried out.

7. Countersignatures for Medical Students

All orders for the therapeutic and diagnostic procedures on patients written by medical students must be authenticated by the attending Practitioner or another licensed Practitioner before such orders are carried out.

8. Countersignature for Other Non-Physician Staff

History and physicals, initial consult notes, discharge notes, discharge summaries and operative reports recorded by non-physician staff shall be authenticated within 30 days following discharge, or death by the supervising staff physician or dentist. Authentication may be obtained through electronic dictation on those items as described above and will be accepted as final authentication.

9. Progress Notes

Pertinent progress notes shall be recorded at the time of observation sufficient to permit continuity of care and transferability.

10. Operative Reports

Operative reports shall include a detailed account of the findings at surgery, the details of the surgical technique, name of primary surgeon, assistants, specimens removed, estimated blood loss and post-op diagnosis. Operative reports shall be recorded immediately following surgery. The report must be promptly signed by the surgeon and made a part of the patient's current medical record unless special circumstances exist. When a full operative or other high risk procedure report cannot be entered immediately into the medical record after the operation or procedure, a post procedure note is entered in the record before the patient is transferred to the next level of care; the note should contain name of surgeon and assistants, procedures performed and descriptions of each procedure, findings, estimated blood loss and specimens removed. A fining system will be implemented for delinquent operative reports. If a Practitioner does not respond to the fining system, the Practitioner will be referred to the Chief of Staff for further action.

11. Consultation Reports

Consultations shall include a review of the patient's medical record and examination of the patient, with the consultant's opinion, recommendations, and pertinent findings. This report shall be made a part of the patient's record.

12. Obstetrical Records

a. Each obstetric patient shall have a complete hospital record which shall include:

1. The history and physical examination. When available, the prenatal record, or a legible copy thereof on the approved hospital form, may serve as the history and physical examination. An interval admission note should be written that updates pertinent additions to the history and physical exam.

2. Prenatal history and findings, including complications, Rh determination, and other matters essential to adequate care;

3. Labor and delivery record, including anesthesia;

4. The Practitioner's progress record;

5. The Practitioner's order sheet;

6. A record of treatment, including nurses notes;

7. Any laboratory or x-ray reports;

8. Any medical consultant's notes;

9. An estimate of blood loss.

b. Each newborn infant shall also have a complete Hospital record which shall include:

1. Record of pertinent maternal data, type of labor and delivery, and the condition of the infant at birth;

2. A record of physical examinations;

3. A progress sheet recording medicines and treatments, weights, feedings and temperatures;

4. The notes of any medical consultant.

13. Record Requirements for Transplants

When an organ or tissue is obtained from a living donor at this Hospital for transplantation purposes, the medical records of the donor and recipient must meet the requirements for any surgical inpatient medical record.

14. Clinical Entries

a. All credentialed providers and designated agents of the Hospital involved in the care of the patient may make entries in the record as appropriate to their discipline.

b. All clinical entries in the patient's medical record shall be accurately dated, timed and authenticated with the name and title of the person making the entry.

c. Orders and notes must be legible. Orders which are illegible or improperly written will not be carried out until rewritten. In such cases, the ordering Practitioner will be contacted as soon as the order is identified as needing clarification. Practitioners whose signatures are judged by the Medical Record Committee to be consistently illegible will be required to either print their name, provider number, or use another committee approved method to identify themselves and appropriately authenticate orders and notes.

15. Abbreviations and Symbols

Symbols and abbreviations are to be used only when they have been recommended for use by the Medical Staff. An official record of recommended abbreviations and those that should not be used is available on the intranet.

16. Electronic Signatures

When electronic signatures are authorized, the individual whose computer key represents that signature shall attest that the computer key represents only that individual and that this individual is the only one who has and will use the computer key for any purpose. Failure to comply with this practice may result in disciplinary action pursuant to Medical Staff Bylaws.

17. Discharge Summary

A discharge summary shall be recorded on all deaths and all inpatient and observation patients. A discharge summary will also be required when a patient is discharged to or from a different level of care, for example the rehabilitation unit. Discharge summaries should be completed at the point of discharge or within 24 hours except under special circumstances. In all instances, the content of the medical record shall be sufficient to justify the diagnoses

and warrant the treatment and end result. All summaries shall be authenticated by the responsible practitioner and include the following:

a. Discharge diagnoses.

b. Condition of patient at discharge.

c. Instructions for continuing care; specifically, activity, diet, discharge medications (dose and frequency) and follow-up care, driving restrictions, return to work, advanced directives/code status – when relevant

d. The reason for admission, physical findings, consultations

e. The pertinent laboratory and x-ray findings

f. Medical and/or procedural treatment, hospital course

18. Medication List

Medications and doses the patient will be taking after discharge from the hospital should be recorded by the attending physician or by a practitioner acting as their designee in either the hospital progress notes, the physician's orders or in the discharge summary if it is available on discharge. When a dictated discharge summary is required, it should also be included there. In the case of transfers to nursing homes or other facilities, the medications, dose and reason why the patient is on the medication can be written on the transfer referral record under the medication section instead of written in the progress notes or orders.

19. Progress Note Substitute for Discharge Summary

A discharge note may be substituted for the discharge summary in the case of patients with problems of a minor nature who require less than a 48-hour period of hospitalization. The final progress note includes diagnosis, reason for hospitalization, significant findings, procedures, treatment rendered, medications, condition of patient on discharge, instructions given, and follow-up care.

20. Documenting Cause of Death

An expiration summary is required on all deaths and includes a final discharge diagnosis and addresses the death and the probable cause.

21. Access to Medical Information

Practitioners and other health care professionals will sign a confidentiality statement before being given on-line access to patient health information. Practitioners will be assigned a login name and access menus based on current job duties. Passwords are confidential and Practitioners create their unique password and shall not be disclosed or shared with other users. Practitioners are permitted to access records only in accordance with applicable legal and ethical standards. Computers are not to be left unattended after entry of the Practitioner's password until proper computer terminal sign-off procedures have been

followed. Failure to comply with this practice may result in disciplinary action pursuant to Medical Staff bylaws. When a Practitioner loses or resigns clinical privileges or Medical Staff membership (or is suspended), password and access codes will be deactivated. In the same manner, when other health care professionals resign their position, their password and access codes will also be immediately deactivated.

22. Authorization to Release Information

Written authorization of the patient or a person authorized by the patient is required for release of medical information to persons not otherwise authorized by law to receive this information.

23. Removing Medical Records from the Premises

Medical records may be removed from the Hospital jurisdiction and safekeeping only in accordance with a court order, subpoena, statute, or by permission of the Hospital President or his/her designee. Minutes or other documents pertaining to peer review activities, conferences, medical audit activities, or other quality assurance mechanisms are not considered to be part of the medical record and are not to be released from Hospital and Medical Staff jurisdiction, except as required by law.

24. Research Using Medical Records

Any study or research performed is subject to the policies and approval of the Hospital and the Institutional Review Board.

Access to medical records of all patients shall be afforded to members of the Medical Staff for bona fide study and research so long as confidentiality of personal information concerning the individual patients is preserved, unless the patient has filed a written objection with the Hospital.

25. Medical Record Completion and Filing

Records shall be completed within 30 days of discharge or death. A medical record shall not be permanently filed until it is completed or is ordered filed by the Medical Record Committee.

26. Preprinted Orders

Pre-printed orders must be approved by the Medical Records Committee for format. Pre-printed order sheets must clearly bear the patient's name and medical history number. It must also be clear which orders are to be carried out. Such orders are subject to the usual dating, timing and authentication requirements.

27. Standing (Routine) Orders

A Practitioner's routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record and subject to the usual dating, timing, and authentication requirements.

C. GENERAL CONDUCT OF CARE

1. General Consent for Admission and Treatment

A general consent form, signed by or on behalf of every patient admitted to the Hospital, must be obtained at the time of admission. The admitting office should notify the attending Practitioner whenever such consent has not been obtained. When so notified, it shall, except in emergency situations, be the Practitioner's obligation to obtain proper consent before the patient is treated in the Hospital.

2. Verbal /Telephone Orders

A verbal/telephone order may be taken only by a Practitioner, registered nurse, respiratory therapist, pharmacist, physical therapist, occupational therapist, or an authorized member of the hospital, Allied Health or hospital contracted staff as appropriate to their job description. The primary attending physician or other appropriate Practitioner in the same group/department as the ordering Practitioner, who has knowledge of the patient's care and is willing to assume responsibility for the order, may sign that Practitioner's telephone order. Inpatient verbal/telephone orders must be authenticated within 48 hours of receipt. The signature must include the date and time of the signature. All verbal/telephone orders shall be transcribed in the medical record and shall include the date, time, name or signature and title of the person transcribing the orders and who gave the verbal/telephone order.

a. The following orders may be given to the Health Unit Coordinator and LPN: all orders except medication, DNR or to infuse blood products. They may clarify blood product orders, i.e., "may use random donor platelets instead of single donor."

b. Only Registered Nurses and Pharmacists may receive medication orders, except as specified in (d) below.

c. Aerosolized medication orders may be given to a Registered Nurse, Pharmacist, or Respiratory Therapist.

d. Verbal and telephone orders shall be confined to circumstances in which patient care needs require them.

e. Any telephone order shall be written and read back to ensure accuracy.

f. Verbal orders may be given in an emergent situation and shall be repeated to verify accuracy.

3. Automatic Cancellation of Prior Orders After Surgery

All previous orders are cancelled when patients go to surgery, unless otherwise specified.

4. Drug Formulary

The hospital will maintain a listing for drugs (i.e. a drug formulary) which are routinely stocked and available. All drugs and medications on the drug formulary shall be listed in

the retest edition of the United States Pharmacopoeia, the American Hospital Formulary Service, or other accepted drug compendium or its update and approved by the Pharmacy and Therapeutics Committee.

b. Investigational drugs (that is, those drugs not approved by the Food and Drug Administration (FDA) but having the status of an investigational new drug (IND) as recognized by the FDA) may be administered in the hospital but must have a protocol approved by the FDA and where appropriate, approved by the local Institutional Review Board (IRB).

c. Use of a patient's home medications is generally not allowed except in the following circumstance: if the drug in question is a non-formulary medication for which the pharmacy does not stock a therapeutic substitute or which cannot be procured within a reasonable amount of time. In such situations, the medication(s) must be positively identified by a pharmacist as to the identity of the drug and its appropriateness including drug stability and storage. Medications that cannot be identified or verified, or are out of date and appear to be stored inappropriately will not be used under any circumstances. If a patient's home medications are not used, patients are encouraged to return the medications to home. Storage of patient's own medication during hospital stay is done in accordance to local hospital policy.

d. Use of drugs not approved for formulary status (e.g. "non-formulary") will be managed according to local hospital policy and procedure.

5. Automatic Stops on Drug Orders

Practitioner orders for Schedule II drugs, antibiotics, anticoagulants, steroids, and hypnotics are automatically discontinued after the designated time period unless: 1) the order indicated the exact number of doses to be administered; 2) the order indicated the exact period of time for which the drug is to be administered; or 3) the attending Practitioner reorders after being notified of the pending stop orders. Stop orders are not enforced during the night, which includes the morning until 1400 hours, in order to allow for Practitioners' daily rounds.

The following is a summary of stop order lengths:

- Schedule II Drugs 3 days
- Antibiotics 10 days
- Anticoagulants 10 days
- Steroids 10 days
- Hypnotics 14 days

All medication orders are automatically stopped when a patient goes into surgery.

6. Eligibility to Perform Consultation

Any qualified Practitioner or Allied Health Staff with clinical privileges in this Hospital may be called for consultation within his/her area of expertise.

7. Responsibility to Request Consultation

The attending Practitioner is primarily responsible for requesting consultation when indicated. The Practitioner will provide written authorization to permit another Practitioner to attend or examine his/her patient, except in an emergency.

8. Required Consultation

Consultation with a qualified Practitioner is required in the following cases:

a. Cases where the patient has or develops a condition that is beyond the approved, delineated privileges of the attending Practitioner.

b. Cases involving unusually complicated situations where the specific skills of other Practitioners may be needed.

c. Cases where a consultation is requested by the patient or the patient's family.

d. Cases where consultation is otherwise necessary to protect the safety of the patient or required by rules, regulations, or policies of the Hospital, the Medical Staff, a department, or a service.

9. Resolving Nursing Staff Questions on Care

If a nurse has reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and not been obtained, the nurse is encouraged to bring this to the attention of the attending Practitioner. Following this, if reservations remain, the nurse may discuss this with his/her Hospital supervisor. If warranted, the supervisor may bring the matter to the attention of the chairperson of the department in which the Practitioner has clinical privileges and the chairperson may take appropriate action.

10. Fee Splitting and Kickbacks

Rebating a portion of a fee or receiving other inducement in exchange for patient referral is forbidden.

11. Declaration of Emergency or Disaster

The Hospital President or his designee, after consultation with the Chief of Staff or substitute, may declare an emergency. The Hospital will then operate under the disaster plan until such time as the Hospital President or designee declares the disaster at an end.

12. Smoking by Patients

Smoking is prohibited throughout the Hospital.

13. Request for Autopsy

The following guidelines present situations for which an autopsy is most desirable. This is not intended to limit or inhibit solicitation in any particular case, but rather to underscore specific situations in which autopsy should be considered.

- Unanticipated death
- Death occurring while the patient is being treated under a new therapeutic trial regime
- Intraoperative or intraprocedural death
- Death occurring within 48 hours after surgery or an invasive diagnostic procedure
- Death incident to pregnancy or within seven days following delivery
- All deaths on a psychiatric service
- Death where the cause is sufficiently obscure to delay completion of the death certificate
- Deaths in all infants (≤ 12 months)
- 2nd and 3rd trimester stillbirth/fetal demise with unexplained cause
- Deaths known or suspected to have resulted from environmental or occupational hazards

D. GENERAL RULES REGARDING SURGICAL CARE

Standards, Rules and Regulations for surgical care are included by reference only and are determined by those sections and departments individually.

E. GENERAL RULES REGARDING OBSTETRICAL CARE

Standards, Rules and Regulations for obstetrical care are included by reference only and are determined by those sections and departments individually.

F. EMERGENCY SERVICES

1. Emergency Services Coverage

The Medical Staff shall adopt a method of providing medical coverage in the emergency services area. This shall be in accord with the Hospital's basic plan for the delivery of such services, including the delineation of the clinical privileges for all Practitioners who render emergency care.

2. Emergency Procedure Manual

The duties and responsibilities of all personnel serving patients within the emergency area shall be defined in a procedure manual relating specifically to this outpatient facility. The contents of such a manual shall be developed by a multispecialty committee of the Medical Staff, including representatives from nursing service and Hospital administration.

3. Emergency Care Record Requirements

An appropriate medical record shall be kept for every patient receiving emergency service and be incorporated in the patient's Hospital record, if such exists. The record shall include:

a. Adequate patient identification.

b. Information concerning the time of the patient's arrival, means of arrival, and by whom transported.

c. Pertinent history of the injury or illness including details relative to first aid or emergency care given the patient prior to arrival at the Hospital.

d. Description of significant clinical, laboratory and radiologic findings.

e. Diagnosis.

f. Treatment given.

g. Condition of the patient on discharge or transfer.

h. Final disposition, including instruction given to the patient and/or family, relative to necessary follow-up.

4. Emergency Record Signatures

Each patient's medical record shall be signed by the Practitioner in attendance, who is responsible for its clinical accuracy.

5. Review of Emergency Room Services

The review of emergency room services shall be a function of the Emergency Department-Disaster Preparedness Committee.

6. Mass Casualties Disaster Plan

There shall be a plan for the care of mass casualties at the time of any major disaster, based upon the Hospital's capabilities in conjunction with other emergency facilities in the community. It shall be developed by an Emergency Department-Disaster Preparedness Committee which includes members of the Medical Staff, the Vice-President of Nursing or designee, and a representative from Hospital administration. Disaster drill will be rehearsed at least twice yearly. A critique of such drills shall be reported to the Medical Staff Executive Committee and Governing Body.

G. SPECIAL CARE UNITS

Special care units shall adopt specific regulations subject to approval by the Medical Staff Executive Committee and Hospital Administration. These units shall be under the general jurisdiction of the Critical Care Committee.

H. CLINICAL DEPARTMENTS

Clinical departments shall be created according to the Medical Staff Bylaws and approved by the Medical Staff Executive Committee. Organizations within a department shall be specifically patterned to the department size and need. Standards of care and rules and regulations for clinical departments are included by reference only and are determined by those sections and departments individually.

I. ADOPTION AND APPROVAL

Adopted by the Active Medical Staff on_____.

_____
Chief of the Medical Staff

Approved by the Governing Body on_____.

_____
Chairman of the Governing Body