

LEE MEMORIAL HEALTH SYSTEM

MEDICAL STAFF

RULES AND REGULATIONS

1. Annual Meeting

The annual meeting of the Medical Staff will occur on the second Monday of September; written notice shall be sent to each staff member.

2. Admitting and Attending Patients

- A. No patient shall be admitted into the hospital until the admitting physician has stated a provisional diagnosis. Physicians admitting patients shall be responsible for issuing orders and information necessary to protect the patient, other patients and hospital staff when any danger exists.
- B. All admitted patients shall be seen by the attending physician or his/her designate within a reasonable period of time after admission.
- C. All admitted patients shall have a complete history and physical recorded on the hospital medical record within 24 hours after admission; surgical patients shall have their history, physical examination, diagnosis and laboratory reports recorded before the time stated for operation or procedure, insofar as possible. The Outpatient Procedure/Observation History and physical may be used for patients admitted for outpatient procedures or short stay observations, which do not exceed 48 hours; anesthesiologists may perform and document the history and physical for podiatric and dental patients. If a patient stay exceeds 48 hours, a full history and physical examination is required.
- D. All laboratory reports must appear on the chart.
- E. Physicians with full training in Neurology and Physical Medicine and Rehabilitation may admit any patient to the Rehabilitation Unit and assume full care of the patient. Physicians fully trained in Orthopedics and Rheumatology may admit to the unit and manage the rehabilitation of orthopedic and rheumatologic disorders respectively. Consults from other specialties should be obtained on a case-by-case basis. Physicians admitting to the unit must follow all regulations and policies of the unit.

3. Consultation Policy

- A. A physician should seek consultation if requested by or on behalf of the patient, or when, in the opinion of that physician, the advice of a specialist or another physician would enhance the quality of care provided the patient obtaining the consult is the responsibility of the attending physician.
- B. In responding to consultation requests, physicians shall abide by the Principles of Medical Ethics as set forth in Appendix A.

- C. A physician is required to respond to a request to serve as a consultant when assigned to the appropriate emergency room call roster. Physicians receiving a consultation request from the Emergency Dept. physician shall have 30 minutes to communicate back to the Emergency Dept. physician.
- D. Emergency consultations must be obtained by direct communication between the consulting and the consulted physicians.
- E. No physician shall be required to accept a non-emergency consult request, unless the physician specialist is called by the attending physician because:
 - 1. The specialist has an established professional relationship with the patient and consultation is requested by the patient; or
 - 2. The consultant has within the previous 30 days performed a surgical, invasive diagnostic or other procedure on the patient, and the professional judgment of the admitting or attending physician is that the patient requires the specialist to provide follow-up care and advice; or the patient's hospitalization is because of complications arising from the procedure performed by the specialist.
 - 3. As required in Section 3 G.
- F. Non-emergency consults, if accepted by the consulted physician, shall be completed within 24 hours.
- G. Notwithstanding any other provision herein, in the event there are specialties that lack 24/7 inpatient consultation coverage at Lee Memorial Hospital and HealthPark Medical Center, consultation will be mandatory unless pre-established consultation coverage is arranged by the section/department and approved by the Executive Committee.

4. Discharging Patients

- A. Patients shall be discharged on the written order of the attending physician.
- B. Patients or representatives of patients who leave the hospital against the orders or advice of the attending physician shall sign the prescribed hospital form releasing the hospital and physician from responsibility.

5. Physician Orders

- A. Medicine, treatments, or corrective procedures shall be administered or carried out only upon the order of a staff physician, dentist or podiatrist; or allied health practitioner as provided elsewhere in these rules and regulations. The administration of ordered medications to patients shall be carried out only by a registered nurse (R.N.), licensed practical nurse (L.P.N.), respiratory therapist (R.T.), radiological technician (C.R.T.), or Cardiovascular Technologist, acting within the scope of their assigned duties.
- B. Orders for treatment shall be written on the doctor's order form and signed by the attending practitioner. An order that is dictated to licensed nurses, either in person or by telephone, shall be considered in writing, or shall be signed by the person taking the order, with the notation of the name of the ordering (responsible) practitioner. Similarly, licensed Respiratory Therapists, Speech Therapists, Occupational

Therapists, Physical Therapists, Pharmacists and Registered Dietitians, Radiology Technologists, Ultrasound Technologists, Nuclear Medicine Technologists, Cat Scan Technologists and Magnetic Resonance Imaging Technologists employed by Lee Memorial Health System may accept verbal orders (either in person or by telephone) from practitioners for procedures or treatments within their respective service; such orders shall be signed by the person receiving them, with a notation of the name of the responsible practitioner. Verbal orders shall be countersigned by a practitioner responsible for the care of the patient within forty-eight (48) hours.

- C. Pre-printed orders shall be formulated by conference between individual physicians and appropriate hospital representatives. Once agreed upon, they may not be changed by either party without the consent of the other. These orders are to be reviewed every two years by physicians and nursing personnel.
- D. All medications will have an appropriate stop date. The physician will be notified prior to the stop date and asked to verify the need for continuation of the medication(s).
- E. Certain classes of medications may be approved for dosing by Pharmacy. The Pharmacy and Therapeutics Committee will approve medication-dosing protocols and/or guidelines with subsequent approval by the Medical Staff Executive Committee.
- F. All elements of a complete medication order need to be present prior to medication order entry, dispensing, and administration. The elements of a complete medication order are: name (generic or brand), exact dosage strength (unless the medication is available in only one form and there can be no ambiguity about the strength ordered (Example: Lomotil 1 tablet), route, dose interval, and reason for administration of PRN medications (i.e. constipation, cough, diarrhea).
- G. All orders for medication, whether written or verbal, shall be expressed by strength of drug per volume or dose (e.g. “25 mg per cc, 20 mg per cc, or 50 mg capsules”); unless the medication is available in only one form and there can be no ambiguity about the strength ordered. Nursing staff shall clarify any verbal medication order expressed by volume only with the prescribing practitioner before administration of medication. Practitioners who are administering the medication shall verify medication and dosage when someone else has drawn up the medication.
- H. All existing medication orders shall automatically expire when the patient undergoes an operative or invasive procedure. Following the procedure, the surgeon or attending physician must write a new order for medications to be administered post-operatively.
- I. Whenever the attending physician is unavailable, he/she shall appoint another member of the Medical Staff, who has appropriate training and staff privileges, to care for his/her patients. The physician appointed must have indicated his/her willingness to assume this responsibility prior to the unavailability of the attending physician. Orders for the use of restraints shall be in accordance with hospital policy.

6. Proctorship Program

- A. Every member of the Associate Staff shall be evaluated pursuant to the proctorship program described in this Rule. Professional skill, competence and personal character shall be evaluated to permit a determination by the Medical Staff that the Associate Staff member is qualified to advance to the Active Staff.

Each department chairman shall be responsible for overseeing the proctorship program for Associate Staff members assigned to the chairman's department, and for making recommendations to the Executive Committee of the Medical Staff regarding whether or not to advance an Associate Staff member to Active Staff.

- B. Each Section Chief shall be responsible to do the following regarding all Associate Staff members assigned to the Chief's Section:

- 1) Review all available information regarding professional performance not less than every six (6) months, to include, but not limited to:
 - a. Quality and Patient Outcome reports
 - b. Activity (admissions, consultations, outpatients)
 - c. Procedure report
 - d. Medical records compliance
 - e. Quality management summary
 - f. Reports from hospital departments
 - g. Complaints
 - h. Reports of any proctor appointed
- 2) Receive, review and evaluate complaints of any nature or any reports of substandard professional performance, and determine an appropriate action, including but not limited to:
 - a. appointing a proctor to scrub with or be present during procedures or treatment performed by the Associate Staff member;
 - b. personally observing the Associate Staff member's performance during surgery or other procedures or treatments;
 - c. reviewing or requesting others to review medical records of the Associate Staff member's patients;
and
 - d. recommending to the department chairman a summary suspension of the Associate Staff member's privileges in whole or in part.
- 3) Confer with the department chairman or other members of the Section regarding the performance of any Associate Staff member.
- 4) Assist the department chairman regarding documentation of all Associate Staff members' performance in support of the recommendation of the department chairman regarding whether or not an Associate Staff member is to be advanced.

The Health System's Quality and Patient Outcomes, analysts shall perform concurrent reviews of the first ten (10) patients (admission, consultation or outpatients) of all Associate Staff Members and shall report their findings in writing to Medical Staff Services

- C. The Executive Committee of the medical Staff may determine and direct, on an individual basis, the use or implementation of additional or special methods of review of a particular Associate Staff member's performance or activities. The same, however, shall in no case be less stringent than the proctorship program described in this rule.

7. Emergency Centers

- A. The "physician on call" refers to a physician designated for emergency duty in the back-up departmental roster. The "Emergency physician" refers to the hospital-based emergency physician.
- B. Each department shall supply the Emergency Centers with a roster of physicians in that specialty with the breakdown within major departments left to the departments themselves. It shall be the responsibility of the physician called to care for the patient directed to him by the Emergency physician. If the patient's illness happens not to fall within his/her physician's specialty, the attending physician shall then make the appropriate referral.
- C. Physicians who desire to be excused from emergency services because of ill health are required to state this desire in a letter. The respective department of each physician, after review of the submitted evidence and after interviewing the physician involved, will determine whether the physician shall continue to serve as a backup to the Emergency Centers or not; this decision will be expeditiously reported to the physician involved, the Executive Committee and to the physician-in-charge of the Emergency Centers.
- D. The twenty-four (24) hour duty in the Emergency Centers shall be from 8:00 a.m. to 8:00 a.m. the following day.
- E. The Emergency Centers are primarily intended to serve traumatic and acute illnesses of an emergency nature. Priority for the use of facilities and personnel belongs to the Emergency doctor on call or to any other staff member treating such an emergency case. Members of the staff are privileged to utilize the facilities and personnel of the Emergency Centers for treatment of non-emergency cases as long as they do not delay or impede the duties of the doctor on call or any other doctor treating an emergency case.
- F. The "physician on call" to the Emergency Centers may direct the hospital nurse that the patient be sent to his/her office for treatment. The physician may issue orders for diagnosis or treatment by telephone, and the carrying out of such orders does not constitute the practice of medicine by the hospital and does not relieve the physician of his/her responsibility to the patient. The physician shall sign the order. The Emergency physician may call upon the appropriate department call roster physician when, in the opinion of the Emergency physician, the condition merits further care. Failure of the "physician on call" to respond to his summons shall subject the offending doctor to disciplinary action described under

Rule 7-g.

- G. When an illness of a physician or his/her immediate family prevents him from covering the Emergency Centers on his/her assigned day, he/she is requested to personally arrange for his/her substitute on that assigned day, and notify the Emergency nurses of the change. If the “physician on call” is unable to arrange coverage, he/she will notify the chairman of the department of which he/she is a member. It will be the responsibility of the department chairman to assign a substitute. The chairman of the department may alter the monthly coverage schedule so that the ill physician may work another day and relieve the substitute physician of the extra day of duty in the Emergency Centers. The Medical Director of the Emergency Centers will not be responsible for assigning another physician to cover a “call” doctor’s absence. Failure of a doctor to cover the Emergency Centers on his/her assigned day or to personally arrange for his/her substitute and notify the emergency nurses of the change or the department chairman that coverage cannot be arranged shall subject the offending physician to disciplinary action. It is the responsibility of the “physician on call” to stay within telephone contact of the Emergency Centers throughout the coverage period. The department chairman will document to the best of his/her ability the unauthorized absence of the “physician on call” and notify the Executive Committee to investigate and substantiate the absence of the “physician on call.” The offending physician will be expected to appear in person to the Executive Committee, explaining his/her failure to provide coverage to the Emergency Centers. If the Executive Committee finds that the failure to provide coverage is not satisfactorily explained, it may impose disciplinary action as provided in the Medical Staff Bylaws.
- H. No patient shall be discharged from the Emergency Centers or transferred to another hospital because the on call physician states that he/she does little or none of his/her practice at Lee Memorial Hospital.
- I. The Executive Committee shall, at least annually, review the manner in which the Emergency Centers are functioning and shall make recommendations for changes in policies or staffing, as it deems necessary.
- J. All complaints regarding matters pertinent to the Emergency Centers are to be channeled through the Executive Committee rather than directly to the Emergency Centers.
- K. All patients presenting to the Emergency Centers will be posed the question, “Do you have a physician whom you wish us to call or do you wish to see the Emergency physician?” If the Emergency physician deems that the patient requires admission or further consultation, the patient’s physician is to be called first.

8. Medical Records

- A. The attending physician is responsible for the preparation and maintenance of a complete medical record for each patient who receives services. All records will be maintained under a medical record number, which forms the basis for the unit record incorporating inpatient, outpatient and emergency medical records. Each medical record contains at least the following: the patient’s name, address, date of birth,

and the name of any legally authorized representative; the patient's legal status, for patients receiving mental health services; emergency care provided to the patient prior to arrival, if any; the record and findings of the patient's assessment, a statement of the conclusions or impressions drawn from the medical history and physician examination; the diagnosis or diagnostic impression; the reason(s) for admission or treatment, the goals of treatment and the treatment plan with episodic review as appropriate; evidence of known advance directives, evidence of informed consent when appropriate; reports of operative and other procedures, tests and their results; records of donation and receipt of transplants or implants; diagnostic and therapeutic orders. If any; all diagnostic and therapeutic procedures and tests performed and the results; progress notes made by the medical staff and other authorized individuals; all reassessments, when necessary; clinical observations, the response to the care provided; consultation reports; every medication ordered or prescribed for an inpatient; every medication ordered or prescribed for an ambulatory patient or an inpatient on discharge; all relevant diagnoses established during the course of care; conclusions at termination of hospitalization; discharge instructions to the patient or family; any referrals and communications made to external or internal care providers and to community agencies; and when performed, results of autopsy.

B. Directions for specific medical record content:

(1) Code/Summary Sheet:

Final diagnosis(es) shall be written out and shall be consistent with the International Classification of Diseases. This should include principal and secondary diagnoses and procedures and shall be signed by the physician. This information may be specified in the discharge summary or on a signed Attestation Statement in lieu of completing and signing this form.

(2) History and Physical Examination:

A physical examination and medical history shall be done no more than 30 days before or 24 hours after an admission or readmission. In addition, an updated medical record entry documenting an examination for any changes in the patient's condition when the medical history and physical examination are completed within 30 days before admission is required. This updated examination must be completed and documented in the patient's medical record within 24 hours after admission. For surgical patients, the anesthesiologist's history and physical may serve as the updated examination. The history shall include the chief complaint, reason for admission and present illness, pertinent past, family and social history. The physical examination shall include pertinent findings resulting from an assessment of all systems of the body and vital signs (pulse, respirations, blood pressure – blood pressure is required on all patients over six (6) years of age). An admitting diagnosis or diagnostic impression shall be included. The proposed treatment plan shall be documented. Podiatrists are responsible for the part of their patients' history and physical examination that relates to podiatry. Dentists are

responsible for the part of their patients' history and physical examination that relates to dentistry. The medical evaluation and risk assessment of patients are the responsibilities of a physician or other practitioner qualified pursuant to the Medical Staff Bylaws and/or rules to perform such evaluations and assessments. When medical histories and physicals are performed by non-physicians, authentication by the responsible physician shall be in accordance with the bylaws and rules. For surgical services there must be a complete history and physical work-up in the medical record of every patient prior to surgery, except in emergencies. If dictated, but not yet on the chart, there must be a statement to that effect and an admission note in the chart is necessary.

(3) Progress Notes:

A progress note shall be written within twenty-four (24) hours of admission and immediately after surgery. Progress notes shall be recorded routinely as indicated by the condition of the patient. The final progress note should include the condition of the patient and any instructions given to the patient and/or family.

(4) Anesthesiology

There is a pre-anesthesia assessment of each patient for whom anesthesia is contemplated and there is a determination that the patient is an appropriate candidate to undergo the planned anesthesia. Immediately prior to induction, an assessment is completed and documented. The patient's post-operative status is assessed on admission to and discharge from the post-anesthesia recovery area. When medical staff approved criteria are used to discharge a patient, compliance with the criteria is fully documented in the patient's medical record. Post-operative documentation includes at least a record of vital signs and level of consciousness; medications (including intravenous fluids), blood and blood components, any unusual events or post-operative complications, including drug and transfusion reactions, and the management of those events; identification of who provided direct patient care, the patient's discharge from the post-anesthesia care area.

(5) Operative Reports:

A preoperative diagnosis is recorded prior to surgery. Operative reports are dictated or written in the medical record immediately after surgery and describe the findings, the technical procedures used, the specimen(s) removed, the pre and post operative diagnosis, and the name of the primary surgeon and any assistants. The operative report is authenticated by the surgeon and filed in the medical record as soon as possible after surgery. An operative progress note is entered in the medical record immediately after surgery or procedure to provide pertinent information for any individual required to attend to the patient.

(6) Consultations

Requests for consultations should be documented in the medical record when the attending physician calls in another physician for consultation and/or treatment. Consultations shall show evidence of review of the patient's medical record by the consultant, pertinent findings on examination of the patient, and the consultant's opinion and recommendations. All consultations are to be completed in writing before the patient's discharge. Psychiatric consultation shall be offered to all patients who have attempted suicide or have taken a chemical overdose, and this shall be documented in the patient's record.

(7) Physician Order

The professional who carries out the practitioner's order shall document the same pursuant to Health System policy and procedure. The discharge order should be written "DISCHARGE PATIENT" and dated. Written orders sent in with the patient should become part of the medical record for physician signatures and the loose slip destroyed after the physician signs the order on the chart.

(8) Drug Sensitivities

Drug sensitivities are to be reported on the order sheet by the physician and labeled on the outside chart holder by the nurse.

(9) Ancillary Department Reports

Original copies of all reports from ancillary departments are to be dated, signed and promptly placed on the medical record.

(10) Electrocardiogram Report

Official interpretation of electrocardiograms done at Lee Memorial shall be done only by those members of the Medical Staff privileged to do so. All electrocardiographic interpretations should be signed by the physician doing the interpretation.

(11) Autopsy Report

While autopsies are encouraged for the following indications, it is recognized that autopsies cannot be performed without consent of the next of kin. The following are appropriate indications for which requests for autopsies should be encouraged by the Medical Staff. In most cases, the attending physician and pathologist must agree that the autopsy would be of educational value to the medical staff and Lee Memorial Health System.

Autopsies may be performed consistent with provisions of the consent for:

1. Any patient with **sudden**, unexpected death under the age of 40 years, declined by the Medical Examiner's office.
2. Obstetrical or neonatal deaths.

3. Patients whose condition may potentially reveal significant occult conditions.
4. Patients whose death is **directly** associated with a drug or transfusion reaction as a major contributory event, if declined by the medical examiner's office.
5. Patients that die in the hospital within 48 hours of a surgical or invasive procedure without underlying chronic disease or major traumatic injuries, if declined by the medical examiner's office.

Therefore, any death when next of kin and/or physician requests and consent is given; an autopsy will be performed in accordance with the provisions of the consent. To facilitate use of autopsy finding in performance improvement activities, the chairperson of the appropriate department receives a copy of each autopsy report for use in morbidity/mortality conferences and any other department-wide performance improvement activities.

(12) Discharge Summary or Death Summary

Upon discharge, a discharge summary shall be completed and signed by the attending physician for all patients hospitalized over 48 hours except normal newborns and uncomplicated obstetric deliveries. In these cases, a final progress note including the final diagnosis(es), procedures, patient's condition at discharge, discharge instructions, and follow-up care may be substituted for the summary. The summary should recapitulate concisely the reason for hospitalization; the significant findings; the procedures performed and treatment rendered; the condition of the patient on discharge and any specific instructions given to the patient and/or family, i.e., instructions relating to physical activity, medication, diet, and follow-up care. When designated by the pathologist, tumor staging (T-N-M) shall be included as part of the discharge summary. A discharge summary is to be completed for all inpatients who expire, even if the length of stay is less than 48 hours.

(13) Emergency Center Records

Emergency Center records contain any emergency care provided to the patient prior to time of arrival; the time and means of arrival; documentation if the patient leaves against medical advice; treatment provided and conclusions at termination of treatment, including final disposition, condition at discharge, and any instructions for follow-up care.

(14) Observation Records

Records of patients designated as observation patients require a pertinent history and physical examination including admitting impression and treatment plan, progress notes with a summary final progress note, and final diagnosis(es).

(15) Outpatient Surgery Records

Physicians are allowed to use the Outpatient Procedure History and Physical form for patients in the Surgery Center but must comply with the rules for the Operative Report. This includes the information required under #4 and #5 above, as well as informed consent as delineated in Rule 8F.

(16) Obstetrical Record

The obstetrical record includes prenatal care, past pregnancies, previous illness, family history, physical at the time of admission, stages of labor, presenting position at the time of initiation of delivery, description of delivery, final detailed progress note as specified in #12. A durable, legible original or reproduction of the office prenatal record will be acceptable if updated by the attending practitioner at the time of the patient's admission.

(17) Newborn Record

The newborn record should be completed, including physical examination, progress note, final detailed discharge note as specified in #12 and order. If a circumcision is done, a note should be written on the newborn record by the physician performing the procedure.

(18) Tumor Registry

Completed in accordance with state law. Cancer cases are to receive TNM staging at the time of diagnosis. The pathologist identifies cases needing T-N-M staging. The physician responsible for recording the TNM stage is in order of default: Surgeon, Oncologist, Radiation Therapist, Attending Physician. The basis for staging must precede the TNM stage. For inpatients and outpatients, the TNM stage must be written in the medical record.

- C. All clinical entries in the patient's medical record shall be accurately dated, timed and authenticated. Entries in medical records are made only by individuals authorized to do so by hospital policy. The appropriate practitioner authenticates the parts of the medical record for which he or she is responsible. Authentication may be by written signature or initials, rubber-stamp signatures or a unique computer key. When a rubber stamp is used or a computer key code is authorized, the individual signs a statement that he or she alone will use the rubber stamp or the computer key code.
- D. The patient's medical record shall be completed within thirty (30) days of discharge. If the medical record remains incomplete on the thirtieth (30th) day after discharge, it will be considered delinquent and Health Information Management (HIM) will notify the practitioner.
- (1) If the practitioner's medical records remain delinquent at sixty (60) days from discharge, the practitioner will be contacted (letter with demonstrated proof of delivery and/or telephone call) by the Medical Director in collaboration with the Chairman of the Department, and may be given

- three (3) days to complete them. If the medical records remain delinquent at the end of the three (3) days, the practitioner will have the right of hospital admitting, consulting, and surgical privileges suspended until all records are completed. The affected practitioners may not admit, consult or do procedures under the name of another practitioner in his group practice. The practitioner may continue care of present patients, but care of new patients is not permitted. On completion of records, the practitioner will be reinstated.
- (2) Each LMHS facility is considered a separate entity for purposes of record completion. Privileges will only be suspended at the facility(ies) at which there are delinquent records.
 - (3) “Administrator on Call” is responsible for supporting the loss of privileges and may grant limited exceptions when appropriate.
 - (4) Receipt of three (3) requests to complete delinquent medical records under the threat of suspension by the Medical Director in collaboration with the Chairman of the Department during any given calendar year shall result in referral to the next Medical Executive Committee Meeting for suspension of Medical Staff membership and privileges. Ratification will be done in the same manner as other corrective actions pursuant to the Medical Staff Bylaws. Health system counsel will determine whether such action is reportable to the Agency for Healthcare Administration.
 - (5) A practitioner whose Medical Staff membership and privileges are terminated may appeal, in writing, in accordance with the fair hearing procedure outlined in the Medical Staff Bylaws.
 - (6) Practitioners terminated for delinquent medical records will be required to reapply to be reinstated to the Medical Staff.
 - (7) All incomplete charts must be completed before being granted an application for reinstatement.
 - (8) To avoid suspension, practitioners are responsible for notifying Health Information Management prior to vacations or other absences. Practitioners should complete records prior to absences. Practitioners will not be granted additional time for record completion if an absence occurs after the practitioner has been placed on suspension.
 - (9) This rule may be administered in accordance with a policy and procedure established by the Executive Committee.
 - (10) No medical record will be filed if incomplete unless the Medical Director, under the authority of the Executive Committee, directs filing of an incomplete record because there is no reasonable method available for its completion.
 - (11) Informed consent to treatment, blood product administration, surgery or other procedures as may be required by Florida law shall be evidenced in the patient’s medical record. Evidence may consist of the original or a copy of a signed consent form or a note by the physician indicating written informed consent has been obtained.

- E. Patients, and when appropriate, their families are informed about the outcomes of care, including unanticipated outcomes, by the attending physician or the physician most closely related to the patient's care. Such conversations will be verified with appropriate documentation in the patient's medical record.
- F. No physician shall inspect the record of a patient not his/her own unless he/she is acting as a consultant, as chairman of a clinical department, or as a representative of any committee of the Medical Staff which is charged with the duty of reviewing the quality of care rendered in the hospital.
- G. All records are the property of the hospital, and shall be removed from the hospital's jurisdiction and safekeeping only in accordance with the court order, subpoena or statute. All x-ray films shall remain the property of the hospital and shall be kept on the file as part of the record, and may be disposed of in accordance with law. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.
- H. The attending physician shall assist the Medical Record Administrator in coding charts in accordance with the International Classification of Diseases and Current Procedural Terminology.
- I. No blocking out or erasure should be made on the existing record. The physician may date and sign a correction at the end of a particular sheet or on a supplemental form, giving the reasons for the change and signing the note. If an error is made, it should be crossed through with a single line, the correction written above, and the correction initialed and dated. Incorrect report forms (lab, x-ray, etc.) shall not be removed from the record. Corrections shall be made by writing "corrected, see supplemental report." Such supplemental reports shall bear the date of submittal, not of the original report.
- J. All writing on the medical record shall be in black or blue ink.

9. Observers

- A. Persons who are not employees of the health system, members of the Medical Staff, or bonafide health care providers acting in their occupational or professional capacity to provide care to patients may not be present on hospital premises as "observer" without written authorization of a sponsoring member of the Medical Staff. The Unit Director will be responsible for maintaining a log of all observers and obtaining the sponsoring member's approval.
- B. The conduct and activities of an approved "observer" shall be the responsibility of the sponsoring member, who shall be subject to corrective action if the "observer" should violate any of the hospital's policies, procedures, rules and regulations, or should the privacy rights of non-consenting patients or physicians be violated.
- C. The making of photographs, motion pictures or videotapes (for non-medical or non-scientific reasons), within the hospital, shall be regulated and subject to prior written approval in the same manner as the presence of "observers."
- D. The various departments of the Medical Staff may establish department rules, regulations, protocols or procedures governing the presence of "observers" in areas under the department's jurisdiction, so long as the same shall be consistent with this rule.

- E. This rule shall not be construed to apply to persons visiting a particular patient in accordance with the hospital's visitation policy.

10. Procedure and Privilege Criteria:

A. Ventilator Privileges

Privileges for all members of the Medical Staff to manage patients on ventilators shall be delineated as follows:

Class I – All members of the Provisional, Active or Courtesy Staff are considered to have Class I ventilator management privileges and may manage their own patients for up to 24 hours on the ventilator. At the end of 24 hours, an automatic consultation will be sent to the Medical Director of Respiratory Care or to another physician with Class III privileges as chosen by the admitting physician.

Class II – Physicians may be granted Class II privileges which would enable them to manage their own patients on a ventilator indefinitely if they make written application for such privileges and include in their written request a statement that they have training, experience and expertise in ventilator management.

Physicians with Class II privileges may not, however, receive consultations from physicians for ventilator management unless the patient for whom they are called is, or has been previously, a patient receiving direct care from the Class II physician, nor may they serve as designees for the Medical Director.

Class II physicians may provide temporary coverage to consultative patients of a Class III physician who is a member of the Class II physician's own professional group or partnership.

Class III – Such physicians as can demonstrate special training, experience or expertise in management of ventilator problems. Such physicians may receive consultations from Class I or Class II physicians and may serve as designees for the Medical Director.

B. Stereotactic Breast Biopsy Criteria

Physicians requesting privileges in stereotactic breast biopsy must apply to their respective departments.

Requirements for Privileges:

(1) Be a member of the Provisional or Active Medical Staff of Lee Memorial Health System in Diagnostic Radiology or General Surgery and:

- a Have two-dimensional imaging training as basis of stereotactic breast biopsy as part of accredited residency in Diagnostic Radiology, or
- b Provide documentation of stereotactic breast biopsy training during an accredited residency in General Surgery; or
- c Provide documentation of stereotactic breast biopsy training at an accredited course.

C. Peripheral Vascular Endovascular Interventional Procedures:

Criteria for the performance of peripheral vascular endovascular interventional procedures by interventional cardiologists include both didactic and “hands on” procedural training

- (1) Didactic: Documentation of attendance at a minimum of three (3) courses specifically designated as focusing on the diagnosis and management of peripheral vascular disease, accruing a minimum of fifty (50) hours of Category 1 CME credits are considered minimum for credentials. Education obtained residency training may substitute for the three (3) courses.
- (2) Procedural: The performance of a minimum of fifty (50) peripheral interventional procedures under the direct supervision of a qualified mentor in a teaching institution is required for credentials. These procedures shall be peripheral interventions to include balloon angioplasty, intravascular stenting, endovascular grafts, intravascular ultrasound, endovascular arthroectomy and laser angioplasty. In addition, credentialing requires twenty (20) proctored cases satisfactorily completed within Lee Memorial Health System (Lee Memorial Hospital or HealthPark Medical Center) under the supervision of a qualified physician sponsor (interventional radiologist or credentialed cardiologist). At least fifty percent (50%) of the mentored cases must be completed prior to beginning the proctoring process.

D. Hyperbaric Medicine Criteria

Category 1 – Physicians who have successfully completed 40 hours of academic training in hyperbaric and diving medicine in courses approved by the Undersea and Hyperbaric Medical Society, or have clinical experience (as approved by the Executive Committee of the Medical Staff) in the management of patients requiring compression and hyperbaric oxygen treatment. Such physicians may direct routine hyperbaric medicine treatments.

Category II – Physicians who have the highest level of competence and training in hyperbaric and diving medicine including at least certification in diving and hyperbaric medicine by one of the United States uniformed military services, an identified fellowship in hyperbaric medicine (recognized by the Hyperbaric Medical Society), certification by the National Oceanic and Aeronautical Administration or the Diving Medical Advisory Committee or the United Kingdom.

Category II physicians qualify to serve as medical director and to act as a consultant.

E. Sedation and Anesthesia Care

Definitions of four levels of sedation and anesthesia:

(1) **Minimal sedation** (anxiolysis):

A drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.

(2) **Moderate sedation/analgesia** (conscious sedation):

A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to

maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

(3) **Deep sedation/analgesia:**

A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained; and

(4) **Anesthesia and Pain Management**

Consists of general anesthesia and spinal or major regional anesthesia. It does not include local anesthesia. General anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance of maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

Moderate or deep sedation and anesthesia are provided by qualified individuals. Therefore, qualified individuals are trained in professional standards and techniques:

- (a) to administer pharmacologic agents to predictably achieve desired levels of sedation, and
- (b) to monitor patients carefully in order to maintain them at the desired level of sedation.

Individuals administering moderate or deep sedation and anesthesia are qualified and have the appropriate credentials to manage patients at whatever level of sedation or anesthesia is achieved, either intentionally or unintentionally.

Included in the qualifications of individuals providing moderate or deep sedation and anesthesia are competency-based education, training and experience in evaluating patients prior to performing moderate or deep sedation and anesthesia and performing the moderate or deep sedation and anesthesia to include methods and techniques required to rescue those patients who unavoidably or unintentionally slip into a deeper-than-desired-level of sedation or analgesia. Specifically, this will include the following:

- (a) Practitioners who have appropriate credentials and are permitted to administer *moderate* sedation are qualified to rescue patients from deep sedation and are competent to manage a compromised airway and to provide adequate oxygenation and ventilation.
- (b) Practitioners who have appropriate credentials and are permitted to administer *deep* sedation are qualified to rescue patients from general anesthesia and are competent to manage an unstable cardiovascular system as well as a compromised airway and inadequate oxygenation and ventilation.

Sufficient numbers of qualified personnel (in addition to the Licensed Independent Practitioner performing the procedure) are present during procedures using moderate or deep sedation and anesthesia to

- Appropriately evaluate the patient prior to beginning moderate or deep sedation and anesthesia,
- Provide the moderate or deep sedation and anesthesia,
- Perform the procedure,
- Monitor the patient, and
- Recover and discharge the patient either from the post-sedation or post-anesthesia recovery area or from the facility.

11. Guidelines for Allied Health Practitioners

As provided in the Medical Staff Bylaws, other licensed non-physician practitioners may be approved to provide patient care services within the scope of approved clinical privileges within Lee Memorial Health System. Based on the individual's professional license and experience, competence, ability, and judgment, the Allied Health Practitioner may be granted permission to provide patient care services within well-defined limits, which shall be predetermined for each category of Allied Health Practitioner. These predetermined limits shall be approved by the Executive Committee and shall be appended to these Rules and Regulations and entitled "Guidelines for Allied Health Practitioners." The "Guidelines for Allied Health Practitioners" shall be reviewed by the Medical Staff Executive Committee at least annually, but may be revised by the Medical Staff Executive Committee as needed. Specific clinical responsibilities for each Allied Health Practitioner shall be detailed in the individual's delineation of privileges, which shall be submitted as part of the application for clinical privileges. The clinical privileges requested on the delineation of privileges must fall within the parameters established for the specific category of Allied Health Practitioner. Prior to any action taken on an application from an allied Health Practitioner, the guidelines for the specific category of Allied Health Practitioner shall have been approved by the Executive Committee.

All Allied Health Practitioners shall submit three (3) clinical letters of recommendation: one from a physician, one from a peer and one from his/her program director or previous employer. The practitioner-employer of a Physician Assistant, Advance Registered Nurse Practitioner, Certified Nurse Midwife or Certified Registered Nurse Anesthetist, who is not an employee of Lee Memorial Health System and Registered Nurse First Assistants, shall be insured under a professional liability policy acceptable to the Executive Committee of the Medical Staff. Guidelines for Allied Health Practitioners are as follows:

A. Physician Assistants:

(1) General Guidelines for Physician Assistants:

All medical facilities of Lee Memorial Health System are appropriate areas of utilization for the Physician Assistant. Physician Assistants will work directly under their responsible physicians as a

member of the health care team, performing duties as delineated. All delineation of privileges for Physician Assistants must have the approval of the responsible physician's department chairman. If a question or issue over the scope of Physician Assistant duties arises between the supervising physician and the department chairman, an appeal may be made to the Executive Committee. The immediate responsibility for the actions of the Physician Assistant will rest with the physician by whom he/she is employed or, if a System employee, with Lee Memorial Health System.

(2) Specific Guidelines for Physician Assistants:

- a. When authorized, the Physician Assistant is a fully responsible participant on the health care team and functions as the direct representative of the physician.
- b. These guidelines are applicable only to Physician Assistants who are:
 - 1) Graduates of two-year Physician Assistant programs that are accredited by the American Medical Association;
 - 2) Graduates of Physician Assistant Programs that are less than two years in length but which are accredited by the American Medical Association. They must have proof of graduation and must pass the National Certifying Examination of the National Board of Medical Examiners. Protocols of practitioners and policies applicable to medical or surgical sub-specialty areas will be determined by the appropriate department.
- c. The supervising physician will be responsible for the Physician Assistant's actions in emergency situation.
- d. Each Physician Assistant shall be considered individually and be assigned only those duties, which are commensurate with his/her training and competency.
- e. Any approval pursuant to this section may be limited or suspended by the department chairman or Executive Committee at any time. The responsible physician shall be promptly notified.
- f. No more than two (2) Physician Assistants may be approved for each physician- employer or responsible physician

(3) Scope of Activities for Physician Assistants:

a. Category A:

Duties which may be performed by the Physician Assistant as a part of his/her specific delineation of privileges may include:

- 1) Performing initial histories and physical examinations on new patients, both on an inpatient and outpatient basis and indicating medical problems.
- 2) Performing periodic physical examinations on inpatients.
- 3) Ordering appropriate laboratory tests (including x-rays and EKGs).
- 4) Drawing blood specimens for testing and performing other comparable procedure when personnel who customarily perform such procedures are not available.

- 5) Ordering medications as outlined in their delineation of privileges and approved by the appropriate department.
- 6) Initiating consultations and monitoring scheduling of patients for special tests.
- 7) Making daily rounds to observe and record pertinent progress of patients, updating and summarizing charts, and notifying responsible physician(s) of changes in the patient's condition.
- 8) Making interim summaries as required.
- 9) Making required notes on all procedures as to preventative care, medical problems, and the use of prescribed treatment and drugs, with the exception of the operative record.
- 10) Counseling the patient and his family as to preventative care, medical problems, and the use of prescribed treatment and drugs.
- 11) Initiating orders for the use of restraints, in accordance with hospital policy.

b. Category B:

Duties, which may be performed by the Physician Assistant only upon specific order of the responsible physician(s) shall include:

- 1) Performing dressing changes and removal of sutures.
- 2) Performing nasogastric intubations.
- 3) Performing routine suturing of lacerations and surgical wounds.
- 4) Ordering blood gas determinations.
- 5) Performing Foley catheter urinary bladder catheterization.
- 6) Starting IV solutions and administering IV medications, which have been ordered and approved by the attending physician.
- 7) Applying and removing casts and traction apparatus.
- 8) Writing notes on procedures and tests performed which fall in category "B" for review and countersigning by the employer physician(s).
- 9) Cystometrogram.
- 10) Harvesting veins for cardiac revascularization.
- 11) Provide hemostasis and exposure through the appropriate use of instruments, sutures, staples, cautery, retractors, suctioning and sponging techniques.

c. Category C:

Procedures which may be performed by the Physician Assistant where the Physician Assistant is involved in a life threatening situation and when there is no licensed physician available:

- 1) Managing cardiac arrest patients, including use of external cardiac compression.

- 2) Managing acute respiratory failure patients.
- 3) Managing life-endangering traumatic injuries.
- 4) Initiating electro-defibrillation.
- 5) Passing endotracheal tubes.
- 6) Ordering and administering oxygen.
- 7) Ordering and starting whole blood.
- 8) Administering emergency medications.

B. Physician Assistants/Anesthetists

Physician assistants with this designation shall meet all the foregoing requirements and in addition shall be required to have graduated from an approved program of P.A. anesthesia with a Masters Degree - Master of Medical Science in Anesthesiology. They must be employed and supervised by anesthesiologists. Their scope of activity is that of certified registered nurse anesthetists as described elsewhere in the bylaws.

C. Speech Pathologists/Audiologists:

Speech Pathologists/Audiologists designated as Allied Health Practitioners with this designation shall have the following qualifications:

A graduate degree appropriate to the professional degree requirements.

- (1) A certificate of Clinical Competency by the American Boards of Speech Pathology and Audiology of the American Speech, Language and hearing Association.
- (2) At least three (3) favorable recommendations from medical and/or professional colleagues regarding the two or more most recent years of clinical experience in Speech Pathology and/or Audiology.
- (3) Registration by the State of Florida.
- (4) Adherence to the Code of Ethics of the American Speech, Language and Hearing Association. (Refer to the Code of Ethics of the American Speech-Language-Hearing Association).

D. Advanced Registered Nurse Practitioners:

Allied Health Practitioners designated as Advanced Registered Nurse Practitioners shall meet the following requirements:

- (1) Education and Training Requirements: Meets the requirements of appropriate Florida statutes for licensure.
- (2) Scope of Activities: Services and procedures performed shall be consistent with requirements of Florida Law, and specialized services and procedures shall be outlined in a protocol, which shall be a part of the nurse practitioner's file.
- (3) Duties which may be performed by the ARNP only upon specific order of the responsible physician shall include:
 - a) Performing dressing changes and removal of sutures
 - b) Performing nasogastric intubations
 - c) Performing routine suturing of lacerations and surgical wounds

- d) Ordering blood gas determinations
 - e) Performing Foley catheter urinary bladder catheterization
 - f) Starting IV solutions and administering IV medications, which have been ordered and approved by the attending physician
 - g) Applying and removing casts and traction apparatus
 - h) Writing notes on procedures and tests performed which fall in Category “B” for review and counter signing by the employer/physician(s).
- (4) Supervision: A member of the Medical Staff or Lee Memorial Health System shall employ and be responsible for the nurse practitioner.
- (5) Licensure: The Advanced Registered Nurse Practitioner must be dually licensed as both a Registered Nurse (R.N.) and an Advanced Registered Nurse Practitioner (A.R.N.P.) by the Florida State Board of Nursing.

E. Advanced Certified Nurse-Midwives:

(1) General Guidelines for Certified Nurse-Midwives

The Certified Nurse-Midwives (C.N.M.) will function under the supervision of an attending staff physician obstetrician performing clinical tasks for normal healthy women with uncomplicated pregnancies. The patient must meet the criteria for C.N.M. management or may be approved for C.N.M. care at the discretion of the obstetrician. The responsibility for the actions of the C.N.M. lies with the obstetrician. The obstetrician will assure that proper certification procedures with the Florida State Board of Nursing are followed and that the job description outlines the actual duties performed by the C.N.M.

The department chairman and the Executive Committee must approve the C.N.M.’s delineation of privileges. Conflicts will be resolved by the Executive Committee. The Performance of the C.N.M. will be evaluated by the supervising obstetrician. These evaluations will assist in determining continuation of employment.

(2) Specific Guidelines for Certified Nurse-Midwives:

The C.N.M. must have written proof of graduation from an accredited school of Nurse-Midwifery and must be licensed and certified by the appropriate State agencies. Clinical privileges are under the auspices of the Department of Obstetrics and Gynecology and in accordance with the Bylaws of the Medical Staff of Lee Memorial Health System. Specific duties, which may be performed by the Certified Nurse-Midwife as part of his/her specific delineation of privileges, may include:

- a. Assess the progress of labor and the laboring woman’s condition.
- b. Order appropriate labor analgesia. Medications used for analgesia will be listed in approved protocols.
- c. Performing vaginal exams.

- d. Perform amniotomies if the vertex is well engaged and labor is well established or if their aminos fetal heart rate patterns on the external monitor tracing (so a fetal scalp electrode can be attached).
- e. Monitor women on IV oxytocin for augmentation of induction with medical collaboration by the attending obstetrician.
- f. Apply external fetal and uterine monitors.
- g. Apply internal fetal scalp electrodes and internal uterine pressure catheters.
- h. Start IVs and draw blood for lab studies.
- i. Conduct complete physical exams and histories.
- j. Conduct deliveries in the LDRP unit, (LDRP unit deliveries should be planned), delivery room or birthday suite.
- k. Perform local perineal infiltration or pudendal block.
- l. Perform and repair midline or mediolateral episiotomies.
- m. Conduct spontaneous deliveries of single fetuses in the vertex presentation in OA or OP position.
- n. Manage the normal third stage of labor.
- o. Perform cervical and vaginal inspection.
- p. Repair cervical, vaginal and perineal lacerations according to protocols.
- q. Take responsibility for management of care in the recovery room of women whose deliveries were conducted by the C.N.M.
- r. Sign women out of the recovery room to be transferred to the postpartum unit.
- s. Manage the postpartum and family planning care of women.
- t. Complete the entire prenatal, intrapartum and postpartum charting record.
- u. Perform as first assist in scheduled and emergency cesarean sections.
- v. Assist with gynecologic surgery.
- w. Vacuum extraction according to approved protocol for emergency situations of fetal distress.

F. Certified Registered Nurse Anesthetists/Anesthesiologists Assistants:

Nurse anesthetists (“CRNAs”) and anesthesiologist assistants (“AAs”) may be utilized by anesthesiologists within the Lee Memorial Health System in accordance with the provisions of the bylaws, subject to the following additional conditions and requirements.

- (1) The supervising anesthesiologist shall not, except in case of emergency, be involved in the administration of anesthesia at the same time that a CRNA or AA under his or her supervision is administering anesthesia. The supervising anesthesiologist may personally relieve the CRNA or AA for short durations (i.e., breaks) if the CRNA or AA remains immediately available. The anesthesiologist may not supervise more than four (4) Allied Health Practitioners assigned to concurrent cases at any one time, of which not more than two (2) practitioners may be

Anesthesiologist Assistants (AAs), pursuant to Florida Statutes, the exception being in the event of a trauma or life-threatening emergency.

- (2) The anesthesiologist will make all preoperative evaluations and select the anesthetic to be administered by the CRNA or AA. The anesthesiologist or his/her designee shall make routine post-operative evaluations.
- (3) The supervising anesthesiologist must disclose to the patient and surgeon in advance that a CRNA or AA will administer the anesthetic, and the consent of the patient to the administration of anesthesia shall be obtained. In extenuating circumstances, such disclosure and consent may be waived.

Current Anesthesia Consent form states: “Your physician has requested that the Anesthesia Department provide care to you during your operation/procedure. The method of anesthesia will be checked by your anesthesiologist after discussion with you. The anesthesia will be administered by an anesthesiologist or a certified registered nurse anesthetist or anesthesiologist assistant under the supervision of an anesthesiologist.”

- (4) The supervising anesthesiologist shall at all times during the course of administration of anesthesia be immediately available (i.e. physically in-house) to the Allied Health Practitioner in the operating room, except when dealing with an emergency of short duration.

The supervising anesthesiologist may be relieved by another anesthesiologist. For purposes of this subsection, “operating room” shall include all anesthetizing locations within the facility.

- (5) During the course of regional anesthesia for pain during childbirth (other than by Cesarean Section), the supervised CRNA or AA shall remain with the patient until vital signs are stable. The patient must be observed at regular intervals by a qualified anesthesia provider or a licensed and trained obstetrical nurse. The supervising anesthesiologist shall remain available (i.e., physically in-house). The supervising anesthesiologist may be relieved by another anesthesiologist. If the sponsoring anesthesiologist then leaves the presence of the patient, he/she must ensure that the patient will be observed.
- (6) The supervising anesthesiologist shall be responsible to ensure that the CRNA or AA maintains records of the anesthetics, which shall contain periodic entries of the monitoring data.

F. Practitioner Employees:

Allied Health Practitioners designated as limited practitioner employees shall meet the following guidelines:

- (1) Medical Staff members may employ limited practitioner employees to assist in the care of hospitalized patients subject to the Medical Staff bylaws. They shall be appropriately licensed or certified, if applicable, by the State.
- (2) Scope of Activities: The duties and procedures which the Limited Practitioner Employees may perform shall be based on proof of training and experience to the Credentials Committee at the time of appointment. The delineation of privileges shall be made by the practitioner-employer’s clinical

department on a case-by-case basis. Any duty or procedure not explicitly outlined and approved shall be presumed to be denied and prohibited.

- (3) Education and Training Requirements: All surgical limited practitioner employees must have either completed an approved surgical technician program or provide documentation of prior experience with aseptic technique in the operating room environment. Absence of these qualifications will require monitoring by operating room staff until proficiencies demonstrated.

G. Registered Nurse First Assistants:

Allied Health Practitioners designated as Registered Nurse First Assistants shall meet the following guidelines:

- (1) Education and Training Requirements: All Registered Nurse First Assistant (RNFAs) are required to have three (3) years recent perioperative nursing experience with proficiency in both circulating and scrubbing roles, must be CNOR (Certified Nurse Operating Room); have BLS (Basic Life Support); and have RNFA certificates of competency and college course credits from an approved RNFA program utilizing AORN (Association of Operating Room Nurses) curriculum guidelines.
- (2) Scope of Activities: Specific duties which may be performed by the RNFA upon specific order of physician are outlined in the delineation of privileges application as Category A and perioperative duties to be performed by the RNFA as Category B.

H. Surgical Technician First Assistants:

Allied Health Practitioners designated as Surgical Technician First Assistants (STFAs) shall meet the following guidelines:

- (1) Medical Staff members may contract with or employ limited practitioner employees qualified as STFAs to assist at surgery, subject to the Medical Staff Bylaws.
- (2) Education and Training Requirements: All STFAs are required to have two (2) years recent perioperative experience.
- (3) Surgical technician experience; have completed BLS (Basic Life Support) training; and have completed training in an approved STFA program and obtained a certificate of proficiency from such program.
- (4) Scope of Activities: The duties and procedures which the STFA may perform shall be based on proof of training and experience to the Credentials Committee at the time of appointment. The Delineation of privileges shall be made by the Department of Surgery on a case-by-case basis. Any duty or procedure not explicitly outlined and approved shall be presumed to be denied and prohibited.

12. Continuing Medical Education

Physicians are encouraged to devote 50% of CME credits to their respective specialty.

Rules and Regulations Revisions

05-29-08

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