

LEHIGH VALLEY HOSPITAL
DEPARTMENT OF FAMILY MEDICINE

Rules and Regulations

I. NAME:

The name of this organization shall be the Department of Family Medicine of Lehigh Valley Hospital and Health Network and will include all department members, as defined below, from the common medical staff of Lehigh Valley Hospital and Lehigh Valley Hospital-Muhlenberg.

II. PURPOSE:

The purpose of the Department of Family Medicine of Lehigh Valley Hospital and Health Network is to be a community of healing based on the traditions of family medicine and community-oriented primary care. The Department will serve as a model for innovation and service excellence at integrating patient care, health professional education, and primary care research in an open, inviting atmosphere. The Department will be a model of collaboration working with others in the Lehigh Valley Health Network family and the community to weave a continuum of primary care, with the goal of improving the collective health of the region.

III. ORGANIZATION:

A. Chair

This board certified family physician is appointed in accordance with the Bylaws of the Common Medical Staff of Lehigh Valley Hospital and Lehigh Valley Hospital-Muhlenberg. The Chair is to provide vision, oversight, coordination, and accountability for the Department as a whole. The Chair is to exemplify servant-leadership in the administrative, clinical educational, and research areas of Family Medicine. The Chair is an ex-officio member of all department committees.

B. Vice Chair of Academic and Community Programs

This board certified family physician is appointed in accordance with the Bylaws of the Common Medical Staff of Lehigh Valley Hospital and Lehigh Valley Hospital-Muhlenberg. The function of this person is to assist the Chair with those management responsibilities related to education, research and community service and to fill in for the Chair in her/his absence.

C. Director of Network Development

This board certified family physician is appointed in accordance with the Bylaws of the Common Medical Staff of Lehigh Valley Hospital and Lehigh Valley Hospital-Muhlenberg. The function of this person is to assist the Chair with those management responsibilities related to clinical care and the development and growth of the Primary Care Network.

D. Vice Chair of Lehigh Valley Hospital-Muhlenberg Family Medicine

This board certified family physician must be an Active staff member whose primary clinical activity takes place at Lehigh Valley Hospital-Muhlenberg and is appointed in accordance with the Bylaws of the Common Medical Staff of Lehigh Valley Hospital and Lehigh Valley Hospital-Muhlenberg. The function of this person is to assist the Chair with those management responsibilities related to family medicine activities at the Lehigh Valley Hospital-Muhlenberg campus.

E. Program Director

This board certified family physician is appointed in accordance with the Bylaws of the Common Medical Staff of Lehigh Valley Hospital and Lehigh Valley Hospital-Muhlenberg. The function of this person is to direct the family medicine residency training program.

F. Division Chiefs

Division Chiefs are board certified family physicians appointed in accordance with the Bylaws of the Common Medical Staff of Lehigh Valley Hospital and Lehigh Valley Hospital-Muhlenberg. They are responsible for supervising and evaluating patient care and suggesting policy within their Division.

IV. SECTIONS WITHIN THE DEPARTMENT OF FAMILY MEDICINE:

A. Geriatrics

B. Occupational Medicine

V. DEPARTMENT MEETINGS:

Active and Provisional Active staff will meet monthly and no less than ten times a year. Non-active members are encouraged to attend and participate without vote.

VI. COMMITTEES:

All committees and divisions will meet on an as needed basis as determined by the chair or as noted below. Minutes and attendance records will be kept for all meetings and maintained in a file by the Department of Family Medicine. All committees will report regularly and no less frequently than once a year at Departmental meetings. All recommendations and actions of committees and divisions will be brought forward to Departmental meetings.

A. Family Medicine Executive Committee

1. Composition - The committee chairperson will be the Chair of the Department. Members will include the Vice Chairs, Program Director, Director of Network Development, Section chiefs, Chief Resident(s), one at-large representative from each of any large physician practice groups (i.e. three or more family practices in the group), two at-large Active staff members representing independent family practitioners, and an at-large senior attending staff member. All members will be appointed by the Chair. The at-large positions will change every three years on a staggered rotation.

2. Purpose - Advisory and reporting functions to the Chair on behalf of Department Active staff.

B. Standing Committees

1. Family Medicine Quality Improvement Committee

- a. Composition - The committee chairperson will be the Director of Network

Development. Members will include the Residency Program Director, the Chair of the Department, one third year family medicine resident and five at-large active staff members. At-large physician membership will be offered in an attempt to balance the spectrum of department members, including members with an active hospital practice, members with an active birthing practice, members with an exclusive outpatient practice, members whose primary clinical activity takes place at Lehigh Valley Hospital – Cedar Crest and members whose primary clinical activity takes place at Lehigh Valley Hospital-Muhlenberg. Non-physician membership will include the Department of Family Medicine Clinical Pharmacist and an invitation will be offered to one at-large member from CRNPs or PAs from the practices of Active staff members. All members will be appointed by the Director of Network Development. The at-large positions will change every three years on a staggered rotation. Case review will be completed by members of the Active staff with cases assigned in rotation by the committee chairperson.

- b. Purpose - To coordinate and oversee the monitoring evaluation and improvement of all aspects of Family Medicine patient care in the Lehigh Valley Health Network. These clinical care enrichment activities will include both inpatient and outpatient quality assurance and clinical improvement. The committee will meet at least 4 times per year.

2. Family Medicine Education and Research Advisory Committee

- a. Composition - The committee chairperson will be the Vice Chair of Academic and Community Programs. Members will include representatives from Community Health and Health Studies, General Internal Medicine, Ob-Gyn, Pediatrics, Surgery, Psychiatry, Chief Resident in Family Medicine, the Department of Family Medicine's Research Education Associate, Family Systems Associate, and Program Director, and two at-large members of the Family Medicine Active staff (one each from Lehigh Valley Hospital and Lehigh Valley Hospital-Muhlenberg). All members will be appointed by the Vice Chair of Academic and Community Programs in consultation with department chairs. The at-large positions will change every three years.
- b. Purpose - To oversee, coordinate and enhance primary care educational and research activities and interdepartmental collaboration as they relate to the Lehigh Valley Health Network and Department of Family Medicine's vision and mission. This will include oversight of monthly Primary Care Grand Rounds, the Family Medicine Residency Program curriculum, and the Department of Family Medicine and Primary Care Network research activities. This committee will meet at least once per year.

VII. REQUIREMENTS FOR FAMILY MEDICINE CARE GIVERS:

A. Department Members

All members of the Department of Family Medicine must meet requirements for staff membership as outlined in the Bylaws of the Common Medical Staff of Lehigh Valley Hospital and Lehigh Valley Hospital-Muhlenberg. Recertification is mandatory, when required by relevant certifying board.

A physician who graduated from a medicine/pediatric residency and meets the bylaws requirements for Board Certifications in General Internal Medicine and Pediatrics is eligible for appointment and credentialing to the Department of Family Medicine.

B. Requirement for Attendance of Deliveries

All family practitioners who actively participate in deliveries are required to have current certification in the AHA approved Neonatal Resuscitation course. Current certification in the AAFP approved Advanced Life Support in Obstetrics (ALSO) is encouraged but is not mandatory.

See ADDENDUMS A and B for the Models of Family Medicine and Obstetrics & Gynecology Collaborations

C. Requirement for Attending Physician Responsibility

The Department of Family Medicine supports department members in solo and group practice who wish to admit and follow their own patients to Lehigh Valley Hospital and Health Network (LVHNN) hospitals and skilled care units.

LVHNN currently has three sites where such care is available: LVH-Cedar Crest, LVH-Muhlenberg, and LVH-17th & Chew. Under hospital by-laws, physicians following patients in these units must provide for 24-hour coverage each day of the week.

As a department, we recognize and support the diversity of practice models in the community, and realize that members who do hospital care may be in coverage groups with colleagues who do not provide hospital care. Because patient care and safety is our foremost commitment, the family physician who is the attending physician of record has the following responsibilities:

1. The physician or physician group attending to or consulting on patients admitted to LVH-Cedar Crest, LVH-Muhlenberg and LVH-17th & Chew must assure 24-hour coverage arrangements for those patients at all times. The physician or physician group responsible for the hospital care of these patients must place a written order in the medical record communicating coverage to hospital staff. This written order must include the name and contact information (phone number, pager or cell phone) of the physician or physician group providing hospital care coverage. If these hospitalized patients are part of a practice that has a different physician providing outpatient coverage, the outpatient coverage physician must also be provided with this contact information so that they are aware of who is providing inpatient care for the practice and how they may be reached.
2. In the event that the attending physician or physician group becomes unavailable to provide hospital care and care must be temporarily transferred to another physician or physician group; this change must be given as a written order in the medical record so that hospital staff is properly informed of the change. It is insufficient for a coverage change to occur between physicians without a written order in the medical record. In addition, the physician or physician group providing outpatient coverage for the practice must also be informed of the change along with contact information. Violation of the above rule may result in disciplinary action.
3. If for some reason the hospital staff is unable to reach the attending physician or physician group listed for hospital coverage, the outpatient covering physician will be responsible for giving assistance to the hospital staff in locating an appropriate hospital covering physician. The outpatient-covering physician is responsible to be aware of the name and contact information of the appropriate hospital coverage physician or physician group for the practice.
4. CAPOE Instructions to write an order for coverage from the order screen, choose NURSING. Under NURSING, choose NOTIFY (+). Under NOTIFY (+) choose COMMUNICATE TO NURSE. When processing this order, indicate details of coverage and contact information in the COMMENTS field.
5. Management and coordination of the patient's care
6. Appropriate consultations; consultations do not remove the responsibility for timely coordination of care from the attending
7. If attending physician responsibility is to be transferred to another physician or physician group, clear understanding of the transfer should appear on the transfer sheet and

documentation which is timed and dated should appear in a progress note and on the order sheet in accordance with Common Medical Staff Bylaws.

VIII. CATEGORIES AND MINIMAL REQUIREMENTS OF DEPARTMENT MEMBERS:

The Medical Staff categories in the Department of Family Medicine will be limited to two--Active and Affiliate.

A. Active Staff

Active staff members will be required to meet minimum activity standards to assure that Department Chair is able to review their performance adequately. They will be eligible for committee assignments, quality assurance case review and able to vote on issues before the Medical Staff. Active staff membership will be subject to the Medical Staff Development Plan.

1. Minimum Requirements:

- a. Patient Care: Inpatient or Outpatient - Minimum 10 hours/week
- b. Department Meetings - Minimum 50% attendance
(Primary care-related Internal Medicine, Pediatrics, Emergency Department, Psychiatry, Ob-Gyn meetings, or others approved by Chair may be attended and will count towards the 50% requirement.)
- c. Plus Active participation in at least One (1) and preferably two (2) listed below per year
 - i. LVH committees
 - ii. LVHN-related committees
 - iii. Department committees
 - iv. LVH/LVHN-related task forces
 - v. Teaching - LVH/LVHN/Affiliate
 - vi. Research-LVHN affiliate
 - vii. Community Service
- d. CME: 150 hours AAFP/AOA approved every three years
- e. Pays dues in accordance with the Bylaws of the Common Medical Staff. Has vote (may vote only in Department credentialed)

Physicians who have not fulfilled their attendance requirements in the Department after being on probation for six months will have a required meeting with the Chair of the Department and the President of the Medical Staff to discuss the situation. A letter of reprimand will be placed in the physician's folder and if the physician does not improve their attendance in the next year to meet the requirement, the reprimand will become part of their permanent record. At that time, discussion between the President of the Medical Staff and the Chair of the Department will occur to discuss what further action will be taken, up to and including removal from the medical staff.

B. Affiliate Staff

This category is designed to accommodate physicians who have a relationship with Lehigh Valley Hospital and Health Network and who are not members of the Active staff. All Affiliate staff members will be able to visit their patients at Lehigh Valley Hospital and/or Lehigh Valley Hospital-Muhlenberg and, if desired, provide additional clinical information in the progress notes. Other specific privileges and activities will be granted on a case-by-case basis based on specific pre-determined criteria upon recommendation of the Chair in accordance with the requirements of the Bylaws of the Common Medical Staff concerning temporary privileges.

1. Minimum Requirements:

- a. Patient Care - Inpatient or Outpatient: Minimum 10 hours/week
- b. CME - 150 hours AAFP/AOA approved every three years
- c. Active staff at JCAHO-approved institution
- d. No Admitting/Orders
- e. Pay dues in accordance with the Bylaws of the Common Medical Staff - No vote

**MODEL OF FAMILY MEDICINE AND OBSTETRICS & GYNECOLOGY COLLABORATION FOR
IN-PATIENT OBSTETRICAL CARE AT LVHHN**

I. POLICY

Regulation within the Department of Family Medicine and the Department of Obstetrics & Gynecology.

II. SCOPE

All personnel who work in Labor & Delivery, MBU, PNU & Health Care Providers in the Department of Family Medicine & Department of Obstetrics & Gynecology.

III. GUIDING PHILOSOPHY

- Foster an attitude of mutual respect, cooperation, collaboration, collegiality and communication.
- Regardless of the specialty, there should exist one standard of perinatal and obstetrical care endorsed by both departments.

IV. BASIC PRINCIPLES

- Recognition that Family Medicine physicians are capable and credentialed to provide prenatal care and to manage intrapartum delivery and postpartum care to pregnant patients.

The Family Medicine physician is responsible and accountable for the quality of that care.

Outcomes data show that there is no difference whether properly triaged patients are managed by Family Medicine physicians or obstetricians.

- Given the unpredictable nature of Labor and Delivery and given the limited credentials of Family Medicine physicians, it is in the best interest of the patient for the Family Medicine attending physician to informally notify the attending obstetrician on Labor and Delivery of their patient's condition upon arrival on Labor and Delivery as a matter of courtesy.
- Situations will exist in the antenatal, intrapartum and postpartum care that may require more formal written consultation with an obstetrician.

The family Medicine physician may consult any obstetrician he or she chooses. For the most part, at this time, we expect that consults on Labor and Delivery will go to the 24-hour attending.

- The consultant must evaluate the patient and provide written documentation of that consultation. Together, the obstetrician and the Family Medicine physician must decide:

A. Family Medicine can continue to manage the care of this patient with obstetrical back-up, availability and assistance (Level II).

B. The obstetrician must assume full management

1) During the critical period with returning subsequent care to the Family Medicine physician (Level III)

2) Complete transfer of the care to the obstetrician (Level IV).

- The following lists are suggestions developed jointly by the Department of Obstetrics and Gynecology and Family Medicine as to how various patients can be triaged.

Recognize that these suggestions may need to be altered by individual circumstances such as:

- 1) Patient condition
- 2) Physician ability
- 3) Patient preference

V. LEVEL I

Management and follow-up by Family Medicine. The Family Medicine attending will notify the obstetrics attending of the patient's presence on the Labor and Delivery Unit. Informal courtesy interaction. Obstetrician on standby.

- Normal labor in term uncomplicated vertex presentation, spontaneous vaginal delivery.
- Management and interpretation of internal and external electronic fetal monitoring stripe.
- Augmentation of labor with Pitocin per protocol.
- Cervical ripening per protocol.
- Induction of labor per protocol.
- Normal postpartum care.
- Management of postpartum endometritis.
- Manual removal of retained placenta.
- Outlet and low vacuum extraction.
- Episiotomy. First degree, second degree, third degree, vaginal and cervical laceration repair.
- Pre-Term onset of labor between 34 and 36 weeks gestation
- PPRM between 34 and 36 weeks gestation
- Maternal abuse of drugs and alcohol

VI. LEVEL II

Family Medicine attending physician requests formal written consultation from obstetrical attending physician. Co-management as negotiated. The Family Medicine attending manages labor, attends the delivery and follows up with postpartum care. Obstetrician on standby.

- Gestational diabetes.
- Second and third trimester IUFD.

- Documented serious malformation with antenatal MFM consultation.
- Patient with HIV with antenatal MFM consultation.
- Management of VBAC in labor with antenatal MFM consultation.
- PIH, mild, moderate pre-eclampsia.
- Arrest of labor in the first stage of labor after augmentation protocol failure.
- Arrest of labor in second degree stage of labor.

VII. LEVEL III

Family Medicine attending requests formal written consultation from obstetrician attending and obstetrician assumes primary responsibility for obstetrical care through the critical period after which Family Medicine may resume primary responsibility.

Addendum A

MODEL OF FAMILY MEDICINE AND OBSTETRICS & GYNECOLOGY COLLABORATION IN OBSTETRICAL CARE AT LVH

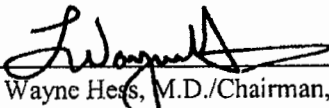
- Forceps delivery.
- Mid vacuum extraction.
- Malpresentation.
- Severe pre-eclampsia.
- Eclampsia.
- Severe maternal medical co-morbidity.
- Pre-term onset of labor <35 weeks.
- PROM < 35 weeks.
- Trauma.
- Significant postpartum hemorrhage.
- Shoulder dystocia.

VIII. LEVEL IV

Family Medicine attending requests formal written consultation from obstetrical attending with complete transfer of care and follow-up by the obstetrical team.

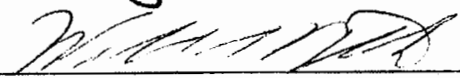
- Cesarean delivery.
- Complicated forceps extraction.
- Isoimmunization.
- Multiple gestation.
- Third trimester bleeding from placenta previa or abruption.

IX. APPROVAL



L. Wayne Hess, M.D./Chairman, Department of OBGYN

10-12-05
Date



William Miller, M.D./Chairman, Department of Family Medicine

2011/2/01
Date

X: *POLICY RESPONSIBILITY*

Conflict should be resolved immediately utilizing each department's chain-of-command policy.

Ultimate responsibility rests with the chairperson from Family Medicine and Obstetrics & Gynecology.

XI. *REFERENCES*

Model of Family Medicine and Obstetrics & Gynecology Collaboration in Obstetric Care at the University of Michigan; Berman, Johnson, Apgar; OB-GYN: 1996 p. 308-313, 8/00

**MODEL OF FAMILY MEDICINE AND OBSTETRICS & GYNECOLOGY COLLABORATION FOR
PRE-NATAL OBSTETRICAL CARE AT LVHHN**

I. POLICY

Regulation within the Department of Family Medicine and the Department of Obstetrics & Gynecology.

II. SCOPE

All personnel who work in Labor & Delivery, MBU, PNU & Health Care Providers in the Department of Family Medicine & Department of Obstetrics & Gynecology.

III. GUIDING PHILOSOPHY

- Foster an attitude of mutual respect, cooperation, collaboration, collegiality and communication.
- Regardless of the specialty, there should exist one standard of perinatal and obstetrical care endorsed by both departments.

IV. BASIC PRINCIPLES

- Recognition that Family Medicine physicians are capable and credentialed to provide prenatal care and to manage intrapartum delivery and postpartum care to pregnant patients.

The Family Medicine physician is responsible and accountable for the quality of that care.

Outcomes data show that there is no difference whether properly triaged patients are managed by Family Medicine physicians or obstetricians.

- Situations will exist in the antenatal period which require formal written consultation with an obstetrician. Risk assessment of the need for consultation will be done by the Family Medicine physician at initial time of care and at 34 weeks using the attached tool.
(Attachment A)
- The consultant must evaluate the patient and provide written documentation of that consultation. Together, the obstetrician and the Family Medicine physician must decide:
 - A. Family Medicine can continue to manage the care of this patient with obstetrical assistance (Level II).
 - B. The obstetrician must assume full management with complete transfer of the care to the obstetrician (Level III).

V. LEVEL I

Family Medicine attending physicians will provide antenatal care, without required obstetrical consultation, to patient with a low risk pregnancy as determined by a standardized risk assessment tool.

VI. LEVEL II

Family Medicine attending physician will request formal out-patient consultation with obstetrical attending physician. Co-management will be negotiated with family physician, obstetrician, and patient.

Addendum B

MODEL OF FAMILY MEDICINE AND OBSTETRICS & GYNECOLOGY COLLABORATION IN OBSTETRICAL CARE AT LVH

- ❖ Patients determined to have a medium or high risk pregnancy by risk assessment
- ❖ Patients with following complications in current pregnancy
 - Gestational diabetes
 - Maternal abuse of drugs and alcohol
 - Documented serious malformation
 - HIV
 - Other severe maternal medical co-morbidity
 - Persistent partial placenta previa
 - Breech or other non-vertex presentation at term
 - Previous cesarean section
 - Twin gestation
 - Incompetent cervix

VII. LEVEL III

Family Medicine attending requests formal written consultation with obstetrical attending with complete transfer of care for pregnancy.

- ❖ Isoimmunization
- ❖ Multiple gestation >2
- ❖ Complete placenta previa

VIII. POLICY RESPONSIBILITY

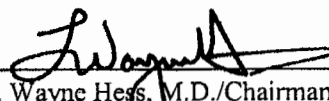
Conflict should be resolved immediately utilizing each department's chain-of-command policy.

Ultimate responsibility rests with the chairperson from Family Medicine and Obstetrics & Gynecology.

IX. REFERENCES

Model of Family Medicine and Obstetrics & Gynecology Collaboration in Obstetric Care at the University of Michigan; Berman, Johnson, Apgar; OB-GYN: 1996 p.308-313, 8/00

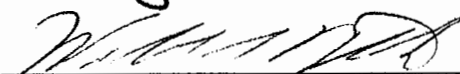
X. APPROVAL



L. Wayne Hens, M.D./Chairman, Department of OBGYN

10-12-05

Date



William Miller, M.D./Chairman, Department of Family Medicine

10/13/05

Date

Addendum B

MODEL OF FAMILY MEDICINE AND OBSTETRICS & GYNECOLOGY COLLABORATION IN OBSTETRICAL CARE AT LVH

X: POLICY RESPONSIBILITY

Conflict should be resolved immediately utilizing each department's chain-of-command policy.

Ultimate responsibility rests with the chairperson from Family Medicine and Obstetrics & Gynecology.

XI. REFERENCES

Model of Family Medicine and Obstetrics & Gynecology Collaboration in Obstetric Care at the University of Michigan; Berman, Johnson, Apgar; OB-GYN: 1996 p. 308-313, 8/00

Section of Occupational Medicine

A. Chief of Section, Occupational Medicine

1. Qualifications

- a. The Section Chief will be a physician who is Board Certified in Preventive Medicine - Occupational Medicine. The Section Chief will have demonstrated leadership and administrative ability made evident by involvement in patient care and related clinical activities, as well as involvement in hospital and community activities.

2. Responsibilities

- a. Insuring the maximal feasible participation by members of the Section in decisions involving the affairs of that Section, as well as the policies and standards of the department
- b. Representing the Section in a fair and equitable manner and assuring participation of the Section in the decision making of the Department of Family Medicine
- c. Attending monthly Executive Committee Meetings of the Department of Family Medicine to discuss and resolve all significant issues affecting the department
- d. Actively encouraging attendance of all members at the monthly meetings for the Department of Family Medicine, Occupational Medicine meetings, or meetings in which the physician's original certification applies
- e. Coordinating and sharing appropriate Occupational Medicine business meetings, which will occur on a quarterly basis or as appropriate to the Section
- f. Recording minutes of all of those meetings
- g. Preparing an annual report for the Section to evaluate and assess the contributions made by the members of the Section as it relates to the Department of Family Medicine. The annual report will include the following elements: Goals and objectives set forth for the coming year for patient care, teaching, and a summary of the accomplishments of the past year.
- h. The annual report will be compiled in early spring and will be reviewed by the Chair of the Department of Family Medicine.
- i. Complying with the responsibilities of appointed Chiefs, as defined in the medical staff by-laws as follows: Participate on a continuous basis in managing the Section through cooperation and coordination with nursing and support services and hospital management of all matters affecting patient care.
- j. Communicate and, as directed, implement within the Section actions taken by the Chair of the Department of Family Medicine, Medical Executive Committee, and the Board of Trustees
- k. Give guidance on overall medical policies of the hospital. Make specific

recommendations and suggestions regarding the Section through the Chair of the Department of Family Medicine to the Medical Executive Committee

- i. Maintain a continuing surveillance of patient care, professional performance of practitioners, and allied health professionals in other specified services in the Section and report regularly to the Chair of this department
- m. Be responsible for the education programs in his/her area:
 1. Must dedicate and adequate portion of his or her professional efforts throughout the year to the Family Medicine Training Program to accomplish the educational goals in their specialty area
 2. Coordinate with the Program Director of the Family Medicine Residency Program concerning the Occupational Medicine educational experience
 3. In-service education
 4. Patient education as may be requested by the Chair of the Department of Family Medicine or required by the Medical Staff
- n. The performance of the Chief in carrying out his/her responsibilities will be evaluated periodically by the Chair of the Department of Family Medicine in consultation with the President of the Medical Staff, the Chief Executive Officer, and the Chief Medical Officer.

3. Organizational Relationship

- a. The Occupational Medicine Chief will be responsible to the Chair of the Department of Family Medicine. The Section Chief will be responsible to his or her Section.

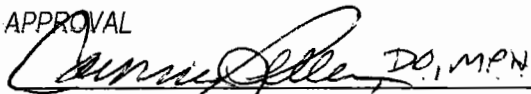
B. Physician Members, Occupational Medicine

1. Physician Active Staff who are members of the Section, Occupational Medicine are responsible for the following minimum requirements:
 - a. Patient care – minimum ten hours per week.
 - b. Meeting attendance – minimum 50% attendance at quarterly Occupational Medical Staff meetings, Family Medicine meetings, Section monthly meetings (those members certified in other specialties may attend department meetings within their original certification, as approved by the Section Chief)
 - c. Ten hours of continuing medical education annually in Occupational Medicine related topics
 - d. Other requirements as required under the active staff included within the Department of Family Medicine Rules and Regulations.
 - e. Other requirements as established by Chief of Section, Occupational Medicine.

Addendum C

- Members of the Section, Occupational Medicine must satisfy all credential requirements as specified in the Medical Staff By-Laws. Members of the Section of Occupational Medicine may be residency trained in Family Medicine, General Internal Medicine, or Emergency Medicine. The Medical Staff Bylaws Board Certification requirements of those specialties for continuous certification apply. Should an individual be Board Certified in Preventive Medicine, continuous certification is required for membership.

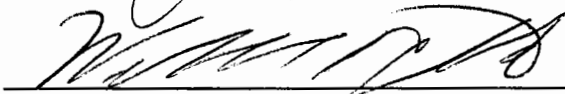
APPROVAL



Carmine Pellosie, DO
Chairman, Section of Occupational Medicine

9/2/06

Date

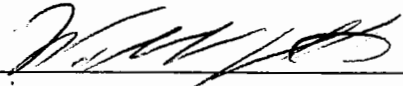


William Miller, M.D.
Chairman, Department of Family Medicine

9/11/06

Date


APPROVALS:



Chair
Department of Family Medicine

9/6/06

Date



Medical Staff President

9/15/06

Date

WLM:dl

- Approved by Medical Executive Committee: 2/1/94
- Amended: 12/6/94
- Amended: 9/5/95
- Amended: 10/96
- Amended: 5/5/98
- Amended: 5/4/99
- Amended: 2/1/00
- Amended: 11/20/01
- Amended: 1/13/03
- Amended: 9/23/03
- Amended: 12/2/03
- Amended: 1/7/04
- Amended: 11/2/04
- Amended: 11/1/05
- Amended: 9/5/06