CHILDREN'S HEALTHCARE OF ATLANTA SURGERY CENTER AT MERIDIAN MARK PLAZA, L.L.C. PROFESSIONAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS

PROFESSIONAL STAFF RULES AND REGULATIONS

SURGERY CENTER

AT MERIDIAN MARK PLAZA, L.L.C.

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ARTICLE 1

DEFINITIONS

The following definitions shall apply to terms used in these Rules and Regulations:

(1) "ADMINISTRATIVE DIRECTOR" means the individual appointed by the Board to act on its' behalf in the overall management of the Surgery Center;

(2) "ALLIED HEALTH PROFESSIONAL" means non-physician practitioners who practice within the Surgery Center;

(3) "APPOINTEE" or "MEMBER" means a physician who has been appointed to the Surgery Center's Professional Staff pursuant to this Policy;

(4) "ATTENDING" means a physician who has been granted Medical Staff appointment by the Board to practice at the Surgery Center and to provide the primary care for a patient;

(5) "BOARD" means the Management Board of Children's Healthcare of Atlanta Surgery Center at Meridian Mark Plaza, LLC, which has the overall responsibility for the conduct of the Surgery Center;

(6) "CHILDREN'S" means Children's Healthcare of Atlanta, Inc.;

(7) "CLINICAL PRIVILEGES" or "PRIVILEGES" means the authorization granted by the Board (or its designee) to an applicant or Professional Staff appointee to render specific patient care services at the Surgery Center within defined limits;

(8) "CREDENTIALS COMMITTEE" means the principal credentialing committee for the Surgery Center;

(9) "DEPARTMENT DIRECTOR" means the individual who is selected to perform the credentialing and peer review functions outlined in the Professional Staff Bylaws for the Surgery Center;

(10) "FELLOW" means a physician in training;

(11) “JOINT COMMISSION” means Joint Commission on Accreditation of Healthcare Organizations;

(12) "LEGAL GUARDIAN" means the parent, legal guardian, or court-appointed designated representative of a minor;

(13) "LOCUM TENENS" means a physician or dentist who would be a temporary substitute covering the practice of a physician or dentist of the same specialty on our Professional

Staff for no longer than thirty (30) days. This is not an individual who is in the process of applying for appointment to the Professional Staff;

(14) "OHCA" means Organized Health Care Arrangement, the arrangement by which the Surgery Center and members of the Surgery Center's Professional staff work together to manage the health care information related to the provision of medical services to patients at the Surgery Center;

(15) "PHYSICIANS" shall be interpreted to include both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s");

(16) "PHYSICIANS-IN-TRAINING" means a member of ACGME-approved residency training programs authorized to provide patient care under the direct supervision of a member of the Professional Staff. This definition includes, but is not limited to, "residents" and "fellows";

(17) "PROFESSIONAL STAFF" means all physicians, dentists and oral surgeons who are granted appointment to the Professional Staff and clinical privileges to treat patients at the Surgery Center;

(18) "RESIDENT" means a physician-in-training;

(19) "SURGERY CENTER" means Children's Healthcare of Atlanta Surgery Center at Meridian Mark Plaza, LLC;

(20) In addition to the Professional Staff Bylaws, there shall be policies, procedures, and rules and regulations that shall be applicable to all members of the Professional Staff and other individuals who have been granted clinical privileges or a scope of practice. All Professional Staff policies, procedures, and rules and regulations shall be considered an integral part of the Professional Staff Bylaws, subject to the amendment and adoption provisions contained in each document.

ARTICLE 2

PATIENT CARE REQUIREMENTS

2.A Admission Procedures

1. Infants and children (from birth to twenty-one years of age) requiring surgery may be cared for within the Surgery Center. Children with special challenges who have reached the age of twenty-one, but who are unable to be cared for in the adult system, may be granted an exception with the permission of the Medical Director, Professional Staff Director, or the Director (or his or her designee).

2. Any Active Staff or Courtesy Staff member of the Professional Staff so privileged may admit patients.

3. All surgical cases scheduled at the Surgery Center are pre-certified by the admitting physician's office with the appropriate third party payor. Authorizations are obtained and communicated to the Surgery Center Admitting Department prior to 3:00 PM two days prior to admission.

4. There is a provisional diagnosis documented by the physician at the time a child is admitted.

5. The attending physician provides the clinical staff with the necessary information to ensure the protection of the patient, other patients, and Surgery Center personnel from infection, disease, self harm or harm to others.

6. Each admitted patient is the responsibility of the attending physician. The attending physician is accountable for:

   - The medical care and treatment of the patient
   - The completeness and accuracy of the medical record
   - Reconciliation of medications at admission, transfer and discharge
   - Communication to the clinical staff, and any and all special instructions for the care of the child
   - Communication to other involved physicians of any data related to the current status of the child
   - Patient and family education as appropriate in collaboration with clinical staff to help involve the patient and family in care and care decisions, improve health outcomes, and promote recovery.

7. A patient is never to be without an attending physician.

8. Planning for continuity of care between the Surgery Center, home, or to another setting is crucial and is initiated as soon as possible after admission. An Interdisciplinary Plan is documented in the medical record as defined in the Surgery Center Policy.

2.B. Patient Transfers

1. As outlined in the transfer Agreement between the Surgery Center and Children's, all patients requiring hospitalization following care received at the Surgery Center will be transferred to Children's.

2. Transfers to the hospital are to be coordinated with the Children's Transfer Center and follow Children's Healthcare of Atlanta policies.

3. The transferring physician documents a note briefly describing the patient's condition at the time of transfer and the reason for the transfer in the medical record, as well as a listing of current and home medications at time of transfer.

4. The transferring physician may remain as the attending physician for the patient at Children's or arrange for another physician to assume responsibility for the patient.

5. The accepting physician assumes the responsibility as attending and is accountable for documenting acceptance of the transfer, future care, communication and documentation responsibilities of an attending physician.

6. Existing orders are required to be rewritten when a child is transferred.

2.C. Discharges

1. Because Children's is a pediatric and adolescent facility, patients under the age of majority, eighteen (18) years, are discharged to the legal guardian. (See Policy on Discharge from the Surgery Center).

2. Discharge Planning is an integral part of the outpatient visit and begins on admission. The plan, documented in the medical record, includes the goals attained prior to discharge, an assessment of the available resources appropriate to meet the needs of the child and family after discharge, and when to obtain additional care or treatment. Goals are prioritized and discharge instructions are provided to the patients and those responsible for their care. Children's provides assistance to the physicians in identifying needed resources and arranging discharge in accordance with protocols outlined in the Utilization Management (UM) plan.

2.D. Management of the Patient

1. Orders:

a) Only Professional Staff members authorized by the Governing Body may order treatment and/or diagnostic testing. When possible, all orders are in writing or online entry. Orders are to be legible, complete, signed, dated and timed by the ordering physician.

b) Verbal orders are acceptable when given by an authorized individual who is detained from writing an order, and telephone orders are acceptable when the authorized individual is remote from the medical record. Verbal and telephone orders are given to an individual authorized by the Surgery Center (Registered Nurse, Pharmacist, or certified/registered individual). The order must relate to the clinical area in which that person is a practitioner.

c) Verbal and telephone orders are read back to the prescribing physician and then documented that the order was 'read back and verified,' signed, and dated by the authorized individual transcribing the orders at the time they are given. Verbal and telephone orders are signed and dated by the physician giving the order within 30 days of discharge.

d) All orders, including "Do Not Resuscitate Orders," are required to be rewritten post-operatively.

e) Requests for diagnostic imaging, pathology or other diagnostic testing which require clinical interpretation contain a statement signifying the reason for the examination and sufficient clinical information to allow for an appropriate evaluation.

2. Medication Orders:

a) Medications administered to patients cared for within the Surgery Center are listed in the latest edition of the United States Pharmacopoeia, the National Formulary, and/or the American Hospital Formulary Service of AMA Drug Evaluations. Unless the FDA has approved a drug, it is not provided to patients.

b) All medication orders clearly state the name of the medication, the dose, the route of administration, the administration times or the time intervals between doses. In addition, orders for PRN medications require an indication, and multiple PRN medication orders require a clear distinction of indication for each medication. If the signature is not legible, the prescriber should include an additional identifier (e.g., the printed name, pager number, physician number, SMS billing code, or Georgia License number).

c) Drugs brought into the Surgery Center by the patient's family are not administered.

d) Medication orders and patient instructions should be reconciled with home and prescribed medications.

3. Consents:

a) It is the right of the legal guardian to be informed regarding care alternatives in order to participate with their physician in the treatment decisions. It is the responsibility of the physician to ensure that this occurs and to document this involvement in the medical record.

b) In order to comply with Georgia Statute and the Surgery Center's policy, an informed consent is obtained from the patient, legal guardian, or designated representative by the Professional Staff member or designee scheduled to perform a procedure. This consent is obtained for any patient who is to undergo a surgical or diagnostic procedure under general anesthesia, spinal anesthesia, or major regional anesthesia, or any sedation requiring consent. Consent is also required prior to receiving a diagnostic procedure that involves intravenous or intradural injection of a contrast material.

c) "Informed consent" is a legal requirement and implies that the physician has personally seen or spoken to the individual granting the consent and explained in general terms the patient's condition, the nature and purpose of the procedure, the likelihood of success, the available alternatives, and the risks that could reasonably be expected if the patient were not to have the procedure. This should be documented in the medical record. (See Children's Informed Consent (to Treatment) # 7.00.)

e) The consent should be signed within thirty (30) days of the operative procedure. If greater than thirty (30) days have passed, a new consent should be obtained or the existing consent should be renewed by dating and re-signing.

4. Infection Control:

No healthcare worker that has direct contact with patients is permitted to wear artificial fingernails. (See Length of Fingernails and Use of Artificial Nails in Clinical Settings, #1.21.)

5. Operative and Invasive Procedures Site Verification:

a) All patients having surgical or invasive procedures that expose them to more than minimal risk require appropriate verification prior to the initiation of the procedure. This includes procedures done in the Operating Room (OR) and non-operative areas such as the special

procedures unit, endoscopy unit, patient bedside, treatment rooms, exam rooms and interventional radiology suites.

b) Site verification consists of three parts:

(1) Pre-operative/pre-procedure verification process

(2) Marking of the operative site

Physicians or allied health professionals who will be scrubbed in and performing the procedures can mark the surgical or procedure site. In addition, a parent or legal guardian may mark the site under the direct supervision of a surgeon, resident or allied health practitioner who will scrub in for the procedure. Nurses or technicians are not allowed to mark the site.

A goal of marking the site is to involve the parent/guardian or patient in confirming the correct site. Therefore, the marking must occur in the presence of the parent, legal guardian or patient.

(3) ”Time Out" process that occurs immediately before starting the procedure.

The purpose of the time out procedure is to conduct a final verification of the correct patient, procedure, site, position, and, as applicable, implants. This requires active communication among all members of the surgical or procedural team. The procedure does not start until any questions or concerns are resolved.

The time out must occur in the location where the procedure will be done (e.g., operating room, special procedures lab), immediately prior to the start of the procedure/operation.

The chief surgeon or physician for each procedure is ultimately responsible that these steps are carried out and that the correct procedure is performed on the correct patient on the correct site.

Documentation reflects that the appropriate verification(s)/ markings/"Time Out" took place. (See Operative and Invasive Procedures site Verification, #2.20.)

6. Restraints:

The use of restraints are authorized by the individual order of the patient's physician. (See Medical Restraints, #1.20 and Behavioral Restraints, #1.15)

7. Death:

a) With the death of a patient, he or she is to be pronounced by the attending physician or designee within a reasonable time.

b) Lifelink is notified for all deaths or impending deaths and is the primary contact with the legal guardian for organ donations.

c) The body remains at the Surgery Center until consent for disposition is obtained from the legal guardian and an entry is made and signed in the medical record of the deceased by a member of the Professional Staff.

d) The Medical Examiner's office is notified of every patient death. See Children's policy # 8.00 Death of a Patient.

e) The attending physician makes every reasonable effort to secure an autopsy where such an exam could provide helpful information related to the cause of death. The hospital pathologist or a physician delegated that responsibility performs autopsies. (See CHOA Policy 13.04, Autopsy Criteria)

8. Consultations:

a) In an emergency situation, a consultation may be requested by the attending physician or anesthesiologist. Consultants should be a member of the Children's Healthcare of Atlanta Professional Staff. The consultation is directly requested between the physicians when possible and documented in writing in the medical record. If the physician is unable to contact the consultant directly, he or she should document the reason for the consultation in the order.

ARTICLE 3

HEALTH INFORMATION

3.A. General Rules

1. The Surgery Center and members of the Surgery Center Professional Staff, (physicians and other health care providers) work together in an Organized Health Care Arrangement to provide medical services to patients at the Surgery Center. This means that the Surgery Center and the members of its Professional Staff will share with each other health care information that they collect at the Surgery Center as necessary to carry out their treatment, payment, and healthcare operations relating to the provision of care to patients at the Surgery Center. This further means that all such information collected at the Surgery Center will be managed in accordance with Children's Privacy Notice. Therefore, each member of the Professional Staff:

    a) must manage information gathered as part of a patient's encounter at the Surgery Center in accordance with the Children's Privacy notice, and in addition;

    b) may also provide the patient/family in advance of any treatment (emergency situations excepted) with a copy of the Privacy Notice that governs his/her office practice (as required by law).

2. Every child or adolescent who has surgery at the Surgery Center has a medical record. It is the responsibility of the attending physician to prepare a complete and legible record for each patient in accordance with the format established by the Surgery Center, the laws of the State of Georgia, and JCAHO standards. The medical record contains sufficient information to: a) identify the patient, b) support the diagnosis, c) justify the treatment, d) document the course and results, and e) facilitate continuity of care.

3. Significant clinical information is to be entered in the record as soon as possible after it has occurred.

4. Unapproved abbreviations, signs and symbols should not be used in the medical record. Those with multiple meanings should not be used without clarification of definition.

5. A single attending physician is identified as responsible for the patient at any given time.

6. The minimum medical record requirements are:

    a) Identification data, including the patient's name, address, age, date of birth, and legal representative,

    b) Date and time of admission and discharge,

c) vital signs,

d) A medical history and physical including:

1. The chief complaint

2. Details of previous illnesses, including, when appropriate, assessment of the patient's emotional, behavioral, and social status

3. Relevant past medical history, including social and family histories appropriate to the age of the patient

4. An inventory by body systems

5. Drug sensitivities/allergic history

6. A provisional admitting diagnosis

7. A physical examination, including but not limited to head, chest, abdomen and extremities, or a note as to the contra-indications for such an examination or valid reasons for why the examination was not performed

8. A statement of the conclusions or impressions drawn from the admission history and physical examination

9. The goals of treatment and the treatment plan

e) Evidence of known advance directives,

f) Diagnostic and therapeutic orders,

g) Evidence of informed consent and the family's involvement and their expectations regarding outcome,

h) Clinical observations, including the results of therapy (e.g. complications, hospital acquired infections and unfavorable reactions to drugs and anesthesia),

i) Reports of procedures, tests, and their results,

j) Conclusions at termination of hospitalization, evaluation or treatment (Discharge Summary – final diagnosis),

k) Condition of the patient upon discharge and instructions given to the patient and family, and

l) Signature and date for each entry.

7. In addition to the above minimum requirements, if moderate or deep anesthesia is used, the following documentation is present in the record:

a) A pre-sedation or pre-anesthesia assessment completed within forty-eight hours (48) of the surgery or procedure,

b) Reevaluation immediately before moderate or deep sedation and before anesthesia induction, and

c) For patients receiving anesthesia. post-anesthesia follow-up completed within forty-eight (48) hours of the procedure, which includes level of consciousness, follow-up care and complications.

3.B. Admission History and Physical

The history and physical may be completed within the prior thirty (30) days, but must be updated, signed and dated within twenty-four (24) hours prior to surgery. The update should include relevant changes or document "No changes."

The history and physical exam will be authenticated by a member of the Professional Staff, and documented with the appropriate level of detail for the patient's stay and complexity.

3.C. Operative Reports

1. An operative progress notes is written immediately after the surgery to provide pertinent information for clinicians and physicians caring for the child during the transcription delay. The note should include at minimum a high level account of: name of primary surgeon and assistants, findings, technical procedures used, specimens removed, postoperative diagnosis, complications and estimated blood loss.

2. Operative Reports are dictated or written in the medical record immediately after surgery. Transcribed reports are signed by the physician and dated within thirty (30) days of discharge.

3. Operative Reports include:

a) Pre-operative diagnosis

b) Post-operative diagnosis

c) Name of the primary surgeon and all assistants

d) Technical procedures used, including description of surgery and findings

e) Specimens removed

f) Complications encountered

g) Estimated blood loss.

3.D. Discharge Summary

1. All patients have a discharge summary at the end of their stay. The discharge summary will document the reason for admission, significant findings, discharge diagnosis, procedures performed and treatment rendered, the patient's response to the treatment, the condition at discharge and any instructions provided to the child or family of the child. Summaries are signed by the physician and dated within thirty (30) days of discharge.

2. A handwritten short stay form may be substituted for the discharge summary.

3. The discharge summary may be handwritten or dictated, and is authenticated by a member of the Professional Staff. Handwritten discharge summaries require that all fields be addressed and documented to the appropriate level of detail for the patient's stay and complexity.

3.E. Countersignatures

1. In a teaching setting, the attending physician is responsible for appropriate oversight of the care provided by the physician-in-training including orders implementing the physician's plan of care.

2. All patient orders, including voice and telephone orders, must be signed by the physician giving the order within 30 days of discharge.

3. Since the purpose of authentication of orders is to verify that they are correct and appropriate for the patient, the intent is met when a covering or group practice physician signs the order of another physician signifying that he/she concurs with the orders.

3.F. Timeliness of Documentation

The medical record is not filed until it is completed, except on the order of the Board. A medical record is completed as soon as possible after discharge but does not exceed thirty days (30) post discharge. Completion means dictation and signature including any required discharge summary or final progress notes.

3.G. Automatic Relinquishment of Privileges

1. The failure of a Professional Staff member to appropriately complete medical records in accordance with the applicable Children's Regulations and Policies shall result in automatic relinquishment of privileges and fines as described in the Surgery Center Bylaws.

2. Attempts to circumvent the automatic relinquishment process through reclassification of patient acuity, or admitting through a partner or associate, shall constitute an egregious issue and immediate referral to the Peer Review Committee.

3.H. Authentication

1. All clinical entries in the patient's medical record are legible, dated and authenticated, (Signature and Title).

2. Signature stamps are not permitted at Children's Healthcare of Atlanta.

3. Electronic signatures will only be honored when used with Children's software. Electronic signatures from physician office software will require a handwritten signature, as well.

4. Transcribed documents should be authenticated with an electronic signature when available in an electronic format (Chartmaxx, Epic) unless edited with an extensive handwritten entry prior to discharge. In addition, if a paper document is scanned, additional signature deficiencies should also be completed electronically unless there is a special circumstance. Redundant paper documentation will be destroyed post-discharge unless there is an extensive addendum warranting the paper revision.

3.I. Possession, Access and Release of Medical Record Information

1. Original medical records, including diagnostic imaging and other machine generated diagnostic reports (EEG, EKG, etc.) are the property of the Surgery Center and Children's and may only be removed from the Surgery Center's jurisdiction and safekeeping in accordance with a court order, subpoena, or appropriate legal authority. When presented with such an order, Health Information Services (HIS) responds and the Children's Legal Department is notified if additional advice is required.

2. If a patient is readmitted to the System, previous records are made available for the use of the attending physician electronically. This applies whether the child is attended by the same Professional Staff member or by another. The entire hard copy of the medical record is made available when requested. Unauthorized removal of the hard copy of the medical record from the Health Information Services department is reportable to the Surgery Center Board for corrective action.

3. The patient (who is not a minor) or legal guardian has the right to reasonable access and review of his/her medical record. The medical record information may be released to the patient (if not a minor), or legal guardian with a written consent. When this occurs, the attending physician is notified prior to release. If the request is to review the record, the attending physician, Health Information Manager or a designee will be identified to review the record with the patient or guardian.

4. If the attending physician, in concurrence with the Medical Director, determines that the release of such information could be detrimental to the physical, mental or emotional health of the patient, parent or legal guardian, to the extent permitted by law, the information is not released without a court order. In these circumstances, Children's will release the information to another healthcare professional upon written request of the legal guardian. When this occurs, the medical record documents and supports such action.

3.J. Medical Record Studies

1. No paper patient record is removed from the Health Information Services department or other locations within Children's where records are housed except for purposes of medical care and treatment of the patient, quality evaluation and professional review activities, teaching conferences, and/or as needed by the Chief Executive Officer or a designee, for risk or legal issues.

2. Access to the medical record information is afforded to Professional Staff members in good standing (their residents and/or fellows) for bona fide study and research (See Children's Policy Number 1.16, IRB Standard Operating Procedure). Patient identifiers are not released except in accordance with HIPAA and IRB policies. When charts are available electronically where IRB applies, IRB approval is required prior to extracting data.

3. In accordance with the parameters listed in O.C.G.A. 31-7-6, research groups, government health agencies, medical associations or societies conducting non-quality assessment related activities approved jointly by Children's and the Professional Staff may access patient information related to the defined conditions and/or treatments.

ARTICLE 4

ALLIED HEALTH PROFESSIONALS

4.A. General

1. Allied Health Professionals are Dependent Practitioners. Dependent Practitioners include:

    - Certified Registered Nurse Anesthetists (CRNA)
    - Nurse Practitioner (NP)
    - Physician Assistant (PA)
    - Surgical Assistant (SA)
    - Audiologist

2. Dependent Practitioners are granted permission to perform within their scope of practice and/or participation only as employees or under the direct supervision of a member(s) of the Professional Staff.

4.B. Responsibilities of the Allied Health Professional

1. Maintain responsibility, within the scope of current professional competence, for the care and supervision of assigned patients.

2. Provide the patients with care at the generally recognized professional level of quality and efficiency established for the Surgery Center.

3. Write orders for treatment under the direction of or to implement the plan of treatment of the Professional Staff members responsible for the child's care. All orders by a Dependent Practitioner are co-signed by the attending physician.

4. Abide by the policies and procedures of the Surgery Center and the Rules and Regulations of the Professional Staff.

5. Abide by the ethical principles of his/her profession.

6. Participate in the quality management/improvement activities of the Surgery Center.

4.C. Responsibilities of the Supervising Physician

1. Evaluation of each patient with supporting documentation in the medical record.

2. Provision of appropriate oversight of the care provided by the Dependent Practitioner. The Supervising Physician, or their designee, will remain available at all times by telephone or pager for immediate consultation to the practitioners who provide services as a Licensed Independent Practitioner or Advanced Practice Professional.

3. Co-signing of all documentation completed by the Dependent Practitioner.

4. Ensuring the Dependent Practitioner practices within their defined scope of privileges.

5. Immediately addressing any concerns raised related to the services provided by the Dependent Practitioner.

ARTICLE 5

PHYSICIANS IN TRAINING

5.A. General

Physicians in training, (residents and fellows) are members of an ACGME accredited residency-training program and are not members of the Children's Professional Staff. Physicians in training are authorized to provide patient care only under the direct supervision of a Professional Staff member authorized by the Board to exercise clinical privileges within the Surgery Center.

5.B. Responsibilities of the Physician in Training

1. Maintain responsibility, within the scope of current professional competence and job description.

2. Provide the patients with care at the generally recognized professional level of quality and efficiency established for the Surgery Center.

3. Write orders for treatment under the direction of or to implement the plan of treatment of the Professional Staff members responsible for the child's care.

4. Abide by the policies and procedures of the Surgery Center and the Rules and Regulations of the Professional Staff.

5. Abide by the ethical principles of his/her profession.

6. Participate in the quality management/improvement activities of the Surgery Center.

5.C. Responsibilities of the Attending/Supervising Physician

1. Evaluating each patient and documenting in the medical record sufficiently to demonstrate that the physician personally reviewed the history, gave a physical examination, and confirmed or revised the diagnosis and prescribed treatment. The attending physician must be recognized by the recipient as the recipient's personal physician.

2. Provision of appropriate oversight of the care provided by the physician in training. Oversight must be sufficiently documented in the medical record.

3. The following documents in the medical record must be signed by the attending or supervising physician:

- Short stay summary
- History and physical
- Consult note
- Operative notes
- Discharge summary
- Any documentation left unsigned by the physician in training.

ARTICLE 6

AMENDMENTS

Particular rules and regulations may be adopted, amended, repealed or added by vote of the Clinical Operations Committee at any regular or special meeting. All such changes shall become effective only when approved by the Board.

ARTICLE 7

ADOPTION

These Professional Staff Rules and Regulations are adopted and made effective upon approval of the Board, superseding and replacing any and all Professional Staff rules and regulations or Children's policies pertaining to the subject matter thereof. Henceforth, all activities and action of the Professional Staff and of each individual exercising clinical privileges at the Surgery Center are taken under and pursuant to the requirements of these Rules and Regulations.

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Director, Surgery Center Professional Staff

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Director, Surgery Center

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Chairman, Management Board