UNIVERSITY OF CALIFORNIA
SAN FRANCISCO HEALTH MEDICAL STAFF

MEDICAL STAFF BYLAWS

Approved on 07/28/2026 by the Medical Staff
Approved on 07/30/2026 by Governance Advisory Council

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PREAMBLE

In recognition of their responsibilities for overseeing, on behalf of the Governance Advisory Council, the quality of patient care, treatment, and services provided at UCSF Medical Center (the "Medical Center"), the physicians, oral and maxillofacial surgeons, clinical psychologists, podiatrists, dentists, and other eligible health care professionals at UCSF Medical Center, hereby organize themselves as the Medical Staff of UCSF Medical Center (the "Medical Staff"). This organization shall be self-governing in conformity with federal and state regulatory requirements, The Joint Commission accreditation standards, and the guiding principles set forth in these Bylaws, as well as the Medical Staff Plans, Rules, Regulations and Policies, and is subject to the ultimate authority of The Regents of the University of California. The Regents have delegated authority for the governance of the Medical Center to the Chancellor of the University of California, San Francisco, who shall govern all activities of the Medical Center consistent with Medical Center and University policies and procedures and actions of The Regents.

These Bylaws address the Medical Staff's rights and responsibilities with respect to self-governance. In particular, these Bylaws address the Medical Staff's responsibilities to establish criteria and standards for Medical Staff membership and privileges, and to enforce those criteria and standards; they establish clinical criteria and standards to oversee and manage patient care, patient safety, performance improvement and resource utilization, and other Medical Staff activities. They provide for periodic meetings of the Medical Staff, its committees, departments, and clinical services, and they describe the means by which the Medical Staff shall participate in the development of Medical Center policy. With respect to all the foregoing, the Medical Staff is accountable to the Chancellor, as The Regents' designated Governance Advisory Council, for complying with and effectively performing the responsibilities set forth in these Medical Staff Bylaws.

Finally, notwithstanding the provisions of these Bylaws, the Medical Staff acknowledges that the Governance Advisory Council must act to protect the quality of medical care provided and the competency of the Medical Staff. In adopting these Bylaws, the Medical Staff commits to exercise its responsibilities with diligence and good faith; and in approving these Bylaws, the Governance Advisory Council commits to allowing the Medical Staff reasonable independence in conducting the affairs of the Medical Staff. Accordingly, the Governance Advisory Council will not assume a duty or responsibility of the Medical Staff precipitously, unreasonably, or in bad faith; and will do so only in the reasonable and good faith belief that the Medical Staff has failed to fulfill a substantive duty or responsibility in matters pertaining to the quality of patient care.

DEFINITIONS

The definitions set forth below apply to these Bylaws and all Governing Documents, including all Medical Staff Plans, Rules, Regulations, Policies and Procedures, unless otherwise stated.

1. ADVANCED PRACTICE PROVIDER ("APP") means an individual nationally board-certified as a midwife, nurse anesthetist, nurse practitioner, or physician assistant who is currently credentialed and privileged at UCSF Health and licensed to practice in California. APPs provide direct patient care services at UCSF Health based on their individually granted privileges; some APPs require standardized procedures/practice agreements and/or supervision by a Medical Staff Member who has been granted clinical privileges.

2. ALLIED HEALTH PROFESSIONAL ("AHP") means a health care provider who is qualified to provide clinical services to patients within their defined professional scope of practice and privileges approved by the Committee on Interdisciplinary Practice, Executive Medical Board, and Governance Advisory Council. AHPs are involved in the delivery of health or related services pertaining to the identification, evaluation, and prevention of diseases and disorders; dietary and nutrition services; rehabilitation; and others. AHPs include, but are not limited to, acupuncturists, genetic counselors, marriage and family therapists, optometrists, orthoptists, pharmacists, registered nurse first assistants, and social workers.

3. CHANCELLOR means the Chancellor of the University of California, San Francisco ("UCSF").

4. CHIEF EXECUTIVE OFFICER ("CEO") means the person appointed by the Governance Advisory Council to serve as Chief Executive Officer of UCSF Medical Center or designee.

5. CHIEF MEDICAL OFFICER ("CMO") refers to the System Chief Medical Officer (unless stated otherwise) who is appointed by the Chief Clinical Officer and subject to approval of the CEO and the Chancellor to serve as a liaison between the Medical Staff and the Medical Center.

6. CHIEF OF SERVICE or SERVICE CHIEF means the applicable Chair of the Department of the UCSF School of Medicine or one or more designee(s) of the Chair, responsible for safe and competent clinical care provided to patients evaluated or treated under that Service.

7. CLINICAL DEPARTMENT means a clinical department at the Medical Center that corresponds to an academic department in the University.

8. CLINICALLY INDICATED means health care services are clinically indicated in either of the following circumstances: (1) a health care provider, exercising prudent clinical judgment, would provide them to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, condition, or its symptoms; (2) as performed, they meet the applicable Standard of Care (as defined below); (3) as performed, they are appropriate, in terms of type, frequency, extent, site, and duration; and (4) as

performed, they are considered potentially effective for the patient's illness, injury, disease, condition, or symptoms.

COMPLETE APPLICATION means an application for either initial appointment or reappointment to the Medical Staff, or an application for clinical privileges, that has been determined by the applicable Department Chair or designee, the Credentials Committee, the Executive Medical Board and/or the Governance Advisory Council to meet the requirements of these Bylaws and related policies and procedures. Specifically, to be complete the application must be submitted timely and in the form approved by the Executive Medical Board and Governance Advisory Council, and include all required supporting documentation and verifications of information, and any additional information requested from the applicant for the required review of qualifications and competence of the applicant.

9. CREDENTIALING means the process of obtaining, verifying and assessing the qualification of a Practitioner to provide patient care or services within the Practitioner's training, license and experience.

10. CREDENTIALS means documented evidence of licensure, education, training, experience, board certification or other qualifications.

11. DATE OF RECEIPT means, unless otherwise stated, the date any Notice or other communication was delivered personally or electronically; or if such Notice or communication was sent by regular US mail, it shall mean seventy-two (72) hours after the Notice or communication was deposited, postage prepaid, in the US mail.

12. DAYS means, unless otherwise stated, calendar days.

13. DEPARTMENT CHAIR or CHAIR OF DEPARTMENT corresponds with the School of Medicine Department Chair. Each School of Medicine Department Chair may serve as a Chief of Clinical Service or may appoint one or more Chief(s) of Clinical Service to carry out their roles and responsibilities as defined in these Bylaws.

14. ELECTRONIC/DIGITAL COMMUNICATION means the use of a secure UCSF electronic mail platform as the sole acceptable means of electronic/digital communication under these Bylaws.

15. EX OFFICIO means service by virtue of office or position held. An ex officio appointment is without a vote unless specified otherwise.

16. EXECUTIVE MEDICAL BOARD means the Executive Committee of the Medical Staff.

17. FAIR HEARING PLAN means the Investigation, Corrective Action and Fair Hearing Plan of the Medical Staff.

18. GOOD STANDING means that, at the time of the assessment of standing, the Medical Staff membership and/or clinical privileges of the Medical Staff Member, Advanced

Practice Provider, or Allied Health Professional are not involuntarily limited, restricted, suspended, or otherwise encumbered for medical disciplinary cause or reason.

19. GOVERNANCE ADVISORY COUNCIL means the group, as chaired by the Chancellor, that facilitates the governance of the UCSF Medical Staff and oversees the quality of patient care, treatment and services provided at the Medical Center.

    GOVERNING DOCUMENTS means the documents that create a system of rights, responsibilities, and accountability between the Medical Staff and the Governing Body, and between the Medical Staff and its members. The Governing Documents of the UCSF Health Medical Staff include the Medical Staff Bylaws, Credentialing and Performance Plan, Organizational Plan, Fair Hearing Plan, Rules and Regulations, and Policies and Procedures.

20. INTERVIEW means, in the context of an investigation by the Executive Medical Board or a committee of the Medical Staff or its designee, the discussion with a Member or others regarding the subject(s) of the investigation. Such discussion does not constitute a formal hearing and no formal hearing rights apply. There is no right to legal representation during an interview.

21. LANGLEY PORTER PSYCHIATRIC HOSPITAL (LPPH) means the acute psychiatric hospital owned and operated by the University of California Board of Regents.

22. LPPH PRESIDENT means the person appointed to serve as President of LPPH, or designee, and is the Chair of the UCSF Department of Psychiatry and Behavioral Sciences.

23. MEDICAL CENTER means UCSF Medical Centers located at the Parnassus, Mt. Zion, and Mission Bay campuses, UCSF Orthopedic Institute, the Langley Porter Psychiatric Hospital, the Peninsula Outpatient Center, and for the purposes of these Bylaws, includes associated clinics.

24. MEDICAL STAFF means the organizational component of the Medical Center as defined above that includes all physicians (M.D. or D.O. or accepted equivalent), oral and maxillofacial surgeons, clinical psychologists, podiatrists, and dentists who have been granted recognition as Members pursuant to these Bylaws. The term Medical Staff shall also be deemed to refer to the "organized medical staff," as that terminology may be used in various laws and regulations, and in any applicable standards of The Joint Commission.

25. MEDICAL STAFF YEAR means the period from July 1 through June 30.

26. MEMBER means any physician (M.D. or D.O. or accepted equivalent), oral and maxillofacial surgeon, clinical psychologist, podiatrist, or dentist who has been appointed to the Medical Staff.

27. NOTICE, unless otherwise specified, means a written communication delivered personally to the addressee or a communication delivered electronically on an approved secure platform or sent by United States mail, first-class postage prepaid, addressed to the

addressee at the last physical address/email address as it appears in the official records of the Medical Staff or the Medical Center.

28. PHYSICIAN means an individual with a M.D. or D.O. or accepted equivalent degree who is currently licensed to practice medicine in California.

29. POLICIES refer to the Medical Staff Policies adopted in accordance with these Bylaws, unless otherwise specified.

30. PRACTITIONER means, unless otherwise expressly limited, any currently licensed or registered or permitted physician (M.D., D.O. or accepted equivalent), oral and maxillofacial surgeon, clinical psychologist, podiatrist, or dentist.

31. PRESIDENT means the person who has been elected by the Medical Staff to act on its behalf.

32. PRESIDENT-ELECT means the person who will become the President after the President's term concludes and who has been elected by the Medical Staff.

33. PRIVILEGES means the permission granted to Medical Staff Members, Advanced Practice Providers, or Allied Health Professionals to render specific patient services.

34. PLANS, POLICIES, RULES AND REGULATIONS refers to the Medical Staff Plans, Policies, Rules and Regulations adopted in accordance with these Bylaws, unless otherwise specified.

35. RESIDENTS/ACGME-APPROVED FELLOWS means post-medical school graduates who are pursuing an accredited course of study (e.g., ACGME-approved programs) at UCSF under the supervision of the Medical Staff.

36. SCHOOL OF MEDICINE means UCSF School of Medicine.

37. SERVICE CHIEF or CHIEF OF CLINICAL SERVICE means the Member of the Active Staff who is responsible for the clinical work of the Service.

38. SEXUAL MISCONDUCT refers collectively to the commission of any act of sexual abuse or misconduct with a patient, client, hospital staff, Medical Staff Member, trainee, or student, or any other unprofessional contact or communication of a sexual nature. In the case of any doubt, please refer to the UC Health Policy on Sexual Harassment and Sexual Violence.

39. SPECIAL NOTICE means the transmission of information that is deemed conveyed when sent by overnight delivery and/or USPS Priority mail with delivery receipt, or when personally delivered.

40. STANDARD OF CARE means the reasonable degree of skill, knowledge, and care, based on credible scientific evidence published in current peer-reviewed medical literature, and ordinarily possessed and exercised by members of a person's profession and specialty

under similar circumstances. The Standard of Care encompasses whether and under what circumstances a procedure is performed and the manner in which it is performed.

41. STANDARDIZED PROCEDURES means the scope of services approved by the Committee on Interdisciplinary Practice and Executive Medical Board granted to some Advanced Practice Providers or Allied Health Professionals to render specific patient care.

42. SYSTEM MEMBERS means those entities or individuals who are part of or affiliated with UCSF Health.

43. THE REGENTS means The Regents of the University of California pursuant to Article IX, Section 9 of the California Constitution.

44. UCSF HEALTH and the term MEDICAL CENTER mean, for the purposes of these Medical Staff Bylaws and Plans, the definition as stated herein. In the event a Medical Staff Member holds membership or privileges at more than one UCSF location, the controlling Medical Staff Bylaws and/or governance documents of the location at which the subject event(s) occurred will apply.

ARTICLE 1. NAME AND DESCRIPTION OF MEDICAL STAFF ORGANIZATION

1.1 Name

The name of this organization shall be the Medical Staff of UCSF Medical Center and is hereinafter referred to as the Medical Staff.

1.2 Relationship Between Medical Staff, Medical Center and UCSF School of Medicine.

a. These Bylaws describe the roles, rights, and responsibilities of the Medical Staff and its Members, in their capacity delivering and overseeing care, treatment, and services to patients. The Organizational Plan of the Medical Staff further defines the structure, roles, responsibilities, and processes of the Medical Staff, including the Executive Medical Board and the committees of the Medical Staff.

b. The Medical Center operates as a teaching hospital to support the educational activities for UCSF training programs. Members of the Medical Staff have clinical roles and responsibilities subject to the Bylaws, Plans, Rules, Regulations, and Policies of the UCSF Health Medical Staff and may concurrently participate in teaching, administrative and/or approved research activities under the auspices of the UCSF School of Medicine.

c. These Bylaws relate solely to responsibilities of Medical Staff Members in their capacity as clinicians delivering and overseeing the delivery of patient care. As such, all activities conducted on behalf of the Medical Staff shall have, as their overriding purpose, the delivery of safe, effective, and high-quality patient care.

d. To accomplish these purposes, each Member is assigned to a medical staff category. The rights, responsibilities, and prerogatives of each staff category are described in these Bylaws and in the Credentialing Plan.

e. Each Clinical Department is subject to oversight by a Department Chair. Each Clinical Department has at least one Chief of Clinical Service, who may be the Chair. The Chief of Clinical Service has the responsibilities enumerated herein and in the Organizational Plan.

f. Medical Staff committees oversee activities of the Clinical Departments and Clinical Services, such as, but not limited to credentialing and peer review, oversight of quality, safety and appropriateness of care, treatment, and services. Additionally, these committees participate on behalf of the Medical Staff in the formulation and/or review of Medical Staff Bylaws and Policies and Medical Center policies, within the purview of the respective committees' responsibilities.

g. The Executive Medical Board, which is comprised of elected and appointed officials of the Medical Staff and the Medical Center, oversees the quality of patient care, treatment and services through Medical Staff committees and Clinical Department activities. All Medical Staff committees and Clinical Departments report to the Executive Medical Board.

h. The Chief Medical Officer serves as a liaison between the Medical Center and the Medical Staff.

i. The Executive Medical Board reports to the Governance Advisory Council, chaired by the Chancellor.

ARTICLE 2. PREROGATIVES AND PURPOSES

2.1 Prerogatives and Purposes of the Medical Staff Organization

The prerogatives and purposes of the Medical Staff Organization shall be:

a. To provide a system for Medical Staff self-governance and accountability to the Governance Advisory Council for patient care, whereby patients treated at the Medical Center or its affiliated locations shall receive the level of care consistent with the generally recognized standards of the profession.

b. To ensure that all patients of the Medical Center receive care and consideration and to ensure that care, treatment, and services are not affected on the basis of race, color, national origin, religion, gender, physical or mental disability, medical condition, ancestry, marital status, age, sexual orientation, gender identity, citizenship, status as a covered veteran or by source of payment, subject to state and federal laws and regulations. Nothing in the foregoing is intended to limit the responsibility of Members of the Medical Staff to assess the appropriateness of treatment considering the patient's total circumstances.

c. To initiate and maintain Bylaws, Plans, Rules, Regulations, and Policies for self-governance.

d. To account to the Governance Advisory Council for the quality of patient care and professional conduct of all Members authorized to practice in the Medical Center through the following measures:

   i. Review and evaluation of the quality of patient care provided through valid and reliable patient care evaluation procedures;

   ii. Implement mechanisms that allow ongoing monitoring of professional conduct and patient care practices;

   iii. Employ mechanisms of appointment, reappointment, and the matching of clinical privileges to be exercised or specified services to be performed with the verified credentials and current demonstrated performance of the Medical Staff applicant or Member;

   iv. Enable continuing education based at least in part on needs demonstrated through the medical care evaluation program; and

   v. Conduct utilization review to provide for the appropriate use of all medical services.

e. Recommend to the Governance Advisory Council actions with respect to appointments, reappointments, staff category, department assignments, clinical privileges and corrective actions.

f. Establish and enforce, subject to the Governance Advisory Council approval, professional standards related to professional conduct and the delivery of health care within the Medical Center.

g. Initiate and pursue corrective action with respect to Medical Staff Members when warranted.

h. Establish and amend from time to time as needed Medical Staff Bylaws, Plans, Rules, Regulations, and Policies for the effective performance of Medical Staff responsibilities, as further described in these Bylaws.

i. Select and remove Medical Staff Officers.

j. Recommend assessment of Medical Staff dues and utilize these dues to support Medical Staff functions.

k. Ensure that all Medical Staff Members demonstrate quality in their performance of professional duties through the appropriate delineation of clinical privileges that they may exercise in the Medical Center.

l. Work collaboratively with Medical Center administrative leadership in ensuring that the Medical Center is fiscally sound.

m. Foster education and research programs of the University of California in an integrated manner with the clinical programs of the Medical Center.

n. Facilitate professional education and community health education and support services.

o. Foster cooperation with other community health facilities and/or educational institutions or efforts.

p. Ensure that the Medical Staff and its Members exercise their rights and responsibilities in a manner that does not jeopardize the Medical Center's license, Medicare and Medi-Cal provider status, accreditations, or mission as an academic medical center.

q. Approve Medical Staff Bylaws, Plans, Rules, Regulations, and Policies, and seek approval of the Governance Advisory Council as required.

ARTICLE 3. MEDICAL STAFF MEMBERSHIP AND CLINICAL PRIVILEGES

3.1 Medical Staff Membership

Each Member of the Medical Staff shall be assigned to a Medical Staff category based upon the qualifications outlined below. The Members of each category shall have the prerogatives and shall carry out the duties defined in these Bylaws. Action may be initiated to change a Medical Staff category or to terminate the membership of any Member who fails to meet the qualifications or fulfill the duties described herein. There are no grounds for the hearing rights set forth in the Fair Hearing Plan when changing a category or reassigning a category due to the Medical Center or Department need that is unrelated to a medical disciplinary cause or reason as defined in California Business and Professions Code Section 805.

3.2 Eligibility and Qualifications for Medical Staff Membership

Eligibility and qualifications for Medical Staff Membership are addressed in Article 14 of the Credentialing and Performance Plan.

3.3 Categories of Medical Staff Membership

a. Attending Staff

Definition: Physicians, oral and maxillofacial surgeons, podiatrists, clinical psychologists, and dentists who are involved in patient care and/or in the supervision of students or residents/ACMGE-approved fellows in their involvement with patient care or contact must be Members of the Attending Staff. Members of the Attending Staff who have not been involved in patient care at the Medical Center or who have not been involved in the clinical supervision of students or residents/ACMGE-approved fellows at the Medical Center for a period of two (2) years shall automatically be transferred to Courtesy Status and/or be subject to a period of Focused Professional Practice Evaluation in order to maintain membership and privileges.

Prerogatives and Responsibilities: Members of the Attending Staff are eligible to vote and hold office and are expected to participate in the activities of the Medical Staff through membership on its committees and attendance at its meetings.

b. Affiliate Staff

Definition: Affiliate Staff shall consist of those physicians who were formerly on the Medical Staff at UCSF/Mount Zion Medical Center prior to December 31, 1999, and who have continuously maintained membership and privileges in active and good standing, and who have not completed full training in their specialty and/or do not meet board certification or eligibility for board examination, but who, nonetheless, appear likely to provide a distinct benefit to the Medical Center, the Medical Staff, and patients. Members of the Affiliate Staff who have not been involved in patient care at the Medical Center for a period of two (2) years shall

automatically be subject to a period of Focused Professional Practice Evaluation in order to maintain membership and privileges. The Affiliate Staff category shall expire automatically upon the cessation of clinical privileges of the last Affiliate Staff Member who qualifies under this Section.

Prerogatives and Responsibilities: Affiliate Staff Members may advise UCSF attending physician(s), may assist in surgery and write progress notes, and, depending on their training and experience, may admit patients and may supervise trainees. Members of the Affiliate Staff are not eligible to vote or to hold office except as otherwise provided in these Bylaws or the Organizational Plan, but they are expected to participate in continuing education activities and in the activities of the Medical Staff through membership on committees and attendance at its meetings.

c. Courtesy Staff

Definition: Physicians, oral and maxillofacial surgeons, podiatrists, clinical psychologists, and dentists who admit patients of a minimal acceptable number as determined by the Executive Medical Board at the Medical Center, may apply for appointment to the Courtesy Staff. Members of the Courtesy Staff who have not been involved in patient care at the Medical Center and/or who have not been involved in the clinical supervision of students or residents/ACMGE-approved fellows for a period of two (2) years shall be subject to a period of Focused Professional Practice Evaluation in order to maintain membership and privileges.

Prerogatives and Responsibilities: Such Members may not vote or hold office and are not required to participate in Medical Staff committees (however, at the discretion of the Department Chair, and with the concurrence of the Member, a Courtesy Staff Member may be appointed to serve on sub-committees with or without vote, as specified by the President of the Medical Staff at the time of appointment.)

d. Clinical Partner

Definition: Physicians, oral and maxillofacial surgeons, podiatrists, clinical psychologists, and dentists who are non-employed by the University and/or non-faculty Members of the University but affiliated and contracted Members of the clinically-integrated physician network. Members of the Clinical Partner category are credentialed Members of the UCSF Health Medical Staff but not required to request and maintain clinical privileges to practice at the Medical Center and its licensed clinics.

Prerogatives and Responsibilities: Clinical Partner Members may not admit patients to the Medical Center. Clinical Partners are not required to supervise trainees. Members of the Clinical Partner category are not eligible to vote or to hold office except as otherwise provided in these Bylaws but they are encouraged to participate in continuing education activities, case conferences, peer review, and in

activities of the Medical Staff through membership on committees and attendance in its meetings. Members of the Clinical Partners category are required to report periodic quality and performance data to necessary stakeholders at UCSF Health.

e. Teaching Only Staff

Definition: The Teaching Only Staff consists of those UCSF School of Medicine and School of Dentistry faculty members who volunteer their clinical input and knowledge only for teaching in the Medical Center or any Medical Center licensed clinic.

Prerogatives and Responsibilities: Teaching Only Members may only participate in the care of patients when incident to performing clinical teaching responsibilities.

Teaching Only Staff may not admit patients to the Medical Center. Teaching Only Members have limited privileges specific to performing their clinical teaching responsibilities. When required, temporary privileges may be extended on a time limited basis. Members of this category have no voting rights and may not hold office in any standing committees or subcommittees of the Executive Medical Board unless so specified at the time of credentialing. Members of this category must meet the general responsibilities of membership, but are exempt from the requirement of federal and state healthcare program participation (such as Medicare/Medi-Cal.) Teaching Only Members must comply with the Medical Staff and UC policies including but not limited to the Code of Conduct and Policy Against Harassment and Sexual Abuse. Members of this category must satisfy the requirements of the service in which they are a member, including participation in committee meetings or departmental meetings as requested.

Since Teaching Only Staff appointment is dependent upon having a UCSF faculty appointment, Medical Staff membership and privileges automatically terminate when the faculty appointment is terminated. This automatic termination does not give rise to procedural rights.

f. Courtesy-Associate Staff

Definition: Physicians, oral and maxillofacial surgeons, podiatrists, clinical psychologists, or dentists who do not provide care for a minimal acceptable number of patients at the Medical Center as determined by the Executive Medical Board sufficient to meet Courtesy status may apply for appointment instead as Courtesy-Associate Staff. Membership in this category shall beconsidered only by recommendation of the Service Chief and/or President of the Medical Staff.

Prerogatives and Responsibilities: Such Members may serve on committees, may vote, and may hold office. Courtesy-Associate staff must:

i. Be those serving in leadership roles and retained to and charged with assisting the Medical Center/School of Medicine with carrying out institutional administrative and operational functions;

ii. Meet all of the basic qualifications for medical staff membership; and

iii. Are determined to adhere to the policies of UCSF Health, the ethics of their professions, and work cooperatively with others so as not to adversely affect their judgment in carrying out their leadership duties for performance improvement and patient safety functions, and properly perform those responsibilities to the satisfaction of the Medical Staff.

ARTICLE 4. INITIAL APPOINTMENT AND REAPPOINTMENT

4.1 Application for Initial Appointment and Reappointment

The Medical Staff shall consider each application for appointment, reappointment, and clinical privileges, and each request for modification of Medical Staff category, using the procedure and criteria and standards for membership and clinical privileges in the Bylaws and the Medical Staff Credentialing and Performance Plan. By applying to the Medical Staff for appointment or reappointment, the applicant agrees that they will comply with the responsibilities of Medical Staff membership and with the Bylaws, Plans, Rules, Regulations and Policies as they exist and as they may be modified from time to time, as well as Medical Center Policies as may be modified from time to time.

4.2 Procedure for Initial Appointment and Reappointment

The verification and processing procedures of applications for appointment and reappointment are set forth in the Medical Staff Credentialing and Performance Plan.

4.3 Burden on Applicant

Applicants for membership appointment, reappointment, and/or clinical privileges have the burden of producing complete and thorough information for a proper evaluation of their qualifications for membership or clinical privileges, including documentation of their general competencies regarding their experience, background, training, board certification or re-certification status, health status, and their ability to provide their patients with care at the generally recognized level of quality. Neither the Medical Staff nor Governance Advisory Council shall have any obligation to review or consider any application until it is complete, as outlined in these Bylaws and the Credentialing and Performance Plan. If further information is required, review and/or action upon an application can be deferred at the discretion of the Credentials Committee or the Executive Medical Board. The applicant must provide accurate, up-to-date information on the application form, and must be responsible for ensuring that all supporting information and verifications are provided as requested. It shall be the responsibility of the applicant to ensure that any required information from their training programs, peer references, or other facilities is timely submitted directly to the Office of Medical Affairs and Governance by such sources. Untimely or incomplete applications will not be processed.

a. Applicant's Responsibilities

The applicant is responsible for resolving any doubts regarding the application and the applicant's qualifications for membership and/or clinical privileges. If during the processing of the application, the Medical Center or the Medical Staff or any committee or representative thereof determines that additional information or verification or an interview with the applicant is needed, further processing of the application will be stayed, and the application will not be considered complete until such additional information or verification is received, or the interview is conducted. The Credentials Committee, Executive Medical Board, or Governance

Advisory Council may request that the applicant appear for an interview with regard to the application. Failure to appear at the requested time and location will cause the application to be deemed incomplete.

4.4 Incomplete Applications

a. A Practitioner or Member whose appointment or reappointment application is not fully completed as defined above shall not be entitled to a credentialing recommendation from any Clinical Service or Committee. If the applicant fails to complete the application within one hundred eighty (180) days of submission or within thirty (30) days of a request for additional information, whichever is later, the application will be deemed withdrawn. Termination of the credentialing process pursuant to this Section shall not entitle the Practitioner or Member to a hearing described in the Fair Hearing Plan.

b. If the applicant's application is deemed withdrawn as provided above, the applicant may apply again no more than twice in the same twelve (12) month period, and any information gathered during the initial process may be used if still valid and timely.

c. An applicant may be given an opportunity to render an incomplete application complete as described above. However, it is the applicant's responsibility to review the application carefully and verify that the information provided is accurate and complete before it is submitted. Any substantial misrepresentation or misstatement in, or omission from, an application shall, itself alone, constitute cause for denial of the application. Similarly, in the event that any substantial misrepresentation or misstatement in, or omission from, an application is discovered after the application has been approved, it shall constitute cause for summary action and/or a recommendation to revoke Medical Staff Membership and/or all clinical privileges.

d. Until notice is received from Governance Advisory Council regarding final action on an application for appointment, reappointment and/or new clinical privileges, the applicant shall be responsible for keeping the application current and complete by informing the Office of Medical Affairs and Governance in writing of any material change in the information provided or of any new information that might reasonably have an effect on the applicant's candidacy. Failure to meet this responsibility will be grounds for summary action and/or a recommendation to deny the application or revoke Medical Staff membership.

4.5 Term of Appointment

a. Appointments shall be effective on approval by the Governance Advisory Council and shall extend for a period not to exceed two (2) years, depending upon the membership category. Membership extended to those providing services in network affiliated clinical settings may have their membership approved for a period not to exceed three (3) years.

b. Initial appointments or the granting of new privileges shall be subject to Focused Professional Practice Evaluation for a period of up to twelve (12) months, and extensions may be considered upon adequate showing.

c. Reappointments will be for a period not to exceed two (2) years, depending upon membership category.

ARTICLE 5. CLINICAL PRIVILEGES

5.1 Delineation of Privileges in General

a. Exercise of Privileges

Except as otherwise provided in these Bylaws, Plans, Rules, Regulations and Policies, every Member, Advanced Practice Provider, or Allied Health Professional providing direct clinical services at this Medical Center shall be entitled to exercise only those privileges specifically granted to him or her.

b. Requests for Privileges

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific privileges desired by the applicant. A request for a modification of privileges must be supported by documentation of training and/or experience supportive of the request.

c. Basis for Medical Staff Member, Advanced Practice Provider, or Allied Health Professional Privilege Determination

Requests shall be evaluated based on the Medical Staff Member, Advanced Practice Provider, or Allied Health Professional's current clinical competence and scope of practice as defined under California law. Please refer below and to the Credentialing and Performance Plan for specific privilege determination.

d. Privileges for Medical Staff Members shall generally require residency program training that encompasses the requested privileges; however, the Departments may establish alternative or additional criteria for specific clinical privileges, provided such criteria are approved by the Executive Medical Board and the Governance Advisory Council. The privileging process includes evaluation of:

i. General competencies obtained from other sources, peer references (especially when there are insufficient peer review data available), and information from other institutions and health care settings where a Member, Advanced Practice Provider, or Allied Health Professional exercises privileges;

ii. Education, training, experience, demonstrated professional competence and judgment, and evidence of physical and mental ability to perform the requested privileges. The review will include available documented results of patient care and other performance metrics, and documented performance of sufficient numbers of procedures applicable to the privileges requested; and

iii. Challenges to any licensure or registration, involuntary restriction, suspension or termination of privileges or membership at any other organization; voluntary termination of privileges or membership from any

medical staff after notice of investigation for a medical disciplinary cause or reason; involuntary relinquishment of any license or registration; voluntary relinquishment of any license or registration after notice of investigation for a medical disciplinary cause or reason; any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a settlement or final judgment against the applicant, charges or convictions for criminal activity bearing upon patient safety or public safety.

e. The processing of applications for clinical privileges is further described in the Credentialing and Performance Plan.

5.2 Categories of Privileges

a. Visiting Privileges

i. Visiting Privileges: In circumstances where patients or an academic program require the services of a provider who is not a Member of the Medical Staff or Advanced Practice Provider/Allied Health Professional Staff, visiting privileges may be granted on a case by case basis to fulfill an important patient care need.

ii. Visiting privileges do not include admitting privileges. No person shall receive more than two (2) visiting privileges appointments in a twelve (12) month period and each visiting privilege appointment shall be granted for no more than sixty (60) days. Providers with visiting privileges are not eligible to vote or hold office.

iii. Visiting privileges may be granted after the applicant submits a complete visiting application and the primary source verification of the following is completed by the Office of Medical Affairs and Governance:

(1) Current licensure;

(2) Relevant education and experience;

(3) Current competence;

(4) Ability to perform the privileges requested; and

(5) Other criteria listed in the Medical Staff Credentialing Policy and Procedures for visiting privileges.

b. Temporary Privileges

i. Temporary privileges may be granted to fulfill an important patient care, treatment and service need. Temporary privileges may also be granted when a new applicant for Medical Staff or Advanced Practice Provider/Allied

Health Professional Staff membership with a complete application approved by the Department Chair or designee, is awaiting approval by the Credentials Committee, the Executive Medical Board and the Governance Advisory Council. Additionally, temporary privileges may be granted when an existing Member in good standing is requesting one or more additional privileges. Temporary privileges are time limited and may be granted for renewable sixty (60) day periods up to one hundred and twenty (120) days.

ii. Temporary privileges may be granted after the applicant completes the Medical Staff membership application and the primary source verification of the following is verified by the Office of Medical Affairs and Governance as follows:

(1) Current licensure;

(2) Relevant education/training and experience;

(3) Current competence;

(4) Ability to perform the privileges requested; and

(5) Other criteria listed in the Medical Staff Credentialing Policy and Procedures for initial appointments.

c. <u>General Conditions and Termination of Visiting or Temporary Privileges</u>

i. All requests for visiting or temporary privileges must include a letter from the Department Chair providing the clinical rationale supporting the needed urgency for the privileges. Visiting or temporary privileges may be granted by the Chief Executive Officer or authorized designee, on the recommendation of the Medical Staff President or authorized designee and the Chair of the Credentials Committee.

ii. The results of the National Practitioner Data Bank and Medical Board of California queries have been obtained and evaluated.

iii. The applicant has:

(1) Filed a complete application with the Office of Medical Affairs and Governance;

(2) Demonstrated no current or previously successful challenge to licensure or registration exists;

(3) Not been subject to involuntary termination of membership and/or involuntary limitation, reduction, denial or loss of clinical privileges for medical disciplinary cause or reason at another organization; and

(4) Not been subject to restriction of clinical privileges for a cumulative total of thirty (30) days or more for any twelve (12) month period for a medical disciplinary cause or reason at another organization.

iv. There is no right to visiting or temporary privileges. Accordingly, visiting or temporary privileges should not be granted unless the available information supports, with reasonable certainty, a favorable determination regarding the requesting applicant's qualifications, ability and judgment to exercise the privileges requested. An individual who is denied temporary privileges is not entitled to hearing rights under the Fair Hearing Plan.

v. If the available information is inconsistent or casts any reasonable doubt on the applicant's qualifications, action on the request may be deferred until the doubts have been satisfactorily resolved.

vi. A determination to grant visiting or temporary privileges is not be binding or conclusive with respect to an applicant's pending request for appointment to the Medical Staff.

vii. Providers granted temporary privileges are subject to Focused Professional Practice Evaluation and supervision specified by the Department, or as described in these Bylaws, Plans, Rules, Regulations, and Policies.

viii. Visiting or temporary privileges automatically terminate at the end of the designated period, unless affirmatively renewed or earlier terminated, as provided in these Bylaws, Plans, Rules, Regulations and Policies.

ix. Visiting or temporary privileges may be terminated at any time by the President of the Medical Staff, the responsible Department Chair, or the Chief Medical Officer after conferring with the President of the Medical Staff or the responsible Department Chair. The termination of temporary or visiting privileges does not give rise to the procedural rights afforded by the Fair Hearing Plan unless such action or recommendation requires the filing of a report pursuant to California Business and Professions Code Section 805.

x. Whenever visiting or temporary privileges are terminated, the appropriate Department Chair or designee shall assign a Member to assume responsibility for the care of the affected provider's patient(s).

xi. All persons requesting or receiving visiting or temporary privileges shall be bound by the Medical Staff Bylaws, Plans, Rules, Regulations, and Policies.

xii. As to Advanced Practice Providers or Allied Health Professionals, visiting or temporary privileges may be granted by the Chief Executive Officer (or designee), on the recommendation of the Medical Staff President (or designee), the Chair of the Committee on Interdisciplinary Practice for

Advanced Practice Providers (or designee), and the Chair (or designee) of the Department where the privileges will be exercised.

d. Disaster Privileges

Disaster privileges may be granted when the Medical Center's emergency management plan has been activated and the organization is unable to handle the immediate patient needs. A medical disaster occurs when the destructive effects of natural or man-made forces overwhelm the ability of the Medical Center to meet the demand for health care services. Disaster privileges are granted pursuant to the Disaster Privileges Policy (Medical Center Administrative Manual: Policy 1.02.13). The Medical Branch Director has the authority to grant privileges once the Hospital Incident Command System (HICS) is activated.

e. Emergency Situations

In the event of an emergency, and whether or not the emergency management plan has been activated, any Member of the Medical Staff or any credentialed Advanced Practice Provider or Allied Health Professional are permitted to do everything reasonably possible, within the scope of their licensure, to save the life of a patient or to save a patient from serious harm, regardless of Department, staff category, or clinical privileges. The clinician must promptly yield such care to a Member with the appropriate privileges when one becomes available.

ARTICLE 6. CORRECTIVE ACTIONS AND AUTOMATIC SUSPENSION OR LIMITATION

6.1 Investigations and Corrective Actions

Investigations, and formal and informal corrective actions are set forth in the Medical Staff Investigations, Corrective Actions and Fair Hearing Plan.

6.2 Fair Hearing Procedure

The grounds for a hearing, hearing procedures, and appellate procedure are set forth in Article 24 of the Medical Staff Investigations, Corrective Actions and Fair Hearing Plan.

6.3 Automatic Suspension, Limitation, or Termination (Administrative)

The President of the Medical Staff or designee shall confirm that all automatic suspensions or limitations are consistent with this Section. A Member's Medical Staff membership and/or privileges shall be automatically suspended, limited, or terminated as described below. Such automatic suspensions, limitations, and terminations do not entitle the Member to hearing rights under the Fair Hearing Plan.

Unless otherwise stated, for each matter listed below, an automatic suspension or limitation that remains in effect for longer than ninety (90) days will result in voluntary resignation of Medical Staff membership and privileges at the end of the ninety (90) day period. Thereafter, reinstatement to the Medical Staff shall require a new application and compliance with the appointment procedures applicable to initial applicants. The Executive Medical Board does not consider an automatic suspension, limitation, or termination based on one of the categories listed below a suspension based on a "medical disciplinary cause or reason," as that term is defined in California Business and Professions Code Section 805.

Unless otherwise expressly stated, any corrective action, automatic suspension or action taken upon a Member's membership and/or clinical privileges at the Medical Center shall apply equally to the Member's clinical activities across and throughout the Medical Center.

a. Action Taken on License or Certification

i. License Revocation, Suspension and Expiration: Whenever a Member's or APP/AHP's license or other legally authorized practice in this state is revoked, suspended, or expired by/with the applicable licensing authority, Medical Staff membership and/or clinical privileges shall be automatically revoked or suspended as of the date such action becomes effective and throughout its term, until reinstated fully by the applicable licensing authority.

ii. Restriction or Limitation of License, Certificate or Permit: Whenever a Member's or APP/AHP's license or other legally authorized practice in this state is limited or restricted by the applicable licensing authority, any

clinical privileges that the Member/APP/AHP has been granted that are within the scope of said limitation or restriction shall automatically be subject to nothing less than the same limitations or restrictions as of the date such action becomes effective and throughout its term.

iii. Terms, Conditions of Probation of License or Certificate: Whenever a Member or APP/AHP is placed on probation or mandatory terms/conditions by the applicable licensing or certifying authority, their membership status and/or clinical privileges shall automatically be subject to nothing less than the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

b. Action Taken on Drug Enforcement Administration (DEA) Certificate

i. Revocation, Limitation, Suspension and Expiration: Whenever a Member/APP/AHP's DEA certificate is revoked, limited, suspended, or expired, and such is required to exercise the privileges the Member/APP/AHP holds, the Member/APP/AHP shall be automatically and correspondingly divested of the right to prescribe, dispense, or administer medications covered by the certificate as of the date such action becomes effective and throughout its term.

ii. Probation of DEA certificate: Whenever a Member/APP/AHP's DEA certificate is subject to probation, and such probation affects the clinician's ability to exercise the privileges they hold, the Member/APP/AHP shall automatically become subject to the same terms of the probation as of the date such action becomes effective and throughout its term.

c. Cancellation of Professional Liability Insurance

Failure to maintain professional liability insurance with limits of liability required by the University and naming The Regents of the University of California as an additional insured, with provision for notice to The Regents thirty (30) days prior to cancellation or termination, shall result in automatic suspension of all privileges and membership on the Medical Staff. The suspension shall be effective until appropriate coverage is reinstated, including coverage of any acts or potential liabilities that may have occurred or arisen during the period of any lapse in coverage.

d. Delinquent Medical Records

Whenever a Medical Staff Member or APP/AHP fails to complete and authenticate the inpatient and/or outpatient medical records of any patient for whom they are responsible as required by the UCSF Medical Center Medical Records Policy and/or UCSF Medical Staff Rules and Regulations/Medical Records Policy, the medical record becomes delinquent. When a clinician has delinquent medical records, they will receive notice of the delinquency that specifies the deadline to complete the medical records to avoid an automatic suspension. If the clinician fails

to complete the medical records by the deadline stated in the notice of delinquency, their privileges will be automatically suspended and will remain suspended until all delinquent medical records are completed.

Unless required by law, such automatic actions do not entitle the Member to hearing rights under the Fair Hearing Plan.

A Member whose membership has been terminated for delinquent medical records in accordance with UCSF Medical Records Policy may not reapply for Medical Staff membership until one (1) year from the effective date of the termination, and their application will be considered as an initial application.

e. Failure to Comply with Government and Other Third-Party Payor Requirements

Whenever a Medical Staff Member or APP/AHP has been excluded by the Office of Inspector General of the United States Department of Health and Human Services, or comparable State authority, from participation in the Federal Medicare or State Medi-Cal program because of fraud or abuse or other Medicare or Medi-Cal program related criminal or improper conduct, or the Member/APP/AHP's ability to provide care to program beneficiaries is restricted or suspended, the Member/APP/AHP's Medical Staff membership and/or clinical privileges will be automatically terminated.

f. Electronic Health Record Security

Whenever a Member fails to comply with the requirements for utilization of the electronic health record (EHR) or other data systems in accordance with UCSF Health Policy, or fails to maintain the security of individual access rights (e.g., sharing passwords) or the confidentiality and security of patient information (e.g., access, use or disclosure of patient information without authorization), the Member's clinical privileges will be automatically suspended and access to and/or use of the EHR system will be limited.

g. Failure to Undergo Evaluation when Requested by the Executive Medical Board

Whenever a Member fails to timely undergo a medical, neuropsychological, cognitive, mental health evaluation or drug/alcohol testing when requested by the Executive Medical Board, the Member's clinical privileges may be automatically suspended until the requested evaluation and/or testing is completed.

h. Failure to Satisfy Request for Information or Special Appearance Requirement

A Member who fails to provide requested information or appear when requested in connection with a peer review matter or investigation in accordance with Section 20.8 shall automatically be suspended from exercising all privileges. The automatic suspension shall remain in effect until the Member has provided the requested information and/or satisfied the special attendance requirement to the satisfaction of the Executive Medical Board.

i. Felony Charges or Conviction

If any Member of the Medical Staff is convicted of, or pleads no contest to, a felony, their Medical Staff membership and privileges will be immediately and automatically terminated. If the Member is charged with a felony related to public safety, the Member's clinical privileges will be automatically suspended until the Executive Medical Board convenes to consider the circumstances and takes appropriate action.

j. Expiration or Termination of Employment or Faculty Appointment

The expiration or termination of a Member's employment or faculty appointment will result in automatic termination of Medical Staff membership and clinical privileges.

k. Failure to Satisfy Testing and Immunization Requirements

Members and APPs/AHPs are required to comply with all Infection Control testing and immunization requirements. Failure or refusal to comply with these requirements after notice of non-compliance will result in automatic suspension of current privileges until such requirements have been met. Refer to Rules and Regulations, Section Two, Article II: Infection Control and Communicable Diseases.

6.4 Automatic Actions and Procedural Rights

Members whose privileges are automatically suspended and/or who have been deemed to have automatically resigned their Medical Staff membership in accordance with Section 6.3 are not entitled to a hearing under the Fair Hearing Plan.

a. Notice of Automatic Suspension or Resignation

Special notice of an automatic suspension or resignation shall be given to the affected Member, but such notice shall not be required for the automatic suspension or resignation to become effective. Patients affected by an automatic action shall be assigned to another Member by the Department Chair or President of the Medical Staff. The wishes of the patient and affected Member shall be considered, where feasible, in choosing a substitute Member.

b. Reinstatement

Except as otherwise provided in the Fair Hearing Plan, the President of the Medical Staff or designee may reinstate the Member when the reason for the automatic suspension no longer exists.

c. Other Corrective Action

In addition to automatic actions imposed pursuant to Section 6.3, the Executive Medical Board may review the circumstances that led to the automatic suspension, conduct or delegate such further investigation as it deems necessary, and impose such other corrective action as it deems warranted. Should that occur, the Member may have hearing rights pursuant to the Fair Hearing Plan, but only if such corrective action(s) are reportable under California Business and Professions Code Section 805.

6.5 Matters Involving Faculty Appointments and Responsibilities

Matters involving faculty appointments and responsibilities are not governed by these Bylaws, rather they are subject to other University policies including the Faculty Code of Conduct. However, matters that are relevant to a Medical Staff Member's status, both as a Medical Staff Member and as a faculty member, are subject to oversight by the responsible Department Chair and the President of the Medical Staff, who together will determine what appropriate action will be taken under these Bylaws and other University policies. If matters are unresolved at this level, Academic Affairs and Medical Staff leadership will determine further appropriate action.

ARTICLE 7. ORGANIZATION

7.1 Departments

a. The Medical Staff shall be organized into the Departments detailed below. Each Member of the Medical Staff must belong to at least one of the following Departments:

Anesthesia & Perioperative Care	Ophthalmology
Dentistry/Oral and Maxillofacial Surgery	Orthopaedic Surgery
Dermatology	Otolaryngology/Head and Neck Surgery
Emergency Medicine	Pathology
Family & Community Medicine	Pediatrics
Laboratory Medicine	Psychiatry
Medicine	Radiology and Biomedical Imaging
Neurological Surgery	Radiation Oncology
Neurology	Surgery
Obstetrics, Gynecology and Reproductive Sciences	Urology

b. Additional Departments may be created, or existing Departments may be combined or eliminated by a three-fourths (3/4) affirmative vote of the Executive Medical Board provided only that such action shall parallel similar departmentalization in the Schools of Medicine or Dentistry.

c. Assignment to Departments: Each Member shall be assigned membership in at least one Department but may also be granted clinical privileges in other Departments consistent with the practice privileges granted.

7.2 Chiefs of Clinical Service/Service Chiefs

The terms Chief of Clinical Service and Service Chief are interchangeable. The School of Medicine Chair of each Department may also serve as its Chief of Clinical Service. Chiefs of Clinical Service have several responsibilities for oversight of Clinical Service activities, including credentials review, peer review, quality of care and utilization review.

a. Qualifications

Each Chief of Clinical Service must be a member of the Attending Staff and a Member of the Service, and must be qualified by training, experience, and demonstrated current ability in clinical care provided by that Service, and able to discharge the functions of the office.

b. Roles and Responsibilities of Chief of Clinical Service

i. Assist in the development and implementation of expectations and requirements for clinical performance for that Service;

ii. Determine and manage the clinically related and administrative activities within the Clinical Service;

iii. Assist in the formulation and execution of programs to carry out the quality review, evaluation, and monitoring functions assigned to that Service;

iv. Continuously assess and improve the quality of care, treatment and services, and maintain quality improvement programs as appropriate;

v. Assist in developing and enforcing the Medical Staff Bylaws, Plans, Rules, Policies, and the Medical Center's Policies that guide and support the provision of patient care, treatment, and services;

vi. Communicate to the appropriate individuals or committee the Service's recommendations concerning appointment, reappointment, delineation of clinical privileges, and disciplinary action with respect to the Members of the Service;

vii. Monitor the quality of patient care and professional performance rendered by Members holding privileges in the Service through a planned and systematic process, including but not limited to ongoing peer review and Ongoing Professional Practice Evaluations (OPPE), and Focused Professional Practice Evaluation functions (FPPE);

viii. Oversee and monitor functions delegated to the Service by the Executive Medical Board in coordination and integration with organization-wide quality assessment and improvement activities;

ix. Coordinate with Well Being Committee (WBC) and Committee on Professionalism in identifying and monitoring Members of the Service who would benefit from or are involved in programs of those committees;

x. Undertake or delegate preliminary peer review investigations of Members of the Service and submit recommendations to the Executive Medical Board if further action is needed;

xi. Perform such other duties commensurate with the office as may from time to time be reasonably requested by the the President of the Medical Staff,or the Executive Medical Board; and

xii. Implement within the Service actions taken by the Executive Medical Board.

c. Term of Office

Each Chief of Clinical Service shall serve in such capacity for a period of time to be determined by the Department Chair.

d. Removal of Chief of Clinical Service

When a Department Chair has appointed a Chief of Clinical Service, removal of the Chief of Clinical Service from office may occur by the Department Chair. If the Chief of Clinical Service is the Chair, removal may occur by majority vote of the Executive Medical Board with concurrence by the Dean of the School of Medicine.

7.3 Committees of the Medical Staff

The Standing Committees of the Medical Staff are outlined in the Organizational Plan of the Medical Staff, as may be amended from time to time.

ARTICLE 8. OFFICERS OF THE MEDICAL STAFF

8.1 Officers and Their Duties

a. Election, Term of Office, Removal of Officers

Election of Medical Staff Officers, term of office, and removal of officers are addressed in the Organizational Plan of the Medical Staff.

b. Identification

There shall be the following general officers of the Medical Staff:

i. President;

ii. President-Elect; and

iii. Immediate Past President.

ARTICLE 9. EXECUTIVE MEDICAL BOARD

9.1 Membership

a. The majority of the Executive Medical Board must be physicians (MDs, MBs, and DOs). The Executive Medical Board consists of the following members who have voting rights if they are Members of the Attending Staff in good standing:

i. The Service Chiefs/Chiefs of Clinical Services specified in these Bylaws, or designees

ii. The Dean of the School of Medicine

iii. The President of the Medical Staff

iv. The President-Elect of the Medical Staff

v. The Chief Nurse Executive

vi. The Chair (or designee) of the Resident and Fellow's Council

vii. Two At-Large Members of the Medical Staff with clinical activity at UCSF Medical Center, elected by the Medical Staff

viii. The Immediate Past President of the Medical Staff

ix. The Chair of the Department of Clinical Pharmacy

x. The Chair(s) of the Quality Improvement Executive Committee

xi. The Chief Executive Officer of the Medical Center

xii. The Chief Clinical Officer of the Medical Center

xiii. The System Chief Medical Officer

xiv. The Chief Medical Officer of Adult Services

xv. The Chief Medical Officer of Children's Services

xvi. The Network Chief Medical Officer

xvii. The Chief Medical Officer of Faculty Practice

xviii. The Chief Medical Information Officer

xix. The Chief Operating Officer of the Medical Center

xx. The Associate Dean of Graduate Medical Education

xxi. The Chair of the Credentials Committee (if not the President-Elect)

xxii. The Chair of the Risk Management Committee

xxiii. Benioff Children's Hospital Physician-in-Chief

xxiv. Benioff Children's Hospital Surgeon-in-Chief

xxv. Benioff Children's Hospital President

xxvi. The Chair of Benioff Children's Hospital Quality Improvement Executive Committee

xxvii. Professionalism Advocate for Patients

xxviii. President of UCSF Ambulatory Business Unit

xxix. President of UCSF Network Business Unit

xxx. President of UCSF Adult Business Unit

xxxi. Chief Strategy Officer or designee

xxxii. Other non-voting members may be appointed at the discretion of the Medical Staff President.

b. Members who are unable to attend meetings may send a substitute. Substitutes do not have a vote.

c. A quorum shall consist of ten (10) voting Members of the Executive Medical Board.

9.2 Duties of the Executive Medical Board

The duties of the Executive Medical Board are as follows:

a. To recommend and enforce Bylaws, Plans, Rules and Regulations of the Medical Staff and Medical Center Policies consistent with the purposes delineated in these Bylaws.

b. To coordinate the activities and general policies of the various Departments, Divisions, Sections, and Services, and to be responsible for the quality of patient care provided by them.

c. To review and make recommendations regarding Medical Center policies that apply to or affect the performance or responsibilities of the Medical Staff.

d. To establish such committees as may be necessary to govern clinical activities at the Medical Center and to receive and act on reports from these committees.

e. To act for the Medical Staff as a whole under such limitations as may be imposed by the Medical Staff.

f. To assure conformity, where indicated, with external licensure, certification, and accreditation requirements.

g. To recommend to the Governance Advisory Council, after considering the recommendations of the Department Chairs and the Credentials Committee, clinical privileges for Medical Staff Members, Advanced Practice Providers, and Allied Health Professionals.

h. To oversee the Ongoing Professional Practice Evaluation (OPPE) of Medical Staff Members, Advanced Practice Providers, and Allied Health Professionals exercising clinical privileges, to make recommendations for improvement, and to initiate Focused Professional Practice Evaluations (FPPE), and to delegate or undertake investigations or corrective actions as the circumstances may warrant.

i. To apprise Medical Center leadership on the sources of the hospital's services that are provided by consultation, contractual arrangements, or other agreements.

j. To report to the Governance Advisory Council regarding the performance and activities of the Medical Staff Members, Advanced Practice Providers, and Allied Health Professionals.

9.3 Meetings of the Executive Medical Board

a. The Executive Medical Board shall meet a minimum of ten (10) meetings per year, and shall hold such additional meetings, at the request of the President or any five (5) Members of the Executive Medical Board, as may be necessary to conduct of its business. These meetings may be held in person or by video conference.

b. Voting Members of the Executive Medical Board are required to personally attend Executive Medical Board meetings unless an authorized delegate/substitute attends in their absence. The authorized delegate/substitute is not entitled to vote.

c. Additional Executive Medical Board meetings, as defined above, may be conducted by telephone and/or video conference. Meetings may also be conducted utilizing other electronic methods that permit the interchange of information prior to the Executive Medical Board making recommendations to Governance Advisory Council. This will include electronic meetings of the Executive Medical Board Executive Committee (a subcommittee comprised of the President of the Medical Staff, the Chief Clinical Officer, the Chief Medical Officer of Adult Services, and Chief Medical Officer of Children's Services, the President-Elect of the Medical Staff, the Immediate Past President, Chair of the Credentials Committee, and the Chair of the Bylaws Committee) for the purpose of expedited review and approval on behalf of the greater Executive Medical Board of:

i. The applications for membership to the Medical Staff that have been approved by the Credentials Committee Chair (or designee); and

ii. Established Medical Center and Medical Staff Plans, Policies and Procedures to be approved for revisions only.

d. A permanent record shall be kept of the minutes of all meetings and a report of Executive Medical Board actions shall be made to the Medical Staff at the Annual Meeting.

9.4 Removal from Membership on the Executive Medical Board

a. As to Executive Medical Board members who are not elected or appointed by the Medical Staff, the member may be removed from the Executive Medical Board for failure to carry out the duties of their office, gross neglect or misfeasance in office, serious acts of moral turpitude, loss of good standing, or loss of the ability to serve effectively. Removal requires a two thirds (2/3) majority of those voting members of the Executive Medical Board who vote on the matter.

b. As to Executive Medical Board members who are elected or appointed by the Medical Staff, the member may be removed in accordance with the provisions regarding removal set forth in Sections 17.2.d (Clinical Services Chiefs), 18.4 (Medical Staff Officers), or 20.3 (Medical Staff Committee members). As to the At-Large members of the Executive Medical Board elected by the Medical Staff, the member may be removed in the same manner and on the same grounds as removal of a Medical Staff Officer under Section 18.4.

c. An Executive Medical Board member will be automatically removed from the Executive Medical Board in the event of a Medical Staff disciplinary or corrective action affecting that member that gives rise to a fair hearing process.

9.5 Filling Vacancy in Member-at-Large Position on Executive Medical Board

If there is a mid-term vacancy in the position of member-at-large of the Executive Medical Board, the Executive Medical Board will appoint a Member of the Medical Staff with clinical activity at UCSF Medical Center to serve the remainder of the term.

ARTICLE 10. AMENDMENT OF BYLAWS

10.1 Amendment Procedure

a. Amendments to the Medical Staff Bylaws are reviewed and recommended by the Bylaws Committee and the Executive Medical Board prior to being submitted for vote of the Medical Staff. Upon at least thirty (30) days' prior written notice to the Executive Medical Board, amendments to the Bylaws may be proposed by petition signed by at least twenty-five percent (25%) of the Members of the voting Medical Staff.

b. The Bylaws may be amended at any Annual or Special Meeting of the Medical Staff, or by mail/electronic ballot, provided that thirty (30) days' advance written notice of the proposed amendments is given to the voting membership.

c. Amendments shall require an affirmative vote of a majority of the Members present and eligible to vote and who do vote, or by a majority of the Members who cast mail/electronic ballots, provided at least fifty (50) ballots must have been timely cast, followed by approval by Governance Advisory Council.

d. Neither the Medical Staff nor Governance Advisory Council may unilaterally amend the Medical Staff Bylaws.

e. In contrast to the above, the Investigation, Corrective Action and Fair Hearing Plan, the Organizational Plan, and the Credentialing and Performance Plan may be amended as needed through the Bylaws Committee with approval by the Executive Medical Board and Governance Advisory Council. Prior to the Executive Medical Board consideration of proposed amendment, notice will be sent to all voting Medical Staff members that proposed changes will be posted on the Office of Medical Affairs and Governance website and inviting commentary from the Medical Staff Members for a period of 30 days. The Executive Medical Board will review any comments prior to voting on the proposed changes.

10.2 Urgent Amendments of Plans, Rules, Regulations, Policies and Procedures

a. In cases of a documented need for an urgent amendment to Plans, Rules, Regulations, Policies or Procedures necessary to comply with law or regulation, the Executive Medical Board may provisionally adopt and the Governance Advisory Council may provisionally approve an urgent amendment without prior notification of the Medical Staff. In such cases, the Medical Staff will be immediately notified by the Executive Medical Board. The Medical Staff has the opportunity for retrospective review of and comment on the provisional amendment.

b. If there is no conflict between the Medical Staff and the Executive Medical Board, the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict between the Medical Staff and the Executive Medical Board is implemented. If necessary, a revised amendment will be then submitted to the Governance Advisory Council for action.

ARTICLE 11. CONFIDENTIALITY AND IMMUNITIES

11.1 General

Medical Staff, Department, Division, Section, Service and committee minutes, files and records, including information regarding any Member, Advanced Practice Provider, Allied Health Professional, or applicant to this Medical Staff shall, to the fullest extent permitted by law, be confidential. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall become a part of the Medical Staff committee files and shall not become part of any patient's file or of the general Medical Center records. Dissemination of such information and records shall be made only where expressly required by law, pursuant to officially adopted policies of the Medical Staff, or, where no officially adopted policy exists, only with the express approval of the Executive Medical Board or its designee.

11.2 Duty of Confidentiality

Inasmuch as effective credentialing, performance improvement, peer review, and consideration of the qualifications of Medical Staff Members, Advanced Practice Providers, Allied Health Professionals, and applicants to perform specific procedures must be based on free and candid discussions, and inasmuch as physicians and others participate in credentialing, performance improvement, and peer review activities with the reasonable expectations that this confidentiality will be preserved and maintained, any breach of confidentiality of the discussions or deliberations of Medical Staff Departments, Clinical Services, Divisions, Sections, or committees, except in conjunction with another health facility, professional society, or licensing authority peer review activities, is outside appropriate standards of conduct for this Medical Staff and will be deemed disruptive to the Medical Center's operations. If it is determined that such a breach has occurred, the Executive Medical Board may undertake such corrective action as it deems appropriate.

11.3 Immunity and Releases

a. Immunity from Liability for Providing Information or Taking Action

Each representative of the Medical Staff and Medical Center and all third parties shall be exempt from liability to a Practitioner, Member, Advanced Practice Provider, or Allied Health Professional for damages or other relief by reason of providing information to a representative of the Medical Staff, APP/AHP staff, Medical Center, or any other health-related organization concerning such person who is, or has been, an applicant to or Member of the Medical Staff or who did or does exercise privileges or provide services at this Medical Center or by reason of otherwise participating in a Medical Staff or Medical Center credentialing, performance improvement or peer review activities.

b. Activities and Information Covered

The immunity provided in this Article shall apply to all acts, communications, reports, recommendations, other information or disclosures performed or made in

connection with this or any other health-related institution's or organization's activities concerning, but not limited to:

i. Applications for appointment, privileges or specified services;

ii. Periodic reappraisals for reappointment, privileges, or specified services;

iii. Corrective action;

iv. Hearings and appellate reviews;

v. Performance improvement review, including patient care audit;

vi. Peer review;

vii. Utilization reviews;

viii. Morbidity and mortality conferences;

ix. Other Medical Center, Department, Clinical Service, Division, Section or committee activities, including but not limited to OPPE/FPPE related to monitoring and improving the quality of patient care and appropriate professional conduct; and

x. A Member, Advanced Practice Provider, or Allied Health Professional's professional qualifications, clinical ability, judgment, physical or mental health, emotional stability, professional conduct, professional ethics, or other matters that might directly or indirectly affect patient care or Medical Center operations.

c. Cumulative Effect

Provisions in these Bylaws, the Plans of the Medical Staff and in Medical Staff application forms relating to authorizations, confidentiality of information and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof.

d. Indemnification

The Medical Center, through the University of California Professional Liability Program, shall indemnify, defend, and hold harmless the Medical Staff and its individual Members ("Indemnitee(s)") from and against losses and expenses (including reasonable attorneys' fees, judgments, settlements, and all other costs, direct or indirect) incurred or suffered by reason of or based upon any threatened, pending or completed action, suit, proceeding, investigation, or other dispute relating or pertaining to any alleged act or failure to act within the scope of peer review or quality assessment activities including, but not limited to:

i. As a Member of or witness for a Medical Staff Department, Clinical Service, Division, Section, committee, ad hoc committee, or hearing committee;

ii. As a Member of or witness for the Governance Advisory Council or any Medical Center task force, group or committee; and

iii. As a person providing information to any Medical Staff or Medical Center group, officer, Governance Advisory Council member or employee for the purpose of aiding in the evaluation of the qualifications, fitness or character of a Medical Staff Member or applicant.

iv. The Medical Center shall retain responsibility for the sole management and defense of any such claims, suits, investigations or other disputes against Indemnitees, including, but not limited to, selection of legal counsel to defend against any such actions. The indemnity set forth herein is expressly conditioned on Indemnitees' good faith belief that their actions and/or communications are reasonable and warranted and in furtherance of the Medical Staff's peer review, quality assessment or quality improvement responsibilities, in accordance with the purposes of the Medical Staff as set forth in these Bylaws and in the Plans of the Medical Staff. In no event will the Medical Center indemnify an Indemnitee for acts or omissions taken in bad faith or in pursuit of the Indemnitee's private economic interests.

e. Releases

Each Practitioner, Member, Advanced Practice Provider, and Allied Health Professional shall, upon request of the Medical Staff, execute general and specific releases in accordance with the tenor and import of these Bylaws and the Plans of the Medical Staff, however, execution of such releases shall not be deemed a prerequisite to the effectiveness of these Bylaws or the Medical Staff Plans.

f. Authority to Act

Any Member who acts in the name of this Medical Staff without proper authority shall be subject to such disciplinary action as the Executive Medical Board may deem appropriate.

11.4 Conflict of Interest

a. A conflict of interest involves a situation where a personal, professional, and/or financial interest, or conflicting fiduciary obligation on the part of a Member or their immediate family member (including a spouse, domestic partner, child or parent) may impact, as a practical matter, the individual's ability to act in the best interest of the Medical Staff without regard to the individual's private or personal interest, or circumstances that create the perception of such a conflict. A conflict of interest depends on the situation. The fact that a Member practices in the same specialty as, or is in direct economic competition with, a Member who is being

reviewed does not, without more, create a conflict of interest for the purposes of engaging in quality review and credentialing activities. The fact that a committee member or Medical Staff leader chooses to refrain from participation, or is excused from participation, shall not be interpreted as a finding of actual conflict.

b. Officers and committee members must disclose to the Medical Staff any personal, professional, or financial affiliations or responsibilities that would, or could reasonably be believed to present, a conflict of interest. Such situations must be disclosed on appointment and at any time when an actual or potential conflict arises.

c. As a matter of procedure, the Chair of the committee designated to review a matter shall inquire, prior to any discussion of the matter, whether any committee member has a conflict of interest or bias. The existence of a conflict of interest or bias on the part of any committee member may be called to the attention of the Chair by any committee member with knowledge of the matter. The existence of an actual or perceived conflict of interest or bias, or the lack thereof, can be determined by a majority vote of the members of the committee where a quorum is present. Any dispute over the existence of a conflict of interest shall be resolved by the Committee Chair, or, if it cannot be resolved at that level, by the President of the Medical Staff. If the conflict of interest involves the President of the Medical Staff, it shall be resolved by the Chancellor or Chief Executive Officer or designee.

d. In any instance where an Officer or committee member has, or reasonably could be perceived to have, a conflict of interest or is biased in any matter involving another Medical Staff Member or any other matter that comes before the individual or committee, or in any instance where the individual brought a complaint against the Medical Staff Member who is the subject of the review, such individual shall not participate in the discussion or voting on the matter and shall be excused from any meeting during that time. However, the individual may be asked and may answer any questions concerning the matter before leaving.

ARTICLE 12. OTHER RIGHTS AND RESPONSIBILITIES OF THE MEDICAL STAFF

12.1 History and Physical Examination Requirements

The requirements for performing and documenting medical histories and physical examinations are determined by the Medical Staff and are specified in policies, Rules and Regulations of the Medical Staff and policies of the Medical Center. Medical history and physical examinations are performed and documented by a physician or an oral and maxillofacial surgeon in accordance with applicable laws, regulations and accreditation standards.

As more fully described herein and in the Medical Staff Rules and Regulations and Policies, prior to surgery or a procedure requiring anesthesia services and except in the case of emergencies, a history and physical examination requires compliance with either of the following:

a. The history and physical examination must be performed and recorded within twenty four (24) hours after the patient physically presents for admission or registration, and within twenty-four (24) hours prior to elective surgery or an elective procedure requiring moderate or deep sedation or anesthesia; or

b. A history and physical examination must be performed and recorded no more than thirty (30) days prior to when the patient physically presents for admission or registration, and an update for changes is performed within twenty four (24) hours after the patient presents for admission or registration, but prior to surgery or a procedure requiring moderate or deep sedation or anesthesia.

12.2 Members Conduct Requirements

a. As a condition of membership and privileges, a Medical Staff Member must continuously meet the requirements for professional conduct established in these Bylaws. Advanced Practice Providers and Allied Health Professionals will be held to the same conduct requirements as Members.

b. Disruptive and Inappropriate Conduct

Disruptive and inappropriate conduct is behavior that affects or could affect the quality of patient care at the hospital as described in the UC Code of Conduct Policy. The following conduct is prohibited and includes without limitation:

i. Harassment by a Medical Staff Member of any individual involved with the hospital (e.g., another Medical Staff Member, resident/ACMGE-approved fellow, hospital employee, patient, patient's family member, or visitor) on the basis, of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, gender or sexual orientation;

ii. "Sexual harassment" is defined in the UC Policy on Sexual Harassment and Sexual Violence and includes unwelcome verbal or physical conduct of a sexual or gender-based nature that may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as the display of derogatory cartoons, drawings, or posters). Sexual harassment also includes unwelcome advances, requests for sexual favors, and any other verbal, visual, or physical conduct of a sexual nature when (1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, or other aspects of clinical duties; or (2) this conduct substantially interferes with the individual's responsibilities or employment or creates and/or perpetuates an intimidating, hostile, or offensive work environment. Sexual harassment also includes conduct that indicates that advancement is conditioned upon acquiescence in sexual activities;

iii. Aggressive, disrespectful or demeaning conduct toward a patient, patient family member, Medical Center employee, team member or colleague. Deliberate physical, visual or verbal intimidation or challenge, including verbal or physical threats or pushing, grabbing or striking another person on hospital premises; and

iv. Inappropriate access and unauthorized release of protected health and patient information.

12.3 Legal Counsel

The Medical Staff may, at its expense, retain and be represented by independent legal counsel with approval by UCSF Chief Campus Counsel at the Office of Legal Affairs and/or by Deputy General Counsel for Health Affairs at the Office of General Counsel.

12.4 Dues

The Executive Medical Board shall have the power to establish reasonable annual dues, if any, for each category of Medical Staff membership, and to determine the manner of expenditure of such funds received. However, such expenditures must be appropriate to the purposes of the Medical Staff and shall not jeopardize the nonprofit tax-exempt status of the Medical Center.

12.5 Disputes with the Governance Advisory Council

In the event of a significant dispute between the Medical Staff and the Governance Advisory Council relating to the independent rights of the Medical Staff, as further described in California Business and Professions Code Section 2282.5, the Medical Staff and Governance Advisory Council will meet and confer in good faith to resolve the dispute.

12.6 Unified Medical Staff

a. Acceptance of a Unified Medical Staff. If the Governance Advisory Council elects to have a Unified Medical Staff with another separately licensed hospital or health facility affiliated with UCSF, then the Medical Staffs of each affected separately licensed facility must vote, by majority, in accordance with its Medical Staff Bylaws, whether to accept unification or remain a separate Medical Staff. Each voting member of the UCSF Health Medical Staff will be eligible to vote on the proposed unification via printed or secure electronic ballot in a manner determined by the Executive Medical Board. All voting members of each Medical Staff shall receive at least thirty (30) days advance notice of the proposed unification. The proposed unification shall be considered approved by each Medical Staff using the bylaws amendment process in its current bylaws when there is a quorum of thirty percent (30%).

b. The Unified Medical Staff takes into account unique circumstances and any significant differences in patient populations and services offered at each separately licensed hospital or health facility. The Unified Medical Staff establishes policies and procedures to ensure that the needs and concerns of Medical Staff members at each separately licensed facility are given due consideration and any issue specific to each separately licensed facility is considered and addressed based on the patient populations and services offered at each separately licensed facility. The privileges granted to Medical Staff members are specific to the services supported and available at each facility.

c. Consideration of Dissolution of Unified Medical Staff. Once there is a Unified Medical Staff, the voting members at each separately licensed hospital or health facility have the ability to vote to "opt out" of the Unified Medical Staff. This requires a petition signed by twenty percent (20%) of the members who would qualify to vote at that hospital or health facility. Not more than one such petition shall be considered in any two (2) year period. Upon presentation of such a petition, a meeting of the Unified Medical Staff will be scheduled to discuss the petition. Each member who would qualify to vote at that hospital or health facility is eligible to vote on the proposed "opt out" proposal via printed or secure electronic ballot in a manner determined by the Executive Medical Board. All voting members of the Medical Staffs of each separately licensed hospital or health facility shall receive at least thirty (30) days advance notice of the proposed changes. The amendment shall be considered approved by each Medical Staff when the proposed unification amendment receives a simple majority (fifty percent plus one) of the valid ballots cast, when there is a quorum of thirty percent (30%), and is approved by the Governance Advisory Council. In the event a vote to opt out prevails in accordance with provisions of this Section, the Unified Medical Staff shall cease existence upon approval of a new set of Medical Staff Bylaws by each of the separately licensed hospitals or health facilities. Such approval shall occur in the manner delineated in these Bylaws, and in no event shall occur more than one hundred eighty (180) days following determination of the outcome of the vote to opt out of the Unified Medical Staff.

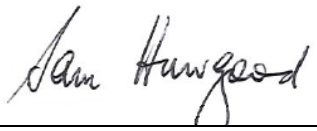
ARTICLE 13. ADOPTION OF THESE BYLAWS

These Bylaws, as distinguished from the separate and individual Medical Staff Plans, shall be adopted by the affirmative vote of a majority of the voting Members of the Medical Staff attending the Annual Meeting or a Special Meeting called for that purpose and shall be implemented following approval of Governance Advisory Council, which shall not be unreasonably withheld. If approval of the Governance Advisory Council is withheld, the reasons for doing so shall be specified by the Governance Advisory Council in writing, and shall be forwarded to the President, the Executive Medical Board, and the Bylaws Committee.

ADOPTED by the Medical Staff on July 28, 2026

Rosanna Wustrack, M.D.
Medical Staff President

ADOPTED by the Governance Advisory Council on July 30, 2026



Sam Hawgood, MBBS
Chancellor