

RULES AND REGULATIONS

OF THE

MEDICAL STAFF OF HALIFAX HEALTH

Adopted by the Medical Staff on September 16, 2025
Approved by the Board of Commissioners on November 12, 2025

APPENDIX I

MEDICAL STAFF RULES AND REGULATIONS

ARTICLE I- ADMISSION AND DISCHARGE OF PATIENTS

1.1 ADMISSION

A patient may be admitted to Halifax Medical Center only by members of its Medical Staff who have been granted privileges in accordance with the Medical Staff Bylaws. Qualified dentists and podiatrists who have been granted privileges may initiate the procedure for admitting a patient. A Physician member of the Medical Staff shall assume responsibility for the overall medical aspects of the patient's care throughout the hospital stay according to appropriate hospital policy. This may include Peer to Peer conversations with third party payers. All Practitioners shall be governed by the official admitting policy of the Hospital.

1.2 RESPONSIBILITY FOR PATIENT CARE

Each patient shall be the responsibility of a member of the Medical Staff. Such Practitioner shall be responsible for the medical care and treatment, for the prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the patient's condition to the referring Practitioner and to relatives of the patient. Whenever these responsibilities are transferred to another Medical Staff Practitioner, a note covering the transfer of responsibility shall be entered via order entry and documented in the medical record.

1.3 DISCHARGE AGAINST MEDICAL ADVICE

Patients shall be discharged only on a written order of the attending Practitioner. Should a patient leave the Hospital against the advice of the attending Practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record.

1.4 EMERGENCY ADMISSION

In the case of an emergency admission, patients who do not have a private Practitioner may request a Practitioner in the Department or Service to which he/she needs to be admitted, or be assigned in rotation to members of the Active or Associate Staff on duty in the Department or service to which the illness or patient indicates assignment. The Chair of each Department shall provide an assignment schedule for attendance of such patients.

In case of an emergency affecting the patient of a member of the Medical Staff who is not immediately available, the Chief of Staff, the Chair of the Department concerned, or their designee, shall have the authority to call in any member of the Medical Staff with the appropriate privileges, to attend such patient until the member of the Medical Staff becomes available to assume responsibility for the patient.

1.5 EMERGENCY DEPARTMENT CALL ROSTER

All members of the Active and Associate Medical Staff shall actively participate in the

Emergency Department service call roster and disaster on-call programs for their Department/subsection unless excused by their Clinical Department as provided in Departmental Rules and Regulations, the Medical Staff Bylaws, or the Bylaws of the Governing Body. Practitioners in other categories may be required to participate in service call, as required by their Department/subsection.

Physicians on Emergency call are expected to admit patients arriving at any Halifax facility to the Halifax Medical Center. Transfer shall not take place without approval of the administrator on call unless the service is not available at this facility. Patients shall have the right to request admission to the hospital of their choice.

Each Clinical Department Chair or his designee shall maintain a roster of Physicians on call for the Emergency Department and submit it to the Chief of Staff and Medical Staff Coordinator. On call Physicians will respond to Emergency Department call in a timely fashion.

The on-call Physician shall accept the evaluation of the emergency physician and follow his/her advice regarding admission, or come to the Emergency Department, or Hospital, and evaluate the patient and make a medically appropriate disposition. Patients seen and evaluated in the Emergency Department, who, in the opinion of the emergency physician, require specialty evaluation or on-going treatment by an on-call member of the Medical Staff shall be accepted by that member or his associate without regard to the patient's ability to pay for services rendered.

If a Physician is unavailable when on call, or is unable to take call for an assigned time, it is that Physician's responsibility to arrange for another Physician member of the Medical Staff with the appropriate privileges to assume the Physician's call responsibilities. The Medical Staff Coordinator must be notified of all such instances as soon as possible.

In the event a Physician does not respond to a call from the Emergency Department concerning a patient, the Chair of the requisite Department/subsection shall direct a member of the Medical Staff, with the appropriate privileges, to attend to such patient. Such instances shall be reported to the Credentials Committee after review by the CMO, CQO and appropriate Department Chair.

The Rules and Regulations of each Clinical Department will specify the arrangements for how service call obligations will be met.

1.6 AUTOPSIES

Autopsies are no longer performed at Halifax Health. Refer requests to the Volusia County Medical Examiner's Office.

ARTICLE II- MEDICAL RECORDS

2.1 MEDICAL RECORDS

2.1-1 Contents of Record

The attending Practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current. This record shall include identification date; complaint; personal history; family history; history of present illness; physical

examination; special reports such as consultations, clinical laboratory and radiology services, and others; provisional diagnosis; plan of action; periodic, appropriate reassessment of the patient's condition and response to treatment as determined by the patient's symptoms and test results; medical or surgical treatment; operative report; pathological findings; progress notes; final diagnosis; condition on discharge; summary or discharge note.

2.1-2 Admission History and Physical Examination

A patient admitted for inpatient care shall have a complete admission history and physical examination within twenty-four (24) hours of admission and prior to any procedure. Said history and physical examination shall be the responsibility of a privileged practitioner (i.e. physicians, oral and maxillofacial surgeons, dentists, podiatrists). Dentists shall be responsible for the part of their patient's history and physical examination that relates to dentistry, and podiatrists are responsible for the part of their patient's history and physical examination that relates to podiatry. This report should include all pertinent findings resulting from an assessment of all systems of the body, to include a physical assessment which has been completed within the first twenty-four (24) hours of admission. If a complete history has been recorded and a physical examination performed within thirty (30) days prior to the patient's admission or registration to the Hospital, a reasonably durable, legible copy of these reports may be used in the patient's Hospital medical record in lieu of the admission history and report of the physical examination, provided these reports were recorded by a member of the Medical Staff. In such instances, an update note indicating any changes or no changes to the history and/or physical findings must always be recorded prior to any procedures requiring anesthesia services or conscious sedation and within 24 hours of admission. An exception to these rules will be granted when the record is prepared by a resident physician in which instance the attending physician countersigns the record.

2.1-3 History and Physical Required Prior to Procedure

An updated history and physical are required before any procedure requiring moderate sedation or anesthesia.

2.1-4 Progress Notes, Routine Orders

Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes shall be documented at least daily on critically ill patients, and those where there is difficulty in diagnosis or management of the clinical problem.

A Practitioner's routine orders, when applicable to a given patient, will be reproduced in detail on the patient's electronic medical record, dated, timed, and signed by the Practitioner.

2.1-5 Operative Reports/Notes

Operative reports shall include a detailed account of the findings at surgery as well as the details of the surgical technique. Operative reports shall be dictated immediately following surgery for outpatients as well as inpatients and the report promptly signed by the surgeon and made a part of the patient's current medical record. An operative progress note shall be entered into the medical record immediately after surgery to provide pertinent information for patient care.

2.1-6 Reports of Consultation

Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record. Except in emergency, so verified on the record, when

operative procedures are involved, the consultation note shall be recorded prior to the operation. Routine consultations will be completed within 24 hours. STAT consultations will be requested by direct physician to physician communication and completed in a timely manner appropriate to the clinical setting. In instances where a pre-existing protocol is in place to facilitate the consult (e.g. radiographs, lab work) the direct physician to physician requirement will be waived. Physician Assistants may see patients for Routine Consults and dictate a note, but the physician must see the patient and dictate a consult within 24 hours.

2.1-7 Dated Entries

All clinical entries in the patient's medical record shall be accurately dated, timed, and authenticated.

2.1-8 Final Diagnosis

Final diagnosis shall be recorded in full, without the use of symbols or abbreviations, and dated and signed by the responsible Practitioner at the time of discharge of all patients. The attending Practitioner has the responsibility to establish the final diagnosis.

2.1-9 Discharge Summary

A discharge clinical summary shall be documented or dictated on all medical records of patients hospitalized over forty-eight (48) hours except for normal obstetrical deliveries and normal newborn infants. In addition, a discharge clinical summary should be documented or dictated on medical records of a patient where hospitalization is less than forty-eight (48) hours and are of a complicated nature. This determination should be made by the attending Practitioner and a clinical summary prepared, as appropriate. For cases where no discharge clinical summary is prepared, a final summation type progress note shall be sufficient. In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result and shall include instructions to the patient relative to condition, activity, diet and medication. All discharge clinical summaries shall be authenticated by the responsible Practitioner.

2.1-10 Release of Medical Information and Records

Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.

Records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. All records are the property of the Hospital and shall not otherwise be taken away without permission of the Chief Executive Officer. In case of readmission of a patient, all previous records shall be available for the use of the attending Practitioners. This shall apply whether the patient be attended by the same Practitioner or by another. Unauthorized removal of charts from the Hospital is grounds for suspension of the Practitioner for a period to be determined by the Executive Committee of the Medical Staff.

Free access to all medical records of all patients shall be afforded to members of the Medical Staff for *bona fide* study and research consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the Institutional Review Board (IRB) before records can be studied. Subject to the discretion of the Chief Executive Officer, former members of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.

2.1-11 Completion of Medical Records

A medical record shall not be permanently filed until it is completed by the responsible Practitioner or is ordered filed by the Quality Council.

All of the patient's medical records shall be completed within seven (7) days from the date of discharge; failure to do so will result in suspension of physician admission privileges. The procedure for the handling of practitioners with incomplete medical records is outlined in the "Chart Completion: Physician Notification for Record Completion" policy.

ARTICLE III- GENERAL CONDUCT OF CARE

3.1 INFORMED CONSENT

Informed consent forms for treatment should be prepared by the Hospital taking into account all special procedures. These are to be adopted by the Medical Staff and the Governing Body with the aid of legal counsel.

3.2 PRACTITIONERS' ORDERS

All orders shall be entered electronically in the EHR. A verbal order shall be considered given if dictated to a registered nurse, licensed practical nurse, pharmacist, dietician, respiratory therapist, or any other licensed professional who is authorized to take orders under their licensure requirements and functioning within their sphere of competence. Verbal orders should be used only to meet the care needs of the patient when it is impossible or impractical for the ordering practitioner to enter it electronically without delaying treatment. All orders dictated over the telephone shall be signed by the appropriately authorized persons to whom dictated, and include the name of the Practitioner. All verbal orders must be authenticated by the responsible Practitioner or if allowed by law, his/her alternate within 48 hours. Telephone and verbal orders should not be used routinely.

Orders must be entered electronically or written clearly, legibly and completely on paper during information system downtimes. Orders which are illegible or improperly electronically entered will not be carried out until rewritten or understood by the nurse.

3.3 ADMINISTRATION OF DRUGS AND MEDICATIONS

All drugs and medications administered to patients shall be those listed in the Hospital Formulary. Drugs for bona fide clinical investigations may be exceptions. These shall be used in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals and all regulations of the Federal Drug Administration.

3.4 TIMELY USE OF CONSULTATION

The good conduct of medical practice includes the proper and timely use of consultation. Judgment as to the serious nature of the illness, and the question of doubt as to the diagnosis and treatment, rests with the Practitioner responsible for the care of the patient. On the other hand, it is the duty of the organized Medical Staff through its departmental Chair and Credentials Committee to see that those with clinical privileges do not fail in the matter of calling consultants as needed.

Any qualified Practitioner with clinical privileges in this Hospital can be called for consultation within his area of expertise.

The attending Practitioner is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant. He will provide written authorization to permit another attending Practitioner to attend or examine his patient, except in an emergency.

3.5 LABORATORY PROCEDURES

A Laboratory shall be provided in the Hospital so that all types of laboratory examinations may be done.

Outside laboratory reports in acute cases will be accepted but are to be discouraged. Reports must be on forms as used by the Hospital. In surgical cases the reports must accompany the patient.

3.6 PREPRINTED ORDERS

Approved protocol orders may be formulated by a Department in conference with the administration. Protocol orders are entered electronically and available in e-forms in preprinted paper format for downtime use. These orders shall be followed insofar as the treatment of the patient will allow and when specific orders are not written by the attending Practitioner, they shall constitute the orders for treatment.

3.7 PRACTITIONER'S VISITS

The attending Practitioner shall visit the hospitalized patient a minimum of once daily. Departmental Rules and Regulations may specify exceptions with appropriate cause. Patient visits must be documented. If the attending Practitioner is unable to visit a hospitalized patient or cover his Emergency Department call roster responsibility, it shall be his responsibility to arrange with a qualified member of the Medical Staff to do so.

3.8 MISCELLANEOUS PROVISIONS

The Chief of Staff may be relieved from rotation from his respective service, duty in the clinics and membership of Committees except from one he/she serves as Chair.

Consultation, methods and restrictions regarding termination of pregnancy shall comply with the prevailing Statutes of the State of Florida.

Rapid response time for critically ill patients is expected.

Medical staff members are required to produce verification of annual tuberculin and PPD testing as prescribed for healthcare workers according to Hospital policy.

3.9 ETHICS

For guidance on non-medical issues related to regulatory compliance or business ethics, members may, at their option, refer to the Hospital's Code of Conduct, or consult with the Hospital's General Counsel or Compliance Officer.

3.10 CLINICAL DUTIES AND PREROGATIVES

NPP may exercise privileges and perform services and duties in the Hospital that have been appropriately credentialed through the process as outlined in the Bylaws. Specifics regarding clinical duties, which are relatively standard for each category and subcategory of NPP shall be delineated in the NPP Policy, though exception to such may be dictated in the credentials process in specified cases.

ARTICLE IV- FAMILY MEDICINE RESIDENTS AND FELLOWS

All patients seen by Family Medicine residents or Sports Medicine Fellows whether in the hospital, Center for Family and Sports Medicine, private office or other setting are ultimately under the care of a licensed non-resident supervising physician. This supervising physician might be the assigned "attending physician" during an inpatient rotation, a community preceptor during an outpatient elective, a Center for Family and Sports Medicine preceptor during the Center for Family and Sports Medicine business hours or the Family Medicine faculty member on call during non-business hours. Each Accreditation Council for Graduate medical Education (ACGME) accredited program must have program specific policies defining the process for supervision.

Residents or Fellows may, with the approval of the non-resident supervising physician execute the clinical privileges with the exception of admitting privileges of the non-resident supervising physician.

The non-resident supervising physician shall assign the resident only those patient care responsibilities which are commensurate with the resident's level of training, experience and competence.

The Residency Program faculty under the leadership of the Residency Program Director will maintain an ongoing evaluation program that will monitor resident "competency" per guidelines established by the ACGME and assure that residents not meeting expected competency standards will receive higher levels of supervision.

The non-resident supervising physician must co-sign the documents written or dictated by residents per the Graduate medical Education Institutional policy of the site where patient care is delivered.

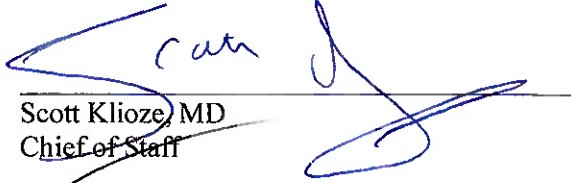
Within Halifax Health, all licensed family medicine residents, except those suspended from clinical activities due to residency disciplinary or probationary actions, are eligible to be members of the Resident Affiliate staff per the Medical Staff bylaws (section 3.5) and are subject to the rules and regulations under those bylaws.

ARTICLE XVII -ADOPTION

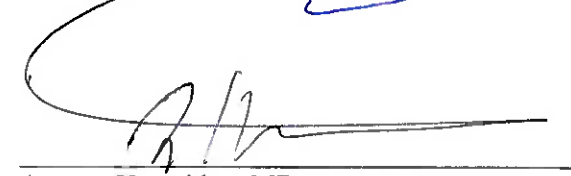
These Medical Staff Rules and Regulations shall be adopted at any regular or special meeting of the Active Medical Staff, shall replace any previous Medical Staff Rules and Regulations and shall become effective when approved by the Governing Body of the Hospital.

Adopted by the Active Medical Staff of Halifax Health Medical Center.

Date: September 16, 2025



Scott Klioze, MD
Chief of Staff



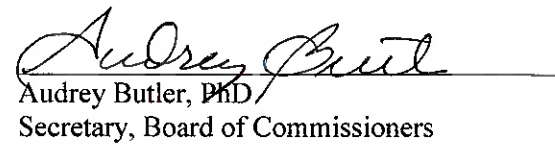
Ammar Hemaidan, MD
Secretary, Medical Staff

Adopted by the Board of Commissioners of Halifax Health Medical Center.

Date: November 12, 2025



Alan Florez
Chairman, Board of Commissioners



Audrey Butler, PhD
Secretary, Board of Commissioners