THE NEBRASKA MEDICAL CENTER

POLICY ON

MEDICAL STAFF

ORGANIZATION AND FUNCTIONS

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ARTICLE 1

GENERAL

1.A: DEFINITIONS

The following definitions shall apply to terms used in this Manual and related bylaws and policies:

(1) ‘ACTIVE STAFF” shall have the meaning assigned by the Nebraska Medical Center Staff Bylaws.

(2) "ALLIED HEALTH PROFESSIONALS" ("Allied Health Professionals") means individuals other than Appointees who are authorized by law to provide patient care services, whose scope of practice is defined in the Policy on Allied Health Professionals.

(3) "APPOINTEE" means any physician, dentist, or oral surgeon who has been granted Medical Staff appointment and clinical privileges by the Board to practice at the Hospital.

(4) "BOARD" means the Board of Directors of Nebraska Health System, which has the overall responsibility for the Hospital, or its designated committee.

(5) "BOARD CERTIFICATION" is the designation conferred by: (i) one of the affiliated specialties of the American Board of Medical Specialties ("ABMS"), (ii) the American Osteopathic Association ("AOA"), (iii) the American Board of Oral and Maxillofacial Surgery (iv) boards recognized by the American Dental Association or (v) a board of another country recognized by the Medical Staff Executive Committee, all upon a physician or dentist who has successfully completed an approved educational training program and an evaluation process, including passing an examination, in the applicant's area of clinical practice.

(6) “BYLAWS” shall mean the Medical Staff Bylaws adopted by the Medical Staff and the Board, as provided therein.

(7) "CCPPA" means the Chair of Clarkson Private Practice Affairs.

(8) "CHIEF EXECUTIVE OFFICER" ("CEO") means the individual elected by the Board as its president.

(9) “CHIEF OF STAFF” means the individual elected by the Medical Executive Committee to such post.

(10) "CLINICAL PRIVILEGES" means the authorization granted by the Board to render specific patient care services.

(11) "CREDENTIALS POLICY" means the Hospital's Medical Staff Credentials Policy.

(12) "DAYS" means calendar days.

(13) "DENTIST" means a doctor of dental surgery ("D.D.S.") or a doctor of dental medicine ("D.M.D.").

(14) “DIRECTOR OF MEDICAL RECORDS” means that person appointed to such post by the Hospital.

(15) "HOSPITAL" means either Clarkson Hospital or University Hospital, both of which are part of Nebraska Health System ("NHS").

(16) "HOUSE STAFF" means all physicians who are assigned for graduate medical education and will ordinarily carry the title of resident or fellow.

(17) “INFECTIOUS CONTROL OFFICER” shall mean that individual appointed to such position by the CEO.

(18) "MEDICAL STAFF" means all physicians, dentists and oral surgeons who have been appointed to the Medical Staff by the Board.

19) "MEDICAL STAFF EXECUTIVE COMMITTEE" means the Executive Committee of the Medical Staff.

(20) “MEDICAL STAFF BYLAWS” shall mean that document adopted by the Medical Staff and the Board intended to serve as bylaws of the Medical Staff.

(21) "NOTICE" means written communication by regular U.S. mail, e-mail, facsimile, Hospital mail, or hand delivery.

(22) "PHYSICIAN" includes both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s").

(23) "SERVICE" shall mean the Services established in this Policy.

(24) "UNASSIGNED PATIENT" means any individual who comes to the Hospital for care or treatment who does not have an attending physician, or whose attending physician or designated alternate is unavailable to attend the patient, or who does not want the prior attending physician to provide him/her care while a patient at the Hospital.

1.B: TIME LIMITS

Time limits referred to in this Manual are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

1.C: DELEGATION OF FUNCTIONS

When a function is to be carried out by a person or committee, the person, or the committee through its chairperson, may delegate performance of the function to one or more designees.

ARTICLE 2

SERVICES AND DIVISIONS

2.A: LIST OF SERVICES AND DIVISIONS

The following services and divisions are established:

Hospital Based Services

(1) Anesthesiology;

(2) Emergency Medicine;

(3) Pathology;

(4) Radiation Oncology

(5) Radiology and Nuclear Medicine

Non-Hospital Based Services:

(6) Family Medicine;

(7) Medicine;

The Medicine Service shall include the following specialties, which may be organized as divisions:

(a) Allergy and Immunology;

(b) Cardiology;

(c) Dermatology;

(d) Endocrinology;

(e) Gastroenterology;

(f) Geriatrics;

(g) Hematology/Oncology;

(h) Infectious Disease;

(i) General Internal Medicine;

(j) Nephrology;

(k) Neurology;

(l) Occupational Medicine;

(m) Pulmonary Disease; and

(n) Rheumatology.

(8) Obstetrics/Gynecology;

The Obstetrics/Gynecology Service shall include the following specialties, which may be organized as divisions:

(a) General Obstetrics/Gynecology;

(b) Gynecologic Oncology;

(c) Maternal Fetal Medicine; and

(d) Reproductive Endocrinology and Infertility.

(9) Ophthalmology;

(10) Orthopedic Surgery;

(11) Otolaryngology;

(12) Pediatrics;

The Pediatrics Service shall include the following specialties, which may be organized as divisions:

(a) General Pediatrics;

(b) Pediatric Cardiology;

(c) Pediatric Endocrinology;

(d) Pediatric Gastroenterology;

(e) Pediatric Hematology/Oncology;

(f) Neonatology;

(g) Pediatric Nephrology;

(h) Pediatric Neurology; and

(i) Pediatric Pulmonology.

(13) Psychiatry; and

(14) Surgery

The Surgery Service shall include the following specialties which may be organized as divisions:

(a) Cardiovascular/Thoracic;

(b) General Surgery;

(c) Neurosurgery;

(d) Oral Surgery and Dentistry;

(e) Plastic Surgery;

(f) Transplantation; and

(g) Urology.

2.B: FUNCTIONS AND RESPONSIBILITIES OF SERVICES AND DIVISIONS

The functions and responsibilities of Services, Service chiefs, divisions and division chiefs are set forth in the Medical Staff Bylaws.

2.C: CREATION AND DISSOLUTION OF SERVICES AND DIVISIONS

(1) Services shall be created and may be consolidated or dissolved by the Medical Staff Executive Committee, upon approval by the Board as set forth below.

(2) The following factors shall be considered in determining whether a Service should be created:

(a) there exists a number of Medical Staff Appointees who are available for appointment to, and are reasonably expected to actively participate in, the proposed service (this number must be sufficiently large to enable the Service to accomplish the functions of a Service as set forth in the Bylaws);

(b) the level of clinical activity that will be affected by the service is substantial enough to warrant imposing the responsibility to accomplish service functions on a routine basis;

(c) a majority of the voting members of the Medical Staff who would be assigned to the proposed service vote in favor of the creation of a new service;

(d) the relevant Medical Staff appointees support that there is a clinical and administrative need for a the service; and

(e) the relevant Medical Staff appointees offer a reasonable proposal for how the new service will fulfill all of the designated responsibilities and functions including, where applicable, meeting requirements.

(3) The following factors shall be considered in determining whether the dissolution of a service is warranted:

(a) there is no longer an adequate number of Medical Staff appointees in the service to enable it to accomplish the functions of a service set forth in the Governance document.

(b) there is an insubstantial number of patients or an insignificant amount of clinical activity to warrant the imposition of the designated duties on the appointees in the Service;

(c) the Service fails to fulfill all designated responsibilities and functions including, where applicable, its meeting requirements;

(d) no qualified individual is willing to serve as Service chief; or

(e) a majority of the voting members of the Service vote for its dissolution.

(4) A group of physicians who practice in the same or similar areas and who wish to have a forum for discussion of those clinical areas may request to function as a division. The request must be signed by a majority of Active Staff appointees in the clinical specialty and shall be submitted to the appropriate Service chief for review and recommendation. The request will be forwarded to the Medical Staff Executive Committee for recommendation and to the Board for approval.

ARTICLE 3

STANDING MEDICAL STAFF COMMITTEES

3.A: MEDICAL STAFF COMMITTEES

(1) Committee chairpersons and Medical Staff members of the committees shall be appointed by the Chief of Staff in accordance with Medical Staff Governance.

(2) Unless otherwise provided, all Hospital and administrative representatives on the committees shall be appointed by the Chief Executive Officer or his or her designee. All such representatives shall serve on the committees without vote.

3.B: MEETINGS, REPORTS AND RECOMMENDATIONS

Unless otherwise indicated, each committee described in this Manual shall meet at least quarterly, or at the discretion of the chairperson, and shall maintain a permanent record of its findings, proceedings and actions. Each committee shall make a timely written report after each meeting to the Medical Staff Executive Committee, if requested by the Physician Quality Committee to it for its consideration and appropriate action any situation involving questions of patient care and treatment or case management, and to other committees and individuals as may be indicated in this Manual.

3.C: BYLAWS COMMITTEE

3.C.1. Composition:

The Bylaws Committee shall consist of at least five (5) persons appointed from the Active Staff.

3.C.2. Duties:

The Bylaws Committee shall:

(a) review the Nebraska Medical Center Medical Staff Governance, this Policy, the Credentials Policy and the Policy on Allied Health Professionals, and associated documents and recommend amendments thereto to the Executive Committee. This review shall include, but not be limited to, the Medical Staff rules and regulations, and appointment and reappointment application forms; and

(b) receive and consider all recommendations for changes in the aforestated documents made by the Board, any committee or hospital Service of the Medical Staff, the Chief of Staff, the Chief Executive Officer, or any individual appointed to the Medical Staff.

3.D: CANCER COMMITTEE

3.D.1. Composition:

The Cancer Committee shall consist of Appointees who are actively interested in the diagnosis and treatment of patients with cancer. Such physicians shall include, but not be limited to, surgeons, pathologists, oncologists, radiation oncologists, diagnostic radiologists, and the cancer liaison physician. Other members of the committee shall include the director or a consultant to the tumor registry, a tumor registrar, a pharmacist, a social services representative, a quality assurance representative, or nursing representative, and an administrative representative of the CEO, the later two to serve without vote, in an ex-officio capacity. The tumor registrar shall serve as secretary of the committee and one member of the committee shall be appointed to assume direct supervision of, and to maintain liaison between, the tumor registry, the Medical Staff, and other hospital Services.

3.D.2. Duties:

The Cancer Committee shall be directly responsible for the technical supervision of the tumor registry, including, but not limited to, issues concerning utilization, continuity, and quality of care. The committee shall also review and approve all forms and letters to be used by the cancer registry and shall plan and implement tumor conferences, at least annually.

3.E: CLINICAL INFORMATION MANAGEMENT COMMITTEE

3.E.1. Composition:

The Clinical Information Management Committee membership shall consist of no less than nine (9) members, including a minimum of five (5) Appointees, one (1) or two (2) members appointed by the Hospital, the Director of Medical Records, and the Executive Director of the Information Technology Department. Additionally persons may be appointed by the Chief of Staff where such persons are actively invested or interested in clinical information management. The chairperson will be a member of the Medical Staff appointed by the Chief of Staff.

3.E.2. Duties:

The Clinical Information Management Committee shall:

(a) oversee the development, use and acceptance of the computer-based patient record as the standard clinical information source;

(b) recommend and monitor compliance with Medical Staff policies and regulatory requirements related to medical records; and

(c) create and oversee groups of individuals as needed, to deal with various dynamic elements of the computer-based patient record.

3.F: CREDENTIALS COMMITTEE

3.F.1. Composition:

The Credentials Committee shall be composed of at least ten (10) members representing equally Active Academic and Active Private Practice Medical Staff membership. Service on this committee shall be considered as the primary Medical Staff obligation of each member of the committee and other Medical Staff duties shall not interfere. The Chief of Staff may appoint up to ten (10) additional members to the committee, for terms of one (1) year each.

3.F.2. Duties:

The Credentials Committee shall:

(a) review the credentials of all applicants for Medical Staff appointment, reappointment, and clinical privileges, make investigations of and interview such applicants as may be necessary, and to make a report of its findings and recommendations. For reappointments, it may make inquiries of the Physician Quality Committee, who will respond and the foregoing duties shall be applicable to those physicians and dentists who participate as a Teaching Staff/Preceptor at the Nebraska Medical Center in accordance with the Academic Affiliation Agreement between The Nebraska Medical Center and the University of Nebraska Medical Center;

(b) review the credentials of all applicants who request to practice at the Hospital as Allied Health Professionals, to make investigations of and interview such applicants as may be necessary, and to make a report of its findings and recommendations; and

(c) review, as questions arise, all information available regarding the clinical competence and behavior of persons currently appointed to the Medical

Staff and of those practicing as Allied Health Professionals and, as a result of such review, to make a report of its findings and recommendations.

3.G: INFECTION CONTROL COMMITTEE

3.G.1. Composition:

The Infection Control Committee, at a minimum, shall be composed of the Infection Control officer, one (1) Medical Staff appointee from each hospital Service, including at least one (1) pathologist, and persons appointed by the Hospital who have expertise in nursing and hospital management.

3.G.2. Duties:

The Infection Control Committee shall be responsible for the surveillance of inadvertent hospital infection potentials, the review and analysis of actual infections, the promotion of a preventive and corrective program designed to minimize infection hazards, and the supervision of infection control in all phases of the Hospital's activities.

3.H: MEDICAL ETHICS COMMITTEE

3.H.1. Composition:

The Medical Ethics Committee shall be composed of at least thirteen (13) members, including seven (7) representatives of the Medical Staff representing the services of Cardiology, Pulmonary, Gerontology, Family Practice, Transplantation, Obstetrics or Pediatrics, and Neurology or Neurosurgery; two (2) ethicists; a Nebraska Medical Center chaplain; a representative of the CEO and other Hospital representatives one of whom shall be a licensed social worker and the other shall be a registered nurse.

3.H.2. Duties:

The Medical Ethics Committee shall meet as necessary and shall support ethical reflection and decision-making in the care of patients through:

(a) a well trained and quickly responsive ethics consultation service;

(b) regular development and updating of Medical Staff ethics policies;

(c) regular education offerings on matters pertaining to clinical ethics and policies;

(d) regular communication with other units responsible for promoting and protecting the health care interest of patients and staff; and

(e) providing a forum to identify areas of potential ethical importance as they arise in patient care, medical research, health profession education, and policies affecting health care delivery and financing.

3.I: MEDICAL STAFF ADVISORY COUNCIL

3.I.1. Composition:

The Medical Staff Advisory Council is an active group appointed by the Medical Staff Executive Committee and consists of at least two (2) Medical Staff appointees of high regard and status. The advocacy activities of the Medical Staff Advisory Council and any administrative or disciplinary action shall function totally separate from one another.

3.I.2. Duties:

The Medical Staff Advisory Council shall meet as often as necessary and shall:

(a) function separately from any Medical Staff disciplinary body;

(b) utilize the services of the Nebraska Medical Association Impaired Physician Committee when an impaired Medical Staff member is identified;

(c) communicate with the Chief of Staff and Medical Staff Executive Committee when an identified impaired Medical Staff Appointee is unwilling to submit to treatment;

(d) act as a resource and intervention group for Medical Staff committees when an impaired Medical Staff Appointee has been identified through the Medical Staff committee process;

(e) inform the Medical Staff of the existence of the Medical Staff Advisory Council and what services are available;

(f) work to increase the Medical Staff general awareness of drug and alcohol abuse within the total Medical Staff population;

(g) serve as a source of information regarding the status of an impaired Medical Staff Appointee when needed by another Medical Staff committee; and

(h) issue a report of its activities to the Chief of Staff.

3.J: PHYSICIAN QUALITY COMMITTEE (PQC)

3.J.1. Composition:

The Physician Quality Committee shall be composed of eight (8) voting members appointed by the Chief of Staff. The Chief of Staff will also appoint the Chair. The terms will be three (3) year staggered terms with three (3) members terms expiring one (1) year from the date of appointment, two (2) members terms expiring two (2) years from the date of appointment and three (3) members terms expiring three (3) years from the date of appointment. The Chief Medical Officer will be a non-voting member.

The Chair of the Committee will become a non-voting member of the Medical Executive Committee and the Hospital Quality Committee.

Four (4) of the members will represent the following four specialties – General Internal Medicine, General Surgery, Obstetrics/Gynecology, and Family Medicine; four members will be "at large". In appointing members of the PQC, the Chief of Staff shall give due consideration to interest, willingness to fulfill the time commitment of PQC membership and a fair balance between academic and private practice physicians.

A member who does not participate in at least 75 percent of the meetings, may be removed by vote of the Medical Executive Committee. The committee will meet at least monthly.

3.J.2 Duties:

The PQC shall assume the responsibility for directing the ongoing development and maintenance of the Quality Improvement Program as it affects the Medical Staff.

Specifically, the PQC shall:

(a) Evaluate specialty specific data and targets using individual case review, aggregate data in clinical standards, and rates which provide an evaluation of a individual practitioner's professional performance based upon the criteria as established by the Chairs and Chief Council for the use of the PQC and at its request.

(b) Provide a mechanism for timely and routine feedback to individual physicians directly. The Chairs and Chiefs Council will also receive copies of the reports as directed by the PQC for the purpose of carrying out functions for the PQC.

(c) Evaluate data provided by Quality Support Services provided at its request and select cases for review based upon the triggers for

increased intensity of review, internal peer review and external peer review as determined by the Chairs and Chiefs Council, assisting the PQC.

(d) Share data with Credentials Committee for its use in the recredentialing process.

(e) Establish criteria which trigger an increased review intensity.

(f) Establish criteria which trigger internal peer review.

(g) Establish criteria which trigger external peer review.

(h) Be responsible for overseeing all monitoring functions, including utilization review, surgical case review, pharmacy and therapeutics, transfusion, and medical records, and serve as a liaison between the Medical Staff and nursing service in matters related to patient care.

3.J.3. PRIVILEGE.

It is intended that the PQC proceedings, minutes, records and reports shall be privileged communications within the ambit of Sections 71-2048, RRS 1943, and shall not be discoverable except as provided by Nebraska law.

3.K : CHAIRS AND CHIEFS RESOURCE COUNCIL (CCC)

3.K.1: Composition

The membership of the Chairs and Chief Resource Council will include all the Clinical Chairs of the departments in the UNMC College of Medicine and the Clinical Service Chiefs. Members of the CCC will be physicians in good standing on The Nebraska Medical Center Medical Staff. Members will participate based upon their position, and as individuals serving in designated positions change, their respective successors shall serve on the CCC. The CCC will be subdivided into four (4) working groups:

1) Surgery, Obstetrics/Gynecology, Otolaryngology, Ophthalmology, and Orthopedic Surgery
2) Medicine
3) Family Medicine, Pediatrics, Psychiatry
4) Pathology, Radiology and Nuclear Medicine, Radiation Oncology, and Anesthesiology

Each working group will be responsible for electing a working group leader to manage the processes of the working group and report to the Chair of the Physician Quality Committee.

3.K.2 Duties

The Chairs and Chiefs Resource Council shall:

(a) At the request of the PQC, establish specialty specific criteria and targets goals using individual case review, aggregate data in clinical standards and rates which provide an evaluation of an individual practitioner's professional performance.

(b) Establish mechanism to obtain physician responses to concerns.

(c) Review all mortality cases monthly and identify any related problems or patterns at the request of the PQC.

3.L: PHARMACY AND THERAPEUTICS COMMITTEE

3.L.1. Composition:

The Pharmacy and Therapeutics Committee shall be composed of at least six (6) Medical Staff Appointees and a nurse, a pharmacist, a member of the Active Medical Staff who is an appointee of the Pathology Service and a representative of the CEO.

3.L.2. Duties:

The Pharmacy and Therapeutics Committee shall:

(a) establish broad professional policies concerning the evaluation, selection, procurement, stocking, storage, disbursement, labeling, use, safety precautions and other matters relating to the utilization of established drugs in the Hospital;

(b) if requested by the PQC, the Executive Committee and/or the Hospital Services, the results of the quality improvement monitors of the use of drugs along with any recommendations for corrective actions or educational programs; and

(c) if requested by the PQC, make a report after each meeting to the PQC.

3.M: SPECIAL CARE UNITS COMMITTEE

3.M.1. Composition:

The Nebraska Medical Center Special Care Units Committee shall include the medical directors of each of the following: Adult ICU (Surgical and Medical), Pediatric ICU, Neonatal ICU, Burn Unit and Medical Director, Emergency Department and OHSCU. Medical directors of future specialty specific critical care units will be included.

The hospital will employ an overall medical director for special care who will be a member of this committee and shall serve as the co-chair.

The hospital appointments shall include the Chief Nursing Officer, Chief Medical Officer, Nursing Director of Critical Care, and the Nursing Executive Director for Critical Care, Pharmacy Director, Respiratory Therapy Director, Director of Women's Services, the hospital-employed Medical Director for Intensive Care and hospital epidemiology representative.

3.M.2. Duties:

The Special Care Units Committee shall meet monthly and shall:

a) Provide oversight to the care of all patients in special care units at The Nebraska Medical Center
b) Regularly review benchmarked outcomes data to ensure care is of the

highest quality.

c) Ensure compliance with accreditation, licensure, and regulatory issues in all special care units. These would include, but not be limited to, Joint Commission defined core measures, National Patient Safety Goals, Leapfrog Defined Intensivist Model, etc.
d) Review policies and procedures and update as necessary. Ensure when possible that policies and procedures are standardized across the enterprise.
e) Serve in a leadership capacity to assess and recommend new technology and standardize where possible.
f) Report findings to the Hospital Quality Committee and Pediatric Quality Committee monthly.
g) Sponsor performance improvement projects specifically for the special care units.

3.N: TISSUE COMMITTEE

3.N.1. Composition:

The Tissue Committee shall be composed of at least six (6) members, including three (3) Medical Staff Appointees, a representative of the Director of Medical Records or his or her designees, a representative of the CEO and a nurse.

3.N.2. Duties:

The Tissue Committee shall meet as often as necessary and shall:

(a) ensure that tissue/surgical case review is performed in accordance with the requirements of the Joint Commission on Accreditation of Healthcare Organizations;

(b) maintain oversight of tissue review to include the review of cases in which any of the following were noted:

(i) a significant discrepancy between pre- and post-operative diagnosis;

(ii) normal tissue removed when diseased tissue was expected;

(iii) inadequate tissue margin or unexpected tissue removed; or

(iv) a significant discrepancy between frozen section and permanent section diagnosis.

(c) ensure the proper handling of surgical specimens; and

(d) if requested by the PQC, make a report after each meeting to the PQC.

3.O: TRANSFUSION COMMITTEE

3.O.1. Composition:

The Transfusion Committee, at a minimum, shall be composed of a pathologist who is active as a transfusion service medical director and his or her associate medical director as well as any other Appointee who shall be actively involved in the assisting the medical director, the Hospital employee acting as a laboratory manager and an individual who is employed by the Hospital and concerned with quality assurance issues; five (5) additional Medical Staff Appointees representing Internal Medicine, Surgery, Anesthesiology, the American Red Cross Blood Services Medical Director, and one at-large representative; a nurse; and the Director of Medical Records or his or her designee.

3.O.2. Duties:

The Transfusion Committee shall:

(a) establish broad policies for the transfusion of blood and blood components;

(b) develop, review and revise the criteria for the audit of transfusion therapy, including the choice of component, transfusion practices

involving specialized components, and preparation of the patient, including informed consent;

(c) conduct ongoing audit of a designated proportion of transfusions administered to patients whose blood components were obtained from The Nebraska Medical Center Blood Bank;

(d) review all adverse events resulting from transfusion and all reported transfusion reactions;

(e) identify areas of transfusion therapy with opportunities for improvement;

(f) assess the adequacy, safety, and quality of the blood supply;

(g) review and approve written policies and procedures dealing with transfusions, and the interplay of nursing and the Medical Staff that pertain to transfusion therapy. Ensure that such policies and procedures conform to the Standards of the American Association of Blood Banks and to the regulations of the College of American Pathologists and the Joint Commission on Accreditation of Healthcare Organizations; and,

(h) if requested by the PQC, will report to the PQC results of its conclusions and recommendations.

ARTICLE 4
AMENDMENTS

This Manual may be amended by a vote of the Medical Staff as provided in the Bylaws.

ARTICLE 5

ADOPTION

This Medical Staff Organization and Functions Manual is adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff Bylaws and policies pertaining to the subject matter herein, and henceforth all clinical service and committee activities of the Medical Staff and of each individual serving as a member of a clinical service or staff committee shall be undertaken pursuant to the requirements of this Manual.

Adopted by the Medical Staff:

Date: October 21, 2009 _____

Chief of Staff

Approved by the Board of Directors:

Date: September 21, 2009 _____

Chairperson, Board of Directors