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A. ADMISSION AND DISCHARGE OF PATIENTS

1. A patient may be admitted to the Hospital only by a physician member of the Medical Staff or a qualified oral surgeon with clinical privileges to do so.

2. A podiatrist or dentist with clinical privileges to do so may, with the concurrence of an appropriate physician member of the Medical Staff, initiate the procedure for admitting a patient. This concurring Medical Staff member shall assume responsibility for the medical aspects of care of the patient throughout the Hospital stay, including the medical history and physical examination.

3. Patients admitted to the Hospital for podiatric or dental care must be given the same basic medical appraisal as patients admitted for other services. A physician member of the Medical Staff must be responsible for the care of any medical problem that may be present on admission, or that may arise during the hospitalization of a podiatric or dental patient.

4. All practitioners with clinical privileges, including dentists, podiatrists and oral surgeons, must comply with all aspects of the Medical Staff bylaws, rules and regulations, and policies, as well as policies and procedures of the Hospital. Podiatrists and dentists with clinical privileges are responsible, respectively, for the podiatric or dental care of the patient, including the patient’s podiatric or dental history, podiatric or dental physical exam and appropriate parts of the patient’s medical record. Podiatrists and dentists with clinical privileges may write orders within the scope of their licenses, consistent with the Medical Staff bylaws, rules and regulations.

5. Prior to admitting a patient, an oral surgeon who is not also a physician, must designate a qualified physician member of the Medical Staff to assume responsibility for the medical aspects of the patient’s care.

6. The discharge of the patient shall be on the order of a physician member of the Medical Staff, except that an oral surgeon may discharge a patient admitted without medical problems provided the patient has remained without medical problems during the entire admission.

7. A physician member of the Medical Staff shall be responsible for the medical care of each patient admitted to the Hospital. The patient must be seen and examined by the patient’s attending practitioner or the responsible “on call” group practitioner upon admission and on a daily basis. The attending practitioner is defined as the practitioner who maintains primary responsibility for determining the patient’s continued need for hospital care and readiness for discharge. The practitioner who admitted the patient is considered the attending practitioner unless he or she formally transfers primary responsibility for treatment decisions, including the continued need for hospital care and readiness for discharge, to another practitioner, or, if the practitioner is admitting the patient to the service of another member of his or her clinic or “on-call” group and clearly notes that in the patient’s electronic medical record, the designated group member will be considered the attending practitioner. When all of these responsibilities are transferred to and accepted by another Medical Staff member, a note regarding the transfer of responsibility shall be entered in the medical record by the transferring practitioner. However, temporary transfer of responsibility for care of the patient, during nights and weekends to “on-call” practitioners from the same clinic or “on-call” group, requires no formal note in the medical record. An electronic call roster shall be available in the BAMC Portal for access by the various Hospital departments and patient care floors so that Hospital and other personnel can readily determine which practitioner is responsible for a patient at any time.
8. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis for admission has been entered into the medical record. In the case of an emergency, such diagnosis shall be recorded as soon as possible.

9. A patient whose practitioner does not have the clinical privileges necessary to manage that patient’s care at the Hospital and who requires admission on an emergency basis shall be referred for admission to the hospitalist on duty or the attending surgeon, obstetrician, or pediatrician.

10. In-House patient transfer priorities shall be as follows:

   (a) From the emergency room to an appropriate patient bed.

   (b) From temporary placement in a clinical service area to the most appropriate area for that patient.

   (c) From the intensive care unit (ICU) or Intermediate Medical Care Unit (IMCU) to a general care unit.

11. If any question as to the validity of admission to or discharge from the ICU/IMCU should arise, the decision to admit or discharge the patient must be made in consultation with the ICU Medical Director. If the ICU Medical Director is not available, consultation should be with the chair of the clinical department responsible for the patient, or, if he or she is not available, with the Chief of Staff.

12. The attending practitioner is required to document the need for continued hospitalization after specific periods of stay as identified by the Hospital’s Health Information Management/Case Management/Information Technology Committee (HIM/CM/IT Committee). This documentation must contain:

   (a) An adequate record of the reason for continued hospitalization. A simple reconfirmation of the patient’s diagnosis is not sufficient;

   (b) The estimated period of time the patient will need to remain in the Hospital; and

   (c) Plans for post-hospital care.

13. Patients shall be discharged only on the order of the attending practitioner. If a patient leaves the Hospital against the advice of the attending practitioner or without proper discharge, a notation of the incident shall be entered in the patient’s medical record, the attending physician shall be notified, and whenever possible, the patient should sign the Hospital’s Against Medical Advice Release form (see Administrative Policy, Management of Patients Leaving AMA or LWBS).

14. In the event of a Hospital death, the deceased shall be pronounced dead by the attending physician or his or her designee within a reasonable time.

15. It shall be the duty of all members of the Medical Staff to secure meaningful autopsies whenever possible. An autopsy may be performed only after obtaining a completed consent form in accordance with Administrative Policy, Autopsies. All autopsies shall be performed by a practitioner authorized by the Hospital.
B. MEDICAL RECORDS

1. The Hospital and the attending practitioner shall be responsible for the preparation of a complete and comprehensible electronic medical record for each patient. The contents of the medical record shall be pertinent and current, and shall include all information specified by Hospital policy.

2. The medical record of a newborn shall also include a record of any pertinent maternal data, the type of labor and delivery, and the condition of the infant at birth.

3. The record of each obstetric patient shall also include the prenatal history and findings, the labor and delivery record, and estimated blood loss.

4. A complete admission history and physical examination shall be completed and documented in the patient’s medical record no more than 30 days before or 24 hours after admission or registration of each patient, but prior to surgery or a procedure requiring anesthesia services. When the medical history and physical examination is completed no more than 30 days before admission, an updated medical record entry documenting an examination for any changes in the patient’s condition must be completed and documented in the medical record within 24 hours of admission, but prior to surgery or a procedure requiring anesthesia services. “Documented in the medical record” means that the history and physical examination has been reviewed and authenticated by the responsible practitioner, and is available in the patient’s medical record for review by anyone caring for the patient. Therefore, Practitioners that utilize the Hospital’s dictation service must consider the additional six (6) hours required for completion of dictated reports in order to ensure that the above standards are met.

5. If the responsible practitioner has not completed and recorded the history and physical examination within the time frames set forth above, the practitioner will be notified. The Chairperson of the HIM/CM/IT Committee shall submit to the Department Chair the names of practitioners who have been notified. It is the responsibility of the Department Chairperson to monitor trends and to determine if a practitioner shall be reported to the MEC.

6. An inpatient history and physical examination report should include all pertinent findings resulting from an assessment of all systems of the body. If a complete history and physical examination has been performed and recorded by a member of the Medical Staff no more than 30 days prior to the patient’s admission to the Hospital for a similar condition, a copy of this report may be entered in the patient’s medical record and may act as the admission history and physical examination. In such instances, an update note must be recorded within 24 hours of admission that includes a physical examination to update any components of the patient’s current medical status, even if there have not been any changes since the prior history and physical. The update note should also confirm that the care is necessary and the history and physical examination is still current. The update note must be completed within 24 hours of admission, or prior to surgery or a procedure requiring anesthesia services, and attached to the history and physical examination report.

7. A copy of the prenatal record of obstetric patients is acceptable as a valid history and physical examination report as long as it includes the required elements and it is updated to reflect the patient’s condition within 24 hours of admission or prior to surgery or a procedure requiring anesthesia services.

8. Non-inpatients undergoing an invasive procedure typically requiring anesthesia services or intravenous sedation require a history and physical examination pertinent to the problem, including an assessment of the patient’s cardiac and respiratory status, as well as the attending practitioner’s diagnostic impression. This history and physical examination is subject to the same timelines for completion and updating that apply to inpatient admissions.
9. When the history and physical examination are not performed and recorded before surgery or any procedure requiring anesthesia services, the surgery or procedure shall be cancelled unless the attending practitioner enters in the medical record that a delay would be detrimental to the patient.

10. Pertinent progress notes shall be recorded at the time of observation and shall be sufficient to permit continuity of care and transferability. 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 treatments.

(a) Progress notes shall be entered at least daily on all patients.

(b) Progress notes shall be entered at least every 12 hours on observation patients.

11. A preoperative diagnosis must be documented in the medical record prior to surgery.

12. The consultation report shall contain evidence of a review of the patient’s record by the consulting practitioner, pertinent findings on examination of the patient, and the consulting practitioner’s opinions and recommendations. This report shall be made a part of the patient's medical record. A limited statement such as “I concur” does not constitute an acceptable consultation report. When consultation is requested in connection with an operative procedure, the consultation report shall, except in emergency situations so noted in the patient’s medical record, be completed and documented prior to the procedure.

13. All clinical entries in the patient’s electronic medical record shall be complete, clear and accurately timed, dated and authenticated by the person responsible for the entry. Authentication means to establish authorship by identifiable initials or electronic authentication.

(a) Narcotic orders may not be initialed, but must be verified by the ordering practitioner by regular signature, or electronic authentication where permitted by law.

(b) When electronic authentication is utilized, the practitioner must sign a statement stating that he or she has been instructed on the proper use of the unique identifier, is the only one who will access the unique identifier, and is aware that failure to maintain confidentiality or any other misuse will result in the Hospital revoking the practitioner’s electronic signature by removing their password from the password file. This signed statement will be on file in the office of the HIM Director.

14. Symbols and abbreviations may be used in the patient’s medical record only when they have been approved by the Medical Staff. An official record of approved abbreviations shall be on file in the HIM Department and shall be available as an electronic resource.

15. A final diagnosis shall be recorded in full in the patient’s medical record without the use of symbols or abbreviations, and shall be timed, dated and signed by the responsible practitioner at the time of discharge. The final diagnosis will be deemed equally as important as the actual discharge order.

16. A discharge summary shall be prepared on all hospitalized patients, with the exception of normal obstetrical deliveries, normal newborn infants, and patients with problems of a concise or succinct nature, which generally includes any stay under 48 hours with no complications. In these cases, a progress note may be substituted for the discharge summary. The progress note must include documentation of the patient's condition at discharge, discharge instructions, the outcome of the hospitalization, disposition of the patient, final diagnosis, and information related to any follow-up care.
(a) In all instances, the medical record must contain information sufficient to justify the diagnosis and warrant the treatment provided to the patient.

(b) Discharge summaries must be completed timely in accordance with medical record completion policy, and shall include the following:

(i) Final diagnosis;

(ii) Reason for hospitalization;

(iii) Significant findings;

(iv) Procedures performed, if applicable;

(v) Condition of the patient upon discharge;

(vi) Any specific instructions given to the patient and/or the patient’s family, including any necessary information related to follow-up care;

(vii) Discharge medications;

(viii) Diet; and

(ix) Activity.

17. Records may be removed from the Hospital pursuant to a lawful court order, subpoena, or in accordance with law and regulation. Unauthorized removal of records from the Hospital is grounds for suspension of the practitioner’s clinical privileges for a period to be determined by the MEC.

18. In case of readmission of a patient, all previous records shall be available for use by the attending practitioner regardless of whether the patient is attended by the same practitioner or by another practitioner.

19. A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the HIM/CM/IT committee.

20. Once a practitioner has determined that his or her routine orders are applicable to a given patient, the orders shall be reproduced in detail on the order sheet of the patient’s medical record, and shall be timed, dated and signed by the practitioner.

21. The medical records of any discharged patient, including, but not limited to, inpatients, observation patients, same day surgery patients, and emergency room patients shall be completed timely in accordance with medical record completion policy. Incomplete records shall be considered delinquent. Medical record delinquency will not be attributed to the practitioner if system or process issues in the HIM Department are responsible for the delinquency. MS Policy, Suspension of Privileges for Delinquent Records, will be followed in the event of delinquent records.

22. All verbal or telephone orders shall be signed, dated, timed and authenticated by the ordering practitioner within 48 hours of issuance.
23. For practitioners who supervise or collaborate (as appropriate) with staff affiliates, the supervising or collaborating practitioner is responsible for timely and accurate documentation, and for countersigning documentation prepared by the staff affiliate within 48 hours.

24. All patient care provided by students at the Hospital, including the preparation of documentation in a patient’s medical record, shall be supervised by an appropriate member of the Medical Staff or other qualified Hospital personnel in accordance with Hospital policy. Students under the direct supervision of a Medical Staff member may document in the medical record so long as any documentation is reviewed and signed by the supervising practitioner.

C. GENERAL CONDUCT OF CARE

1. All orders for treatments shall be in writing. All verbal and telephone orders shall be transcribed by a person authorized to accept the order, and shall be read back to and verified by the ordering practitioner or staff affiliate and signed by the transcriber. The order must include name and title of the ordering practitioner or staff affiliate. The ordering member of the medical staff or staff affiliate must authenticate the order, in writing, within 48 hours. The phrase “in writing” includes electronic authentication. It is acceptable for another member of the medical staff who is responsible for the patient's care to authenticate the order. For practitioners who have an on call or shared call relationship, the collaborative physician will be responsible for the authentication of verbal orders within the 48 hour time frame when the ordering physician is not available. Verbal and telephone orders shall be limited to those circumstances in which patient care needs require them.

2. The following categories of personnel are authorized to accept and transcribe telephone orders and verbal orders from practitioners and staff affiliates:

   (a) Nursing – Registered Nurses;
   (b) Anesthesia – Certified Registered Nurse Anesthetists;
   (c) Pharmacy – Registered Pharmacists and pharmacy interns;
   (d) Rehab Services – Licensed Therapists;
   (e) Dietary – Registered Clinical Dietitians;
   (f) Respiratory Therapy – Respiratory Care Practitioners;
   (g) Case Management Supervisors & Social Workers;
   (h) Emergency Department – Paramedics.

   In all cases, the above personnel may only implement orders consistent with their scope of practice.

3. All orders must be comprehensible, clearly entered, and complete. Orders which are unclear, incomprehensible or improperly entered will not be carried out until re-entered.

4. All previous orders are cancelled when patients go to surgery. All post-operative patients must have orders re-entered for post-operative care.
5. All drugs and medications administered to patients at the Hospital shall be those listed in the Aurora Health Care Formulary. Drugs for bona fide clinical investigations may be exceptions, and shall be used in accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals, and all applicable laws and regulations of the Food and Drug Administration. All additions or deletions to the formulary are approved by the Pharmacy and Therapeutics/Nutrition Committee.

6. Except in an emergency, consultation is required in the following situations:
   
   (a) When an unusually complicated situation arises where specific skills of other Practitioners are needed. Judgment as to the complicated nature of the situation and any question of doubt as to the diagnosis and treatment rests with the physician responsible for the care of the patient.
   
   (b) When requested by the patient’s family.
   
   (c) Under such other conditions as are specified by the Medical Executive Committee.

7. Consultation is encouraged:
   
   (a) When the diagnosis remains obscure after appropriate diagnostic procedures.
   
   (b) When there is serious doubt regarding the choice of therapeutic measures.
   
   (c) Whenever it seems advisable to the attending physician.

8. The attending practitioner is responsible for requesting consultation and for calling in a qualified consultant with appropriate clinical privileges. Except in an emergency, the consulting practitioner may not attend to or examine the attending practitioner’s patient without the attending practitioner’s authorization as documented in the medical record.

9. Discharge planning shall be initiated through the Case Management Department upon admission in accordance with Hospital policy.

10. If a practitioner suspects abuse or neglect of a child or adult, he or she will prepare a report in accordance with Administrative Policy, Abuse, Neglect and Physical Assault.

D. GENERAL RULES REGARDING INVASIVE PROCEDURES

1. Informed consent shall be obtained prior to any procedure that involves more than minimal risk of harm to the patient, in accordance with Administrative Policy, Informed Consent.
   
   (a) Should the patient require an additional surgery or procedure during the same stay in the Hospital, a second informed consent, specific to the additional procedure, must be obtained.
   
   (b) If it is known in advance that two or more procedures will be performed at the same time, these procedures may be described and consented to on the same consent form.

2. Except in emergencies, the following must be documented in the patient’s medical record prior to any procedure:
   
   (a) Pre-operative diagnosis;
(b) Appropriate consent;
(c) Required laboratory, radiology, and diagnostic reports;
(d) Consultation reports, when applicable;
(e) History and physical examination report;
(f) Admission note, entered by the admitting practitioner, regarding the medical problems of the patient; and
(g) Note by the operating surgeon stating the indication for surgery and what surgery is planned.

3. The hospital policy on Universal Protocol will be followed for all invasive procedures regardless of where they are performed. Site marking will be done as appropriate when the procedure involves laterality.

4. It is the operating surgeon’s or other attending proceduralist’s responsibility to be readily available to the surgery suite prior to anesthesia induction.

5. All procedures performed at the Hospital shall be described by the operating surgeon in an operative report. The operative report must include, at a minimum, the following:

(a) The name of the operating surgeon and any assistants;
(b) The name of the procedure(s) performed;
(c) Findings of the procedure;
(d) A description of the procedure;
(e) Any specimen(s) removed;
(f) Postoperative diagnosis; and
(g) Any estimated blood loss.

6. The operative report shall be completed and documented by the operating surgeon in the patient’s medical record immediately following the procedure. The operative report must be completed before the patient is transferred to the next level of care.

7. Any practitioner with undictated operative reports 24 hours after the procedure shall be notified. The Chairperson of the HIM/CM/IT Committee shall submit to the Department Chairperson the names of practitioners who have been notified. It is the responsibility of the Department Chairperson to monitor trends and to determine if a practitioner shall be reported to the MEC.

(a) If an operative note cannot be entered immediately into the patient’s medical record, the operating surgeon may, in the interim, complete a progress note.
(b) The progress note must be entered immediately into the medical record, must include the same minimum elements required for an operative note, and must be entered into the patient's medical record before the patient is transferred to the next level of care.
8. The anesthesiologist or nurse anesthetist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation and post-anesthetic evaluation per policy *Documentation of Anesthesia Care*. Specimens removed during a procedure shall be sent to the Department of Pathology for examination, unless otherwise specified by the attending practitioner or Hospital policy. The pathologist’s authenticated report shall be made a part of the patient’s medical record.

E. **EMERGENCY SERVICES**

1. Appointees to the Medical Staff shall accept responsibility for emergency service care in accordance with emergency service policies and procedures.

2. The Emergency Room Medical Director shall have the overall responsibility for emergency care, subject to the authority of the Governing Body.

3. A physician shall be available to provide emergency patient care at the Hospital 24 hours per day, 7 days per week.

4. Per the hospital’s call/continuing care policies, members of the Medical Staff shall be available either personally or by designee, for Hospital emergencies involving their patients and during those times that the Medical Staff member is on call.

5. Each practitioner shall have a method for informing the emergency room and whoever may need to contact the practitioner, how or where the practitioner may be reached.

6. Medical Staff Policy, *Continuity of Care for Obstetrical Patients*, requires every practitioner with obstetrical privileges to have an approved call coverage plan. If an obstetrical emergency exists and the attending physician or his or her designee cannot be reached, the chief of the Obstetrics Department shall be notified.

7. An appropriate Emergency Room medical record shall be kept for every patient receiving emergency services and shall be incorporated in the patient's previous inpatient medical record, if such exists.

8. The Emergency Room medical record shall also include the following:

(a) Adequate patient identification;

(b) Information concerning the time and means of the patient’s arrival, including who transported the patient;

(c) Pertinent history of the injury or illness and physical findings, including vital signs, details relative to first aid or emergency care given the patient prior to the patient’s arrival at the Hospital and history of allergies;

(d) Description of significant clinical, laboratory and radiologic findings;

(e) Diagnosis, including condition of patient;

(f) Treatment given and plans for management;

(g) Final disposition, including instructions given to the patient and/or family as those instructions relate to necessary follow-up care, or the patient's condition on discharge or transfer;
(h) Clinical observations, including results of treatment;

(i) If the patient left the Hospital against medical advice, documentation regarding the incident as required by Hospital policy;

(j) A copy of any information made available to the practitioner or organization providing follow-up care; and

(k) Appropriate time notations, including the time of any physician notifications, administration of medications or and other treatments, and the time of discharge or transfer to a floor or unit of the Hospital or to another facility.

9. Each patient’s Emergency Room medical record shall be signed by the practitioner in attendance who is responsible for its clinical accuracy.

10. The Emergency Room Medical Director shall be responsible for the ongoing evaluation of the quality and appropriateness of patient care provided in the Emergency Room.

11. The Emergency Room medical record shall be available as part of the electronic medical record for patients being admitted to the Hospital from the Emergency Room.

12. Patient with conditions whose definitive care is beyond the capabilities of the Hospital shall be referred to the appropriate facility, when in the judgment of the attending practitioner, the patient's condition permits such a transfer. No patient shall be arbitrarily transferred, nor shall any patient be transferred without acceptance of the patient by the receiving facility and physician. A copy of all pertinent medical records shall be sent to the receiving facility upon transfer. The Hospital’s policies and procedures related to patient transfers to other facilities shall be followed at all times.

13. The Emergency Room Medical Director is responsible for proper coordination of emergency service procedures with the Hospital’s disaster plan.

14. Personnel Authorized to Perform Medical Screening Examinations

(a) Physician members of the medical staff and advanced practice professionals (that is, nurse practitioners and physician assistants) are authorized to perform medical screening examinations for emergency medical conditions.

(b) A registered nurse trained for labor and delivery that has completed the comprehensive orientation and skills inventory in accordance with professional standards and practice guidelines may perform a medical screening exam for specific presenting complaints.

F. FEE SPLITTING

No member of the Medical Staff shall receive from or pay to another member of the Medical Staff, either directly or indirectly, any part of a fee received for professional services.

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ADOPTED by the active medical staff on February 13, 2020.

Mohamed El-Jack, MD
President of the Medical Staff

APPROVED by the governing body on February 17, 2020.

Ed Harding
President
Edward A. Harding, FACHE

Dennis Potts
Chair, Advocate Aurora Health Wisconsin Hospital Board

2/26/2020
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