Banner Desert Medical Center

&

Cardon Children's Medical Center

Allied Health /Ancillary Staff
Rules and Regulations

September 2018

BANNER DESERT MEDICAL CENTER/CARDON CHILDREN'S MEDICAL CENTER

ALLIED HEALTH /ANCILLARY STAFF
RULES AND REGULATIONS

TABLE OF CONTENTS

ALLIED HEALTH/ANCILLARY STAFF PROFESSIONAL
RULES AND REGULATIONS

ARTICLE I: DEFINITIONS/CATEGORIES

Section I Definitions

Allied health professionals (AHPs) and Ancillary Staff (AS) are individuals who:

(a) Are qualified by training, experience, and current competence in a discipline permitted to practice in the hospital; and

(b) function in a medical support role to physicians who have agreed to be responsible for such AHPs and/or AS(s). AHPs/ASs are not members of the medical staff.

Section II Categories

As of the effective date of these Rules and Regulations the Board has authorized pursuant to these Rules and Regulations the following categories of Allied Health/Ancillary Staff Professionals to provide specified services in the Hospital:

1.2.1 Current AHP Categories.

a. Clinical perfusionists
c. Nurse practitioners (Advanced Practice Registered Nurse)
d. Certified Registered Nurse Anesthetists
e. Physician Assistants
f. Master's Level Social Workers
g. Master's Level Psychologists
h. Master's Level Psychiatric Nurses
i. Audiologists
j. Crisis Counselors
k. Optometrists
l. Certified Nurse Midwife

1.2.2 Current AS Categories.

a. Clinical neurophysiological intraoperative monitor
b. Non-Physician first assistants (RNFA/Certified Surgical Technician)
c. Private Scrubs
d. Orthopedic Assistants
e. Dental Assistants

1.2.3 New Categories: The Executive Committee may recommend to the Banner Board that additional AHP/AS categories be authorized to provide services in the Hospital or that AHP/AS categories be removed. Such change will be final once approved by the Executive Committee and the Banner Board.

Section III Departments

Each Allied Heath/Ancillary Staff Professional shall be assigned membership in at least one department and shall comply with the policies and procedures of each department. AHP/AS will be assigned to the same department as their Sponsoring/Supervising Physician. Refer to Medical Staff Bylaws, Section 9.1.1.1 if current Clinical Departments.

ARTICLE II: PURPOSE

The purpose of these Rules and Regulations is to establish the rules and procedures for credentialing and the authorized activities of Allied Health/Ancillary Staff Professionals who assist in the care of Hospital patients.

ARTICLE III: CONDITIONS OF AHP/PEROGATIVES, OBLIGATIONS, TERMS AND

CONDITIONS

Section I Prerogatives

A. The prerogatives of an AHP are to:

(a) Provide such specifically designated patient care services as are granted by the Board upon recommendation of the Executive Committee and consistent with any limitations stated in the Bylaws, the policies governing the AHPs practice in the Medical Center, and other applicable medical staff or Medical Center policies;

(b) Serve on committees when so appointed;

(c) Attend open meetings of the staff or the department; and

(d) Exercise such other prerogatives as the Executive Committee with the approval of the Board may accord AHPs in general or to a specific category of AHPs.

B. The prerogatives of an AS are to:

(a) Provide such specifically designated patient care services as are granted by the CEO upon recommendation of the Credentials Committee and consistent with any limitations stated in the Bylaws, the policies governing the AS practice in the Medical Center, and other applicable medical staff or Medical Center policies;

(b) Serve on committees when so appointed;

Section II Obligations

3.2.1 Each AHP and AS shall:

(a) Meet the basic responsibilities required by Part I and Part II of the Credentialing Procedures Manual for medical staff members;

(b) Meet the general qualifications required by Bylaws Section 3.2 Qualifications for Staff Membership for medical staff members;

(c) Retain appropriate responsibility within his or her area of professional competence for the care and supervision of each patient in the Medical Center for whom services are provided;

(d) Participate when requested in quality review program activities and in discharging such other functions as may be required from time to time;

(e) When requested, attend meetings of the staff, the department, and the section;

(f) Refrain from any conduct or acts that could be reasonably interpreted as being beyond the scope of practice authorized by the Board.

(g) Prior to practicing at BDMC/CCMC each AHP and AS is required to present to Medical Staff Services to obtain a BDMC/CCMC photo identification badge which has been verified by legible photo identification.

(1) The AHP is required to present legible Federal/State government issued photo identification (i.e. driver's license, passport, etc.)

3.2.2 Leave Of Absence Status:

As outlined in the Credentials Procedures Manual.

ARTICLE IV: APPOINTMENT/REAPPOINTMENT

4.1 General

The procedures for processing individual applications from AHP/AS for appointment and reappointment shall be established by the Credentials Committee, the Medical Executive Committee and the Board.

Applications must be completed accurately and completely and generally require the same information, same consents and same agreements as required by the Medical Staff application. (See Section – of the Medical Staff Bylaws for a complete listing of required information, consents and agreements.) Applications will be deemed to be voluntarily withdrawn if requested information is not submitted timely.

4.2 Processing the Application/Applicant's Burden

Every applicant for appointment and reappointment must document background, education,

experience, training and demonstrated competence, adherence to professional ethics, good reputation, health status so as not to compromise the care of patients, and ability to work with others. The applicant is responsible for producing sufficient information to allow a proper evaluation and to resolve any doubts about the applicant's qualifications. Applications not meeting compliance with the requirements for allied health staff or ancillary staff membership and scope of service will be deemed to be incomplete. Incomplete applications will not be processed.

4.3 Verification of Information

Applications shall be submitted to the Medical Staff Office. Representatives of the Medical Staff Office or its agent as approved by the Executive Committee and BH Board, working with the Credentials Committee, shall collect and verify references, licensures, and other qualification evidence submitted and notify the applicant of any problems in obtaining the required information. Upon such notification, it is the applicant's obligation to obtain the required information. When collection and verification is accomplished, the application shall be deemed to be preliminarily complete and shall be transmitted with all supporting materials to the chairman of the Credentials Committee.

Substance Testing. The applicant will be tested for use or abuse of alcohol and other controlled substance use. Testing will include urine, blood and/or hair testing. The applicant may be required to pay a portion of the cost of such testing and will be required to authorize the release of results to the Medical Staff.

4.4 Consents. Each applicant (and the applicant's sponsoring Medical Staff member when applicable) shall consent in writing to:

4.4.1 the inspection of all records and documents that may be material to the applicant's professional qualifications and current competence;

4.4.2 the release of information from other hospitals and organizations with which the applicant has been associated, from past and present malpractice insurance carrier(s), and from any Data Banks;

4.4.3 the use of any material misstatement in or omission from the application as grounds for denial or revocation of authority to practice in the Hospital.

4.4.4 the consultation by duly authorized representatives of the Hospital and Medical Staff with representatives of other hospitals, organizations and medical staffs for information bearing on the applicant's qualifications;

4.5 Agreements. Each applicant (and the sponsoring Medical Staff member when applicable) shall agree in writing to:

4.5.1 appear for interviews;

4.5.2 be bound by these Rules and Regulations and all pertinent Hospital and Medical Staff policies, bylaws and rules during the credentialing process and thereafter, whether or not authority to practice in the Hospital is granted.

4.5.3 abide by the applicant's professional code of ethics and State Board's professional conduct requirements.

4.5.4 notify Medical Staff Services, both during the application process and thereafter, within three (3) days of any lapse or change in professional liability coverage, employment, or authority to practice (supervise) and promptly of any other circumstances arising after

submission of the application that materially change information provided in the application;

4.5.5 exhaust the administrative remedies afforded by these Rules and Regulations before seeking external recourse as indicated in Article 8**.**

4.5.6 release from all liability those persons and organizations authorized to act on the processing of the application and evaluation of the applicant's qualifications, regardless of whether the applicant is authorized to provide services at the Hospital.

4.6 Application Process.

4.6.1 Credentials Committee. The Credentials Committee shall review the completed application, the supporting documents, and any other relevant information and determine if the applicant meets all of the necessary qualifications for AHP/AS membership and privileges as requested and refer its conclusion for final determination.

Prior to submitting a recommendation for final determination, the chairman of the Credentials Committee shall determine whether an application is expedited or routine. Applications meeting any of the following criteria may not be eligible for expedited review:

- Where there is a current challenge or previously successful challenge to an applicant's licensure or registration.
- Where the applicant has received an involuntary limitation, reduction, denial or loss of clinical scope of practice.
- Where the Credentials Committee determines that there has been either an unusual pattern of liability actions brought against the applicant, or an excessive number of professional liability actions resulting in a final judgment against the applicant.
- Any felony criminal conviction or any conviction involving healthcare.
- Adverse information on reference letters or comments suggesting potential problems.

4.6.2 Final Determination

Allied Health Professional

The Executive Committee, at its next regular meeting, shall review the application, the supporting documentation, the report and recommendation from the Credentials Committee and any other relevant information. The Executive Committee shall prepare a written report with recommendations as to approval or denial of, or any special limitations on, appointment, and prerogatives and scope of permission to provide patient care services, or defer action for further consideration.

Board

At its next regularly scheduled meeting, the Board or a subcommittee thereof may adopt or reject, in whole or in part, a recommendation of the Executive Committee or refer the recommendation back to the Executive Committee for further consideration stating the reasons for such referral. Favorable action by the Board or a subcommittee thereof is effective as its final decision. If the Board's action is adverse to the applicant in any respect, the CEO shall, by special notice, promptly so inform the applicant who is then entitled to procedural rights provided in these Rules and Regulations. Board action after completion of the procedural rights provided in the AHP Rules and Regulations or after waiver of these rights is effective as its final decision.

Ancillary Staff

The Credentials Committee shall report its actions to the Hospital Administrator for final review and approval. The Hospital Administrator (CEO or his/her designee) review concludes the AS application process. If the CEO/designee's action is adverse to the applicant in any respect, the CEO shall, by special notice, promptly so inform the applicant who is then entitled to procedural rights provided in these Rules and Regulations.

4.6.3 Interview. Committees authorized to make a recommendation or take action on the application may require a prior personal interview of the applicant.

4.6.4 Non-Discrimination. AHP/AS practice shall not be denied or limited on the basis of sex, race, creed, color, national origin, or any other criterion lacking professional justification.

4.7 Renewal of Privileges and/or Authorization to Practice. Consideration of renewal of authorization shall be by application not more than every two years, as provided in the Credentialing Procedures Manual. Renewals of authorization to practice at BDMC/CCMC are conditional upon the individual's demonstrated continuing competence, character, professional conduct, ethical behavior, health status, compliance with these Rules and Regulations, pertinent Hospital, Medical Staff and AHP/AS policies, rules and Bylaws, and fulfillment of responsibilities.

4.8 Breach. Breach of professional competence or conduct or any requirement of these Rules and Regulations, Medical Staff Bylaws, or hospital policy is grounds for Corrective Action.

4.9 Effect of Prior BDMC Adverse or Corrective Action. Reapplication subsequent to an Adverse or Corrective Action will not be considered for twenty-four (24) months following the effective date of any prior Adverse or Corrective Action. The AHP/AS must demonstrate that the basis for the earlier Adverse or Corrective Action no longer exists. If such information is not provided, the application/ request will be considered incomplete and voluntarily withdrawn.

ARTICLE V: OBLIGATIONS

5.1 Limitation of Practice. AHP/AS are authorized to perform only those activities expressly permitted under a duly approved "Delineation of Privileges/Scope of Practice." Every AHP/AS must be qualified to perform the requested duties.

5.2 Delineation of Privileges/Scopes of Practice. Each Delineation of Privileges/Scope of Practice shall be developed pursuant to Bylaws Article 5 and shall specify:

5.2.1 Authorized Activities. Each Delineation of Privileges/Scope of Practice shall delineate the authorized activities of the AHP/AS acting in a specific capacity. For example, it will state whether the AHP/AS performing a specific privilege or scope may make entries in the medical record, administer a medication, and write an order (and if so, whether the order must be confirmed by the supervising physician prior to being filled); and

5.2.2 Qualifying Criteria. Each Delineation of Privileges/Scope of Practice shall specify the qualifying criteria that each individual AHP/AS must satisfy to be authorized to practice at BDMC/CCMC in a specified capacity, including education, training, experience, certification, licensure, health status, demonstrated competence and judgment. Qualifying criteria must be approved by the Board on recommendation of the Medical Staff.

5.2.3 Documentation of Patient Care. AHP/AS who are expressly authorized by their scope or delineation of privileges to make entries in patient records shall document all patient care (including discharge planning and teaching) provided by the AHP/AS.

5.2.4 Dictated Reports. AHP/AS who are authorized to dictate reports into medical records

shall use their own dictation number and state the name of the attending/supervising Medical Staff member for whom they are dictating the report. Dictated reports must be forwarded to the attending/supervising Medical Staff member for counter-authentication in accordance with Medical Staff Rules and Regulations.

5.3 Temporary Practice Authority.
As outlined in the Medical Staff Bylaws.

ARTICLE VI: OPPE/FPPE

6.1 Allied Health Professional

6.1.1 Ongoing Professional Performance Evaluation (OPPE)
The Department Committee or its designee shall review findings at least every nine months regarding the AHPs ongoing professional practice and performance (OPPE). Such information may include:

a. Findings from quality review and utilization activities
b. Findings from reviews on behavior, conduct and professional ethics
c. Aggregate data on competence
d. Findings regarding the timely and accurate completion of medical records, if applicable
e. Compliance with applicable bylaws, rules and regulations, policies and procedures of the medical staff and Hospital.

6.1.2 Focused Professional Practice Evaluation (FPPE)
A period of focused professional practice evaluation will be conducted for all AHPs six to nine months after initial appointment or initial granting of privileges and as identified by the Department Committee or its designee in review of performance as outlined in Article VIII of these rules and regulations. At the time of initial appointment, each AHP will be subject to a retrospective review of three (3) cases performed at BDMC/CCMC. The three (3) cases must be cases which represent privileges granted.

6.2 Ancillary Staff
The performance of all ancillary staff will be evaluated on a yearly basis as part of the Department Committee's routine performance improvement processes. The annual competency assessment consists of a competency evaluation by a peer reference and a review of information received by the Department Committee or its designee.

ARTICLE VII: PERFORMANCE REVIEW

This Article 7 describes in general terms the processes for internal reporting of AHP/AS performance: to whom to report; who is responsible for making, receiving and verifying such reports; who is authorized to take action; and what constitutes taking action.

7.1 AHP/AS Performance

7.1.1 Reports to Department Committee. Any person who reasonably believes that an AHP/AS is practicing outside the scope, is or may be incompetent or unable to practice safely, is or may be guilty of unprofessional or disruptive conduct (not 8.1), or is otherwise engaged in activities inconsistent with these Rules and Regulations; or that a supervising Medical Staff member is not supervising the AHP/AS as required should report the reasonable belief to Medical Staff Services, either directly or indirectly through his/her supervisor. Medical Staff Services will communicate the report promptly to the Department Committee which will determine the truth of the alleged conduct. When so requested, the identity of the reporter shall be kept confidential to the extent permitted by law.

7.1.2 Complaints about unprofessional or disruptive conduct should be reported to, and dealt

with by, the Hospital department supervisor or Director. Serious concerns about conduct and/or futile attempts by the Hospital department supervisor to correct the conduct should be reported under 8.1.

7.1.3 Department Committee Action Options. The Committee shall:

a) Dismiss, if the report is unfounded.

b) Continue investigation, if further fact-gathering is necessary to come to a conclusion.

c) Take Corrective Action.

ARTICLE VIII: ADVERSE ACTION REVIEW AND APPELLATE REVIEW, AUTOMATIC AND NONREVIEWABLE ACTIONS

Section I Adverse Action Review and Appellate Process for Allied Health Professionals

8.1.1 Initiation of Adverse Action Review and Appeal Process

Allied Health Professionals ("AHPs") who are subject to Adverse Action (other than Nonreviewable or Automatic Actions defined below) shall be afforded an Adverse Action Review and appeal process in accordance with these Rules & Regulations. Adverse Action includes: denial of a request to provide any patient care services within the applicable Scope of Practice or revocation, suspension, reduction, limitation or termination of permission to provide any patient care services within the applicable Scope of Practice. AHPs are not entitled to due process rights set forth in the Medical Staff Bylaws, and none of the procedural rules set forth therein shall apply.

8.1.2 Notice of Adverse Recommendation or Action

Within fifteen (15) days after Adverse Action is taken against an AHP, the AHP shall be notified in writing of the specific reasons for the Adverse Action and the AHPs rights per these Rules & Regulations**.**

8.1.3 Request for Review of Adverse Recommendation or Action

The AHP may request an Adverse Action Review following the procedure set forth in these Rules & Regulations. If the AHP does not deliver a written request for an Adverse Action Review to the Chief Executive Officer within ten (10) days following the AHP's notice of the Adverse Action, the Adverse Action shall be final and non-appealable.

8.1.4 Composition of the Review Committee

The Medical Staff Department to which the AHP is assigned or departmental committee consisting of at least three members of the Department and a Nursing Administration representative will consider the request and serve as the Review Committee.

8.1.5 Notice of Time and Place for Review

The AHP shall be given ten (10) days prior written notice of the time, place and date of the Adverse Action Review and a list of witnesses, if any, that will be called to support the Adverse Action.

8.1.6 Statements in Support

The Medical Staff Representative and the AHP shall be entitled to submit a written statement in support and/or to introduce all relevant documentation by supplying two (2) copies of the statement and/or documentation to the Medical Staff Services Office at least five (5) days prior to the review.

8.1.7 Rights of Parties

During the Adverse Action Review, the parties will be given an opportunity to present relevant evidence, call witnesses and make arguments in support of their positions. Neither the AHP, Hospital nor the Medical Staff Representative shall be entitled to legal counsel at the Adverse Action Review or Appellate Review.

8.1.8 Burden Of Proof

The Medical Staff Representative has the initial obligation to present evidence in support of the adverse action or recommendation. Thereafter, the AHP has the burden of demonstrating, by a preponderance of the evidence, that the adverse action or recommendation lacks any substantial factual basis or is otherwise arbitrary, unreasonable, or capricious.

8.1.9 Action on Committee Review

Upon completion of the review, the Review Committee shall consider the information and evidence presented, make a recommendation, which shall include the basis therefor, and forward it to the Chief of Staff. The AHP and the Medical Staff Representative shall be provided with a copy of the Committee's recommendation.

8.1.10 Duty To Notify Of Noncompliance

If the AHP believes that there has been a deviation from the procedures required by this Adverse Action Review Plan or applicable law, the AHP must promptly notify the Chief of Staff of such deviation, including the Adverse Action Review Plan/Allied Health Professionals Rules & Regulations or applicable law citation. If the Chief of Staff agrees that a deviation has occurred and is substantial and has created demonstrable prejudice, he/she shall correct such deviation.

8.1.11 Request for Appellate Review

If the AHP is dissatisfied with the Committee's recommendation, such party may submit a written request for an Appellate Review, provided that the Chief Executive Officer receives such request within ten (10) days following the AHP's receipt of the Committee's recommendation. The request must identify the Grounds for Appeal and must include a clear and concise statement of the facts in support of the request. Grounds for Appeal include: that the Adverse Action Review failed to comply with these Rules & Regulations or applicable state law and that such noncompliance created demonstrable prejudice or that the Review Committee's recommendation was not supported by substantial evidence. If the request for an Appellate Review is not requested properly and/or timely, the Committee's recommendation shall become final and non-appealable.

8.1.12 Interview with Medical Executive Committee

Upon a proper and timely request for an Appellate Review, the AHP shall be given an interview with the Medical Executive Committee or a subcommittee thereof consisting of at least three (3) members. The AHP shall be given at least five (5) days prior written notice of the time, place and date of the Appellate Review. At the appeal, the parties shall be allowed to present written and/or oral arguments as to why the Committee's recommendation should be reversed or modified.

8.1.13 Final Determination by the Medical Executive Committee

The Medical Executive Committee shall make a final determination on the Adverse Action, which shall be provided to the parties. The decision of the Medical Executive Committee shall not be subject to further appeal.

The final decision will be submitted to the Medical Staff Subcommittee of the Board.

8.2 Grounds for Automatic Suspension. An AHP's/AS's authorization to practice shall be automatically suspended for the grounds outlined in the Medical Staff Bylaws and is final without a right to review except to resolve a bona fide dispute about whether the circumstances have occurred, which may be disputed by submitting a written statement to the Department Committee:

8.3 Non-reviewable Actions. In addition to automatic suspensions, the following actions are not reviewable under Article 7:

8.3.1 imposition of heightened supervision, consultation or other monitoring to determine if corrective action is warranted; to evaluate professional practices; or to protect patients pending review;

8.3.2 issuance of a warning or letter of admonition or reprimand;

8.3.3 termination or limitation of temporary authority to practice;

8.3.4 denial of authority for failure to complete an application or provisional requirements;

8.3.5 any requirement to complete an educational, health, psychiatric or psychological assessment, follow-up treatment, and/or training program;

8.3.6 termination of authority for lack of a required supervising physician.

If nonreviewable action is taken, the AHP/AS has the right to submit to the Department Committee information demonstrating why such action was not appropriate. The AHP/AS has no other right to appeal these actions.

Section II Adverse Action Review and Appellate Process for Ancillary Staff

8.1.1 Initiation of Adverse Action Review and Appeal Process

Ancillary Staff (AS) who are subject to Adverse Action (other than Nonreviewable or Automatic Actions defined below) shall be afforded an Adverse Action Review and appeal process in accordance with these Rules & Regulations. Adverse Action includes: denial of a request to provide any patient care services within the applicable Scope of Practice or revocation, suspension, reduction, limitation or termination of permission to provide any patient care services within the applicable Scope of Practice. ASs are not entitled to due process rights set forth in the Medical Staff Bylaws, and none of the procedural rules set forth therein shall apply.

8.1.2 Notice of Adverse Recommendation or Action

Within fifteen (15) days after Adverse Action is taken against an AS, the AS shall be notified in writing of the specific reasons for the Adverse Action and the AS's rights per these Rules & Regulations**.**

8.1.3 Request for Review of Adverse Recommendation or Action

The AS may request an Adverse Action Review following the procedure set forth in these Rules & Regulations. If the AS does not deliver a written request for an Adverse Action Review to the Chief Executive Officer within ten (10) days following the AS's notice of the Adverse Action, the Adverse Action shall be final and non-appealable.

8.1.4 Composition of the Review Committee

The Department Committee will consider the request and serve as the Review Committee.

8.1.5 Notice of Time and Place for Review

The AS shall be given ten (10) days prior written notice of the time, place and date of the Adverse Action Review and a list of witnesses, if any, that will be called to support the Adverse Action.

8.1.6 Statements in Support

The Medical Staff Representative and the AS shall be entitled to submit a written statement in support and/or to introduce all relevant documentation by supplying two (2) copies of the statement and/or documentation to the Medical Staff Services Office at least five (5) days prior to the review.

8.1.7 Rights of Parties

During the Adverse Action Review, the parties will be given an opportunity to present relevant evidence, call witnesses and make arguments in support of their positions. Neither the AS,

Hospital nor the Medical Staff Representative shall be entitled to legal counsel at the Adverse Action Review or Appellate Review.

8.1.8 Burden Of Proof

The Medical Staff Representative has the initial obligation to present evidence in support of the adverse action or recommendation. Thereafter, the AS has the burden of demonstrating, by a preponderance of the evidence, that the adverse action or recommendation lacks any substantial factual basis or is otherwise arbitrary, unreasonable, or capricious.

8.1.9 Action on Committee Review

Upon completion of the review, the Department Committee shall consider the information and evidence presented and make a decision, which shall be final. The decision will include the basis therefor, and will be forwarded it to the Chief of Staff. The AS and the Medical Staff Representative shall be provided with a copy of the Committee's recommendation.

8.1.10 Duty To Notify Of Noncompliance

If the AS believes that there has been a deviation from the procedures required by this Adverse Action Review Plan or applicable law, the AS must promptly notify the Chief of Staff of such deviation, including the Adverse Action Review Plan/Allied Health Professionals Rules & Regulations or applicable law citation. If the Chief of Staff agrees that a deviation has occurred and is substantial and has created demonstrable prejudice, he/she shall correct such deviation.

ARTICLE IX: DEPARTMENTS

Each AHP/AS is subject to pertinent provisions of the Policies and Procedures of his/her supervising Medical Staff member's Department. (See Medical Staff Bylaws at 5.13.2)

ARTICLE X: AMENDMENTS

11.1 All recommendations for amendment to these Rules and Regulations shall be made to the Bylaws Committee.

11.2 The Bylaws Committee will review recommendations for consistency with the rest of the AHP Rules and Regulations, Medical Staff Bylaws, Rules and Regulations, BHS policies.

11.3 The Bylaws Committee shall refer favorable recommendations to the Executive Committee for its recommendation to the Board.

MEC Approved: 8/02, 5/05, 6/7/12, 2/5/15, 3/2/17, 8/2/2018
Banner Board: 12/19/02, 7/05, 6/14/12, 2/12/15, 3/9/17, 9/13/2018