APPROVAL FOR RESIDENT MOONLIGHTING

Academic Year:

To Be Completed by Resident/Fellow

Please check type of activity you will be performing. One form is required per site.

Resident Name: PGY: Training Program:

Date Moonlighting Starts:

Moonlighting Employer (Facility Name, City, State):

Name of Moonlighting Supervisor: Maximum Hours/Week of Moonlighting:

Nature of Moonlighting Activity**:**

Colorado Medical License #: Expiration Date:

Name of Malpractice Carrier: Malpractice Policy # (if applicable):

Internal/External Moonlighting – Check one:

☐ External Moonlighting – The facility **IS NOT** a site of practice for your training program.
If External Moonlighting, personal DEA number

☐ Internal Moonlighting – The facility **IS** a site of practice for your training program.

Malpractice Insurance:

☐ I have independtly obtained malpratice insurance outside of the CU Trust
- Attach proof of malpractice insurance

☐ Malpractice is covered by the CU Trust as part of my CU SOM Instructor/Fellow appointment through my academic department
- Attach signed CU School of Medicine Instructor/Fellow Letter of Offer

Acknowledgment of Moonlighting Policy

- I understand that moonlighting activities are prohibited during regular program work hours, as defined by my Program Director.
- I acknowledge that my performance will be monitored for the effect of this activity. Adverse effects on achieving my program's goals and objectives may lead to rescinding this permission.

For ACGME Trainees:

- I understand that this activity will not be credited toward ACGME training program requirements.
- I understand that time spent moonlighting must be counted toward the 80-hour maximum weekly limit, as required by ACGME. I agree to submit another moonlighting approval form should the moonlighting location, activity, or hours change. I acknowledge that violation of the GME Moonlighting Policy constitutes a breach of the Resident Training

Agreement between University of Colorado School of Medicine and myself and may lead to corrective action.

- I attest that the moonlighting activity is outside the course and scope of my approved training program.

For External Moonlighting:

- I understand that the University of Colorado School of Medicine assumes no responsibility for my actions in connection with this activity. I will so inform the organization by which I am employed, and I will make no representation which might lead that organization or its patients to believe otherwise. While employed in this activity, I will not use or wear any items which identify me as affiliated with the University of Colorado School of Medicine, nor will I permit the organization by which I am employed to represent me as such.
- I give my Program Director permission to contact this moonlighting employer to obtain moonlighting hours for auditing purposes.
- I am not paid by the military or on a J-1 or H1B VISA.

By signing below, I also attest to all of the above statements:

Resident Signature:_____ Date:____

Program Director Approval - Obtain before submitting to GME Office

With my signature, I:

- approve this moonlighting
- affirm time spent moonlighting does not conflict with the schedule of the training program
- attest that this resident is in good standing (not on Focused Review nor Probation)
- attest that this resident is not on a J-1 or H1B Visa
- for ACGME trainees, I attest that the moonlighting duties/procedures are outside the course and scope of the training program
- for ACGME trainees, I agree to monitor this resident for work hour compliance and the effect of this activity performance, and
- may withdraw this permission if adverse effects are noted

Program Director Name (Print):

Program Director Signature: Date:

Approval – Completed by the GME Office

Associate Dean for Graduate Medical Education or Designee: Date:

FOR ACGME Trainees: Additional signatures required if moonlighting occurs at a UCHealth hospital other than UCH

Hospital Government Reimbursement Dept.

Date:

Hospital CFO Date: