

**APPROVAL FOR RESIDENT MOONLIGHTING**

**July 1, 2016-June 30, 2017**

To Be Completed by Resident/Fellow

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

\_\_\_\_\_ **External Moonlighting** - any medically-related professional activity, which is outside the course and scope of the approved training program, and takes place at a hospital, clinic, business, or other practice site that is not a site of practice for the program. You must have malpractice coverage purchased by either you or the hiring entity. You are not covered by the GME component of the University of Colorado malpractice insurance for this work. You are not supervised by an attending and you need a full Colorado medical license. Hours worked **DO COUNT** towards Duty Hours.

\_\_\_\_\_ **Internal Moonlighting**—any medically-related professional activity that is outside the course and scope of the approved training program and is provided in a site of practice for the program. You must have malpractice coverage purchased by either you or the hiring entity. You are not covered by the GME component of the University of Colorado malpractice insurance for this work. You are not supervised by an attending and you need a full Colorado medical license. GME Instructor/Fellow appointment required if moonlighting at UCH or Children’s Hospital Colorado (CHCO) in order to be covered under the Faculty Trust Malpractice Policy. Hours worked **DO COUNT** toward Duty Hours.

**Note: Internal Moonlighting Billing**—If a provider is submitting claims to payers for your professional services, the services submitted may only be provided in the outpatient setting and must be outside the course and scope of the approved training program..

Resident Name		PGY		Training Program:	
Date Moonlighting Starts:					
Moonlighting Employer (Facility Name, City, State):					
For External Moonlighting Only – Name of Contact Person:					
Maximum Number of Hours Per Week of Moonlighting:					
<b>Nature of Moonlighting Activity</b>					
Colorado Medical License #:		Expiration Date:			
Name of Malpractice Carrier:		Malpractice Policy #:			

**Acknowledgement of Moonlighting Policy**

**Important:** Initial to indicate that you have read and agree with each statement

I understand that moonlighting activities are prohibited during regular program duty hours, as defined by my Program Director. Additionally, I understand that this activity will not be credited toward my current training program requirements. \_\_\_\_\_

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. \_\_\_\_\_

I understand that time spent in Internal and External Moonlighting must be counted toward the 80-hour Maximum Weekly Hour Limit, as required by ACGME. \_\_\_\_\_

I understand that I am responsible for accurately recording all moonlighting duty hours in my program's duty hour tracking system. Failure to do so may result in Corrective Action and revocation of moonlighting privileges.

\_\_\_\_\_

I understand that the GME component of the University of Colorado malpractice insurance does not cover moonlighting activities outside the course and scope of my program. I hereby certify that I have professional liability insurance which covers any liability for this moonlighting.

\_\_\_\_\_

I agree to submit another form should the moonlighting location, activity, or hours change.

\_\_\_\_\_

I acknowledge that violation of the Moonlighting Policy set forth in the Resident Manual 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.

\_\_\_\_\_

Additional Questions For External Moonlighting Only:

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.

\_\_\_\_\_

By signing below, I also attest that I am not paid by the military nor on a J-1 Visa.

Resident Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

**Program Director Approval - Obtain before submitting to GME Office**

With my signature, I:

- 1) approve this moonlighting
- 2) attest that the moonlighting duties/procedures are outside the course and scope of the training program
- 3) attest that this resident is in good standing (not on Focused Review nor Probation)
- 4) attest that this resident is not on a J-1 Visa
- 5) agree to monitor this resident for duty hour compliance and the effect of this activity performance, and
- 6) may withdraw this permission if adverse effects are noted

\_\_\_\_\_  
Program Director Date: \_\_\_/\_\_\_/\_\_\_

**Final Approval - Completed by the GME Office**

\_\_\_\_\_  
Associate Dean for Graduate Medical Education or Designee Date: \_\_\_/\_\_\_/\_\_\_