SALESFORCE PHYSICIAN SUBMISSION
INSTRUCTOR/FELLOW or CHIEF RESIDENT

https://login.salesforce.com/

The following information is specific to what ACE needs in order to assign a CU Medicine billing number.

1. Department will create/update a Physician record within Salesforce* and attach the following documents:
    A. Completed/Signed Affidavit of Chief Resident or Fellow
        i. Sections 8-11 must be signed. If the answer is Yes for #11, an Approval for Moonlight Form must be completed and signed.
    B. Copy of signed letter of offer or FRF (required)
    C. Copy of medical school diploma
    D. Copy of Certificate of Residency completion **
    E. Copy of board certification (includes number and start/end dates)
    F. Copy of DEA (if applicable)
    G. Copy of driver's license
    H. Copy of current Colorado license (DORA)
    I. Copy of CV
    J. Copy of Social Security Card (requested)

2. All providers must have a National Provider Identifier (NPI). Full-time faculty must update their NPI to list Shanna Smith as the contact person. If a provider does not have an NPI one must be applied for and issued prior to submitting this request.

3. Once the Salesforce record is complete it will first be submitted to the DFA for review and approval before being submitted to ACE for review and approval.

4. The provider will attend CU Medicine Provider Orientation where he/she will sign paperwork. After this is completed his/her CU Medicine billing number will be activated.

* Salesforce help:
    Becca Morgan
    303-493-8341 UPI direct
    303-968-9312 cell phone
    Rebecca.Morgan@cumedicine.us

** If residency has not been completed more than one month prior to provider's start date please send the packet without the certificate of completion but send it to us as soon as the provider receives it.

*** For packet and instructions on how to obtain hospital privileges, please contact the Medical Staff Offices at Children's Hospital Colorado or University of Colorado hospital.

CU MEDICINE
AFFIDAVIT OF CHIEF RESIDENT OR FELLOW

ALL SECTIONS MUST BE COMPLETED AND SIGNED – NO EXCEPTIONS

LINES ONE THROUGH EIGHT TO BE COMPLETED BY THE CHIEF RESIDENT/FELLOW

1. Name_____

2. **If you are an International Medical Graduate (IMG), do you have a current J-1 clinical visa? YES**_____ **NO**_____ **NA**_____

3. Date of Instructor/Fellow appointment: _____ End Date:_____

4. Sub-specialty Training Program Name_____

5. Year in Program 1st_____ 2nd_____ 3rd_____ Other_____

6. Is this clinical year necessary for board eligibility? Yes_____ No_____

   Board Eligible in:_____

   Will your fellowship lead to a board certification by the **ABMS**? Yes_____ No_____

   Board Certified in: _____

7. Are you currently on **probation** in your training program? Yes_____ No_____

8. **Chief Resident/Fellow Certification**
   I attest to the accuracy of the information presented above.

   _____ _____
   Signature of Chief Resident/ Fellow Date

9. **Approval of Program Director**

   _____ _____
   Signature of Program Director Date

10. **Department Administrator Certification**

    Is this Fellow listed on the Hospital Cost Report? Yes_____ No_____

    Services provided are in a _____ Non-Provider or _____ Hospital Setting

    Salary source Account Number _____
    (Must not be hospital funds or federal funds)

    I accept full responsibility for the accuracy of the information presented above.

    _____ _____
    Signature of Department Administrator Date

11. GME Office Certification

Is this fellow in an ACGME Accredited Program? Yes_____ No_____

Moonlighting Form required for this Fellow? Yes_____ No_____

_____ _____
Signature of Ashley Walter GME Office Date

APPROVAL FOR RESIDENT MOONLIGHTING
July 1, 2017-June 30, 2018

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 <u>DO COUNT</u> 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 <u>DO COUNT</u> 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 <u>outpatient</u> 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:					
Nature of Moonlighting Activity					
Colorado Medical License #:		Expiration Date:			
Name of Malpractice Carrier:		Malpractice Policy #:			

Acknowledgement of Moonlighting Policy

<u>Important:</u> 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

_____ Date: ___/___/___

Program Director

Final Approval - Completed by the GME Office

_____ Date: ___/___/___

Associate Dean for Graduate Medical Education or Designee