PrimaryPlus Institutional Moonlighting Acknowledgement

Department:_____

Resident:_____

I am requesting the Program Director's permission to moonlight at:

Facilty:_____

City/State:_____

Contact_____ Phone #:_____

Approximate number of hours to moonlight monthly:_____

Medical License:_____ State:_____

Malpractice Insurance: _____

Carrier:_____ Policy #:_____

Residents are not required to engage in moonlighting. I acknowledge that I have received a copy of the PrimaryPlus institutional and program policies on moonlighting and I understand if found to be in violation of these policies I may face disciplinary action up to and including termination. Moonlighting must not interfere with the ability fo the resident to achieve the goals and objectives of the educational program. Time spent by residents in internal and external moonlighting must be counted towards the 80-maximum weekly hour limit. PGY-1 residents are not permitted to moonlight. The program director has the right to suspend or terminate moonlighting privileges at his/her discretion. The resident is required to maintain their own medical malpractice and other liability insurance as may be required for the services provided during moonighting. PrimaryPlus has no responsibility for any activities undertaken by the resident during moonlighting as this is not a part of their educational program. PrimaryPlus does not provide any assurances regarding capabilities of the resident providing the moonlighting services. I also understand that my performance will be monitored for the effect of these moonlighting activities upon performance and that adverse effects may lead to withdrawal of permission.

Resident signature:_____ Date:_____

This request has been reviewed and approved _____ or not approved _____ by the program director

PD signature:_____

If not approved, reason:_____