VCU Health System Resident/Fellow Moonlighting Policy

Request To Engage In Moonlighting Activity

Resident/Fellow Name: ______________________________________________________________________________

Training Program: ______________________________________  Current PGY Level: _________

Requested Moonlighting Site:  _________________________________________________________________

- Is this moonlighting activity (check one):
  - [ ] Internal (to be performed within VCUHS or the McGuire VA Hospital)
  - [ ] External (outside of VCU Health System and McGuire VA Hospital)

Estimated Hours per shift: _____________________________ Estimated Hours per week: _______________________

Description of duties: _______________________________________________________________________________

- I have submitted the following to the GME Office prior to submission: [Please check ALL that apply]
  - [ ] Copy of current full, unrestricted medical license [Temporary Training License is unacceptable]
  - [ ] Copy of insurance (malpractice) certificate showing coverage in force for outside employment

- I certify that I understand and agree to the following:
  - [ ] Outside employment will not be considered an excuse for poor job performance, absenteeism, tardiness, early departure, refusal to travel, refusal to work overtime or different hours, or refusal to accept additional assignments.
  - [ ] I have informed my outside employer that the residency or fellowship is of top priority. The outside employer has agreed to accommodate the residency or fellowship schedule and avoid conflicts with my educational program.
  - [ ] I will inform the program director of any changes, corrections or additions to moonlighting place, schedule, duties or total work hours. Additional moonlighting sites require an additional form.
  - [ ] I understand that internal moonlighting hours (VCUHS or McGuire VA Hospital) count toward the duty hour limit, and I will not moonlight in excess of my program’s limits.
  - [ ] My approval to moonlight may be revoked if difficulties with learning, performance, patient care, fatigue or other issues arise.
  - [ ] This approval is time-limited and applies for six (6) months.

- [ ] We understand that ALL moonlighting hours will be entered into New Innovations weekly.

(Resident Signature) _______________ PRINT NAME ___________________________ Date: ___________

(Program Coordinator Signature) PRINT NAME ___________________________ Date Approval Received: ___________

(Program Director Signature) PRINT NAME ___________________________ Date Approval Received: ___________

VAMC MOONLIGHTER: ______________________________________ Approval Given: __________________________

(ACOS/E, VAMC: Dr. Lenore Joseph) [Date]

Approval Given: ___________________________ Entered Into NI: ___________________________

(Director, VCUHS GME: Dr. Brian Aboff) [Date] [Date]