

Internal Moonlighting Request Form

For residents and fellows (hereinafter referred to as "residents")

PART I:

To be completed by requestor: (Requestor is individual who wants to utilize resident's services)

1. Name of requestor:

2. Requestor's department and contact information (phone/e-mail):

3. Name of resident:

4. Training specialty and PGY of resident:

5. Describe proposed "Moonlighting" Activity: (Be specific. Describe the services that will be provided and the patient population that the services will be rendered to.)

6. Effective Date(s) and Times: _____

I have reviewed the credentials of this individual and affirm that he/she is qualified to perform this moonlighting activity. I affirm that the duty hours for the core-training program will not be violated under the terms of this moonlighting arrangement. I understand the restrictions placed on residents by the ACGME and will not place the institution at risk with conflicts under this arrangement. I have discussed the proposal with the resident and the resident understands these limitations.

Requestor's Name (print)

Date

Requestor's Signature

Forward form to the resident's Residency Program Director

PART 2:

To be completed by Residency Program Director:

1. Is resident on a visa which prohibits moonlighting? (if unsure, contact GME office). If yes, cannot pursue.

Yes No

2. Is the resident/fellow qualified to function independently and bill for services identified in this request without senior faculty supervision? If no, then resident cannot do. If yes, then please indicate specialty.

Yes No Specialty _____

3. Does this resident have approval to moonlight documented in his/her file: Yes No

4. Are you in agreement with your resident participating in this activity: Yes No

If no, the process is to be terminated. Residency Program Director should communicate such to the Requestor.

5. Does participation in this activity pose a problem in relation to the ACGME's duty hour requirements? Yes No

6. Describe any limitation(s) on this moonlighting activity you care to impose:

Residency Program Director Name:(Print)_____

Phone:_____

Residency Program Director's Signature:_____ Date: _____

If approval granted, forward form to the Office of the Graduate Medical Education

PART 3:

To be completed by GME Office:

- Yes No Licensed MD in State of Kentucky
- Yes No In an approved program certified by the ACGME
- Yes No Certificate available by a member board of the ABMS
- Yes No Included in resident count for DME payment under Medicare Part A

Comments: _____

Name (Print): _____

Authorized Signature

Date

Return completed information to MMCC.

PART 4:

To be completed by MMCC:

- Yes Resident/Fellow approved for requested moonlighting activity. Medical malpractice insurance will cover this activity.

Describe limitations, if any:

- No Resident/Fellow was not approved by the MMCC for participation in the moonlighting activity.

Comments:

(Return form to requestor)

Name (Print): _____

Authorized Signature: _____

Date: _____

If approved, return completed information to KMSF and Medical Staff Affairs Office.

PART 5:

To be completed by KMSF:

- Yes Resident/Fellow approved for billing capabilities

- No

- Yes, but with the following limitations: _____

Name (Print): _____

Authorized Signature: _____

Date: _____

Return completed form to Requestor, Residency Director, GME Office, and Medical Staff Affairs Office