GME Graduate Medical Education

UMKC School of Medicine

UMKC Medical Resident/Fellow MOONLIGHTING APPROVAL FORM

Name:_____
Last First Middle

Social Security Number/Employee ID No._____ Pager No._____

E-mail:_____ Contact Tel. No:_____

Department:_____

Requested Dates: From_____ To:_____
MM/DD/YR MM/DD/YR

Place of Moonlighting:_____

Contact Information: Name_____ Telephone No._____

Professional Liability Coverage Provided: Yes { } No { }

Name and Address of the Insurance Carrier:_____

_____

(Attach to this form a copy of the Certificate of Insurance)

Certificate: I understand that the duty hours spent in moonlighting and as a Resident/Fellow at UMKC does not exceed 80 hours per week, averaged over a four week period. I am responsible for keeping track of my duty hours.

_____ _____
Resident/Fellow Signature Date

Approval

Request Approved from _____ to _____
(begin date) (end date)

_____ _____
Program Director Date

_____
Office of GME Official Date

*** A signed copy will be sent to the resident/fellow and the department ***

Approved by the Graduate Medical Education Council on September 18, 2003. Modifications incorporated on September 26, 2008.