UNIVERSITY OF IOWA HOSPITALS AND CLINICS

INDIVIDUAL MOONLIGHTING REQUEST FORM (MRF)

- **PRINT OR TYPE ALL INFORMATION**
- **FORM TO BE COMPLETED BY THE INDIVIDUAL RESIDENT/FELLOW FOR EITHER EXTERNAL OR INTERNAL MOONLIGHTING ACTIVITIES**

1. PROGRAM NAME:	2. PROGRAM DIRECTOR:
3. RESIDENT OR FELLOW NAME:	4. LEVEL OF TRAINING:
5. MEDICAL LICENSE NUMBER:	6. ACADEMIC YEAR FOR THIS REQUEST: (NOTE: A NEW MRF MUST BE FILED WITH THE GME OFFICE FOR EACH ACADEMIC YEAR)
7. IS THE RESIDENT/FELLOW A J-1 OR J-2 VISA HOLDER? □ YES □ NO	*J-1 VISA HOLDERS CANNOT MOONLIGHT.

- **SITE INFORMATION**

8. CONTACT AT MOONLIGHTING SITE:	9. CONTACT'S TELEPHONE NUMBER AND E-MAIL:
10. NAME OF CLINIC, UNIT OR HOSPITAL:	11. CITY/STATE:
12. DESCRIBE THE MOONLIGHTING ACTIVITY AND THE REASON FOR THIS MOONLIGHTING ACTIVITY:	
13. DESCRIBE THE MALPRACTICE COVERAGE YOU WILL RELY UPON WHILE AT THE MOONLIGHTING SITE (IF APPLICABLE):	
14. LIST ALL OTHER CURRENT MOONLIGHTING SITES:	

14. WILL THIS ACTIVITY CAUSE YOU TO VIOLATE DUTY HOUR LIMITATIONS?	□ YES □ NO
15. CLARIFY WHEN THIS MOONLIGHTING ACTIVITY WILL OCCUR AND HOW FREQUENTLY YOU WILL PARTICIPATE: (ESTIMATE TYPICAL NUMBER OF HOURS PER WEEK OR PER MONTH FOR THIS MOONLIGHTING)	
16. WILL THIS ACTIVITY:	
• INTERFERE WITH YOUR ABILITY TO ACHIEVE THE GOALS AND OBJECTIVES OF YOUR TRAINING PROGRAM?	□ YES □ NO
• INTERFERE WITH YOUR FITNESS FOR WORK WITHIN YOUR TRAINING PROGRAM?	□ YES □ NO
• COMPROMISE PATIENT SAFETY AT UIHC?	□ YES □ NO

Acknowledgment, Authorization and Release:

I understand that:

- I cannot be required to moonlight. My signature below is my attestation that I am not being required to moonlight.
- If this request is approved, its duration cannot exceed the length of my current GME Contract.
- This approval must be obtained *prior to* the activity occurring and may be revoked at any time pursuant to department or GMEC policy.
- By engaging in moonlighting external to UIHC I do so as a private practitioner and that neither the UIHC nor my Program Director accepts any responsibility for my Non-Program Activity.
- Any proposal for internal moonlighting at UIHC must be proposed by my Program Director and Approved by the GME Associate Dean Prior to my participation.
- A State of Iowa "Resident Physician" or "Resident Dental" license is not valid for activity outside my training program and that I am solely responsible for obtaining appropriate**,** Permanent licensure, including the renewal of my license to ensure that it has not expired. (Note: The Iowa Board of Medicine advises that once a physician receives a permanent license, the Board does not allow that physician to return later to a lesser license such as a resident, temporary or special license.)
- I am responsible for all liability or other legal matters associated with moonlighting external to UIHC, and I must obtain and maintain adequate medical malpractice insurance. I attest that I have obtained adequate malpractice insurance to cover my moonlighting, as required.
- If my commitment to this moonlighting activity changes from what is specified in this MRF, I will notify my Program Director immediately and Modify this request.

I hereby authorize UIHC, its clinical staff and their representatives to consult with members of the administration and medical staffs of other hospitals for whom I have engaged in moonlighting and to consult with malpractice carriers for the purpose of verifying the nature, scope and schedule of any professional activity.

I hereby release from liability the UIHC, its clinical staff and all representatives of the UIHC for their acts performed without malice in connection with evaluating this application and monitoring my professional activities. I hereby release from liability any and all individuals and organizations who provide information to the UIHC, or to members of its clinical staff or representatives, without malice, concerning moonlighting activities in which I engage including but not limited to work hours, nature and scope of duties and performance thereof, and I hereby consent to the release of such infomration.

I have read and understand that all Duty Hour limitations apply as described in the *UIHC Moonlighting Policy and Procedures for House Staff Physicians and Dentists*; my failure to adhere to this policy and the procedures outlined within it can be grounds to Revoke approval to moonlight OR grounds for my immediate dismissal from the training program.

Signature of House Staff Member (**Required**)	Date*	Signature of Site Director of Moonlighting Activity (**Required**)	Date

I Certify that this resident/fellow is in good standing and I approve this request. As Program Director, I will monitor moonlighting activities to ensure Compliance with all UIHC, GMEC and ACGME Policies and Standards related to Moonlighting:

		Signature of Department Chair (DEO) (**if** Required by Department or Program)	Date
Signature of Program Director (**Required**)	Date	**IF** REQUIRED BY DEPARTMENT: Signature of Department GME Director	Date

*Permission to moonlight at must be obtained prior to the activity occurring. This completed form must be filed with the GME Office at C123 GH.