UNIVERSITY OF IOWA HOSPITALS AND CLINICS

MOONLIGHTING REQUEST FORM (MRF)

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

PROGRAM NAME:	PROGRAM DIRECTOR:
RESIDENT OR FELLOW NAME:	LEVEL OF TRAINING:
"PERMANENT" LICENSE NUMBER AND STATE:	ACADEMIC YEAR FOR THIS REQUEST:

- SITE INFORMATION

CONTACT AT MOONLIGHTING SITE:	CONTACT'S TELEPHONE NUMBER:
NAME OF CLINIC OR HOSPITAL:	CITY/STATE:
DESCRIBE THE MOONLIGTHING ACTIVITY AND THE REASON FOR THIS MOONLIGHTING ACTIVITY:	
DESCRIBE THE MALPRACTICE COVERAGE YOU WILL RELY UPON:	
LIST ALL OTHER CURRENT MOONLIGHTING SITES:	

WILL THIS ACTIVITY CAUSE YOU TO VIOLATE DUTY HOUR LIMITATIONS?	□ YES □ NO
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)	
WILL THIS ACTIVITY INTERFERE WITH YOUR EDUCATIONAL OR CLINICAL DUTIES AS A RESIDENT OR FELLOW?	□ YES □ NO

ACKNOWLEDGMENT, AUTHORIZATION AND RELEASE:

I UNDERSTAND THAT:

- I CANNOT BE 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 OUTSIDE PRACTICE.
- ANY PROPOSAL FOR INTERNAL MOONLIGHTING AT UIHC MUST BE PROPOSED BY MY PROGRAM DIRECTOR AND APPROVED BY THE GME DIRECTOR PRIOR TO MY PARTICIPATION.
- AS A STATE OF IOWA "RESIDENT PHYSICIAN" OR "RESIDENT DENTAL" LICENSE IS NOT VALID 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 EXTERNAL MOONLIGHTING.
- 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 CLINCIAL 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.

Additional Approvals as Required by the Applicant's Department:

SIGNATURE OF HOUSE STAFF MEMBER	DATE*	SIGNATURE OF DEPARTMENT CHAIR (IF REQUIRED BY DEPARTMENT OR PROGRAM)	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 NO INTERFERENCE WITH THE HOUSE STAFF MEMBER'S ABILITY TO ACHIEVE THE PROGRAM'S EDUCATIONAL GOALS AND OBJECTIVES.

SIGNATURE OF PROGRAM DIRECTOR	DATE	SIGNATURE OF DEPARTMENT GME DIRECTOR (IF REQUIRED BY DEPARTMENT OR PROGRAM)	DATE

*Permission to moonlight at any site must be obtained prior to the activity occurring.
This completed form must be filed with the GME Office through Mary Reichardt at C123 GH or mary-reichardt@uiowa.edu.

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INTERNAL MOONLIGHTING PROPOSAL

UIHC's *Moonlighting Policy and Procedures for House Staff Physicians and Dentists* defines internal moonlighting as an activity which is outside the responsibilities of a house staff member but occurs at UIHC. Internal moonlighting occurs infrequently. All internal moonlighting must be approved by the GME Director prior to the house staff member engaging in it. Any modification to an approved internal moonlighting proposal must be reviewed and approved by the GME Director prior to its commencement.

DESCRIBE THE INTERNAL MOONLIGHTING ACTIVITY PROPOSED, THE REASON FOR THE ACTIVITY, AND LOCATION:
WILL A SUPERVISOR BE IMMEDIATELY AVAILABLE? □ YES □ NO IS THE RESIDENT/FELLOW REQUIRED TO INTERNALLY MOONLIGHT? □ YES □ NO
PROVIDE AN EXAMPLE OF A TYPICAL WEEKLY OR MONTHLY SCHEDULE OF MOONLIGHTING FOR THIS ACTIVITY:
DESCRIBE THE MALPRACTICE COVERAGE THAT WILL BE IN PLACE FOR THIS INTERNAL MOONLIGHTING PROPOSAL:

SIGNATURE OF PROGRAM DIRECTOR (REQUIRED) _____ DATE _____

SIGNATURE OF DEPARTMENT GME DIRECTOR (IF REQUIRED BY DEPARTMENT OR PROGRAM) _____ DATE _____

SIGNATURE OF SITE DIRECTOR OF MOONLIGHTING ACTIVITY (REQUIRED) _____ DATE _____

SIGNATURE OF DEPARTMENT GME DIRECTOR (IF REQUIRED BY DEPARTMENT OR PROGRAM) _____ DATE _____

MARK C. WILSON, MD, MPH, GME DIRECTOR (REQUIRED) _____ DATE _____