

**MOONLIGHTING REQUEST FORM (MRF)**

PROGRAM NAME:		PROGRAM DIRECTOR:	
TRAINEE'S NAME:		LEVEL OF TRAINING:	
PERMANENT LICENSE NUMBER:		NUMBER OF HOURS PER WEEK DEVOTED TO THIS ACTIVITY:	
NAME OF CONTACT AT MOONLIGHTING SITE:		CONTACT'S TELEPHONE NUMBER:	
NAME OF CLINIC OR HOSPITAL:		CITY/STATE:	
DESCRIBE THE <b><u>MALPRACTICE INSURANCE</u></b> COVERAGE THAT WILL COVER THE RESIDENT/FELLOW DURING THIS MOONLIGHTING ACTIVITY:			
STATE THE <b><u>REASON(S)</u></b> FOR THIS MOONLIGHTING REQUEST:			
DESCRIBE THE TYPE OF PROFESSIONAL ACTIVITY TO BE ENGAGED IN AND ITS EDUCATIONAL VALUE, INCLUDING <b><u>SPECIFIC DAYS AND TIMES</u></b> :			
LIST ALL <b><u>OTHER CURRENT MOONLIGHTING SITES</u></b> :			

**ACKNOWLEDGMENT, AUTHORIZATION AND RELEASE:**

I UNDERSTAND THAT IF THIS REQUEST IS APPROVED, THE **APPROVAL IS FOR ONLY ONE PROGRAM YEAR**. I UNDERSTAND THAT THIS **APPROVAL MUST BE OBTAINED PRIOR TO THE ACTIVITY** OCCURRING AND MAY BE REVOKED AT ANY TIME PURSUANT TO DEPARTMENT POLICY. I FURTHER UNDERSTAND THAT BY ENGAGING IN PROFESSIONAL ACTIVITY OUTSIDE THE TRAINING PROGRAM I DO SO AS A PRIVATE PRACTITIONER AND THAT NEITHER THE UIHC NOR MY PROGRAM DIRECTOR ACCEPT ANY RESPONSIBILITY FOR MY OUTSIDE PRACTICE. **I UNDERSTAND THAT A STATE OF IOWA “RESIDENT PHYSICIAN” OR “RESIDENT DENTAL” LICENSE IS NOT VALID OUTSIDE THE TRAINING PROGRAM AND THAT I AM SOLELY RESPONSIBLE FOR OBTAINING APPROPRIATE LICENSURE.** I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR ALL LIABILITY OR OTHER LEGAL MATTERS ASSOCIATED WITH SUCH OUTSIDE PROFESSIONAL ACTIVITY, INCLUDING OBTAINING AND MAINTAINING ADEQUATE MEDICAL MALPRACTICE INSURANCE. I ATTEST THAT I HAVE OBTAINED ADEQUATE MALPRACTICE INSURANCE TO COVER MY OUTSIDE PRACTICE. I UNDERSTAND THAT ALL UIHC AND DEPARTMENTAL DUTY HOUR POLICIES APPLY. IF MY COMMITMENT TO THIS MOONLIGHTING ACTIVITY CHANGES FROM WHAT IS SPECIFIED IN THIS MRF, I WILL NOTIFY MY PROGRAM DIRECTOR IMMEDIATELY.

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 OUTSIDE PROFESSIONAL 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 THIS INFORMATION.

I HAVE READ AND UNDERSTOOD THE *UIHC POLICY AND PROCEDURES REGARDING PROFESSIONAL ACTIVITY OUTSIDE THE TRAINING PROGRAM BY PHYSICIANS AND DENTISTS*, AND I UNDERSTAND THAT MY FAILURE TO ADHERE TO THIS POLICY AND THE PROCEDURES OUTLINED THEREIN CAN BE GROUNDS FOR MY IMMEDIATE DISMISSAL FROM THE TRAINING PROGRAM.

\_\_\_\_\_  
SIGNATURE OF HOUSE STAFF MEMBER

\_\_\_\_\_  
DATE\*

I APPROVE THIS REQUEST:

\_\_\_\_\_  
SIGNATURE OF PROGRAM DIRECTOR

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF DEPARTMENT CHAIR IF REQUIRED

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF DEPARTMENT GME DIRECTOR, IF REQUIRED

\_\_\_\_\_  
DATE

Approved by Graduate Medical Education Committee	9/2/03
Approved by University Hospital Advisory Committee	11/5/03

**\*Permission to moonlight at any site must be obtained prior to the activity occurring.**