CARILION CLINIC

VTC Virginia Tech Carilion School of Medicine

REQUEST FOR APPROVAL TO MOONLIGHT

PLEASE TYPE OR PRINT (Incomplete or illegible forms will be returned to you)

Resident/Fellow Name:_____

Program Name: _____

Program Director: _____

Site and Times of Activity: _____

Estimated number of hours per block and proposed schedule:_____

Beginning and End Dates of Approval: _____
Approval expires on June 30th. A new request must be submitted for each academic year.

MUST be approved by the Program Director prior to commencement of duties. The performance of the resident/fellow will be monitored by the Program Director and the Clinical Competency Committee for the effect of moonlighting activities on the resident's/fellow's training, and any adverse effects may lead to withdrawal of permission. **Moonlighting is not permitted for PGY1 level trainees or holders of a J-1 Training Visa.**

The resident/fellow must initial each of the following criteria for moonlighting:

_____ The resident/fellow named above has a permanent medical license, if moonlighting outside of Carilion Clinic.

_____ Adequate malpractice/liability coverage is obtained if moonlighting outside of Carilion Clinic.

_____ The resident has appropriate training skills to carry out assigned duties.

_____ The total number of hours worked, including moonlighting in primary program and/or sponsoring institution and the participating institution do **NOT** exceed 80 hours per week, averaged over a four week period.

_____ **Residents performing any moonlighting must record all hours (regular program hours and moonlighting hours in MedHub).**

Signature of Resident/Fellow: _____ Date: _____

Signature of Program Director: _____ Date:_____

Additional Signature: _____ Date:_____

The above moonlighting hours as defined above in our program and/or participating institution have been included in the 80 hour/week limit for the resident.

Signature of DIO: _____ Date: _____