



INSTITUTIONAL MOONLIGHTING ACKNOWLEDGMENT

Department _____ Resident _____
I am requesting the Chairman/Residency Program Director's permission to moonlight.

Name, location, and contact at institution in which moonlighting occurs:

Facility: _____

City/State: _____

Contact: _____ Phone #: _____

Approximate number of hours to moonlight each month: _____

Medical License: _____ (State) _____ (License #)

Malpractice insurance: _____

_____ (Carrier) _____ (Policy #)

Residents are not required to engage in moonlighting. I acknowledge that I have received a copy of the James H. Quillen College of Medicine institutional and program policies on moonlighting and I understand if found to be in violation of these policies I may face disciplinary action up to and including termination. Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program. Time spent by residents in Internal and External Moonlighting must be counted towards the 80-maximum weekly hour limit. PGY-1 residents are not permitted to moonlight. The Program Director has the right to suspend or terminate moonlighting privileges at his/her discretion. The resident is required to maintain their own medical malpractice and other liability insurance as may be required for the services provided during moonlighting. East Tennessee State University, James H. Quillen College of Medicine has no responsibility for any activities undertaken by the resident during moonlighting as this is not a part of their educational program. East Tennessee State University, James H. Quillen College of Medicine does not provide any assurances regarding capabilities of the resident providing the moonlighting services. I also understand that my performance will be monitored for the effect of these moonlighting activities upon performance and that adverse effects may lead to withdrawal of permission.

Resident/Date

This request has been reviewed and approved ___ or not approved ___ by the Chairman/Program Director.

Chairman/ Program Director/Date

If not approved, reason for no approval _____