APPROVAL FOR RESIDENT MOONLIGHTING
(This form is to be completed prior to commencing moonlighting activity.)

TO BE COMPLETED BY RESIDENT

Please check type of activity you will be performing. One form per site.

_____ **External Moonlighting - defined as any professional activity, which is outside the course and scope of your approved training program, and takes place at a hospital/clinic which is not a site of practice for your program. You must have malpractice coverage which either you or the entity hiring you for this moonlighting service has purchased. You are not covered by your GME malpractice insurance for this work, you are not supervised by an attending and you need a full Colorado medical license. Hours worked do not count towards Duty Hours.**

_____ **Internal Moonlighting (when you bill under your name) – defined as professional activity that is outside the course and scope of your approved training program and is provided in the outpatient setting only at a site of practice for your program. You must have malpractice coverage which either you or the entity hiring you for this moonlighting service has purchased. You are not covered by your GME malpractice insurance for this work, you are not supervised by an attending and you need a full Colorado medical license. Hours worked DO COUNT towards Duty Hours.**

_____ **Internal Moonlighting (when you do not bill under your name) – defined as professional activity that is outside the course and scope of your approved training program and is provided in the inpatient setting only at a site of practice for your program. You must have malpractice coverage which either you or the entity hiring you for this moonlighting service has purchased. You are not covered by your GME malpractice insurance for this work, you are not supervised by an attending in your program and you need a full Colorado medical license. Hours worked DO COUNT towards Duty Hours.**

_____ **Additional Pay for Additional Work – defined as professional activity that is within the course and scope of your approved training program. Your GME malpractice insurance covers this activity. You are supervised by an attending and this activity can be done with a training license. Hours worked DO COUNT towards Duty Hours.**

Name of Resident: _____ Date Moonlighting Starts : _____

Location (name, city and state) of Proposed Moonlighting: _____

Specific Dates and Hours of Proposed Moonlighting: _____
OR
Maximum Number of Hours Per Week of Moonlighting: _____

Nature of Moonlighting Activity: _____

Colorado Medical License # _____

Name of Malpractice Carrier: _____Malpractice Policy #: _____

_____ _____ _____
Signature of Resident Program Date

TO BE COMPLETED BY PROGRAM DIRECTOR (please check)

I approve the above request to do _____ external moonlighting _____ internal moonlighting _____ additional work as described above.

___ This resident is not on probation ___ This resident does not hold a J-1 visa. ACGME program? Y N

_____ _____
Signature of Program Director **Date**

_____ _____
GME Office Verification **Date**

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