Acknowledgement of Supplemental Clinical Activity Policy

Please initial after each of the following statements.

I understand that supplemental clinical activities are voluntary and prohibited during regular UAMS work hours, as defined by my Program Director and/or Department Chair. Additionally, I understand that this activity will not be credited toward my current training program requirements. _____

I understand in requesting approval for any supplemental clinical activity, my performance will be monitored for the effect supplemental activities have upon patient care responsibilities and education performance related to ACGME requirements, and if the supplemental activities adversely affect either of these areas of care or learning, then permission to participate may be withdrawn. _____

I understand that time spent in supplemental clinical activities must be counted toward the 80-hour maximum weekly limit, as required by the ACGME. _____

I understand that I am responsible for accurately recording all work hours including regular duty, moonlighting, and supplemental clinical activities in my institution's work hour tracking mechanism. Failure to do so could result in corrective action and suspension of supplemental clinical privileges. _____

I understand that supplemental clinical activities are prohibited during CAVHS rotation months/blocks. _____

I agree to submit another form should the location, activity, or hours given on this form change. _____

I acknowledge that violation of this policy constitutes a breach of the House Staff Agreement between UAMS Medical Center and myself and may lead to Corrective Action. _____

Resident/Fellow Signature:

Name_____Signature_____Date_____