

Resident/Fellow Acknowledgement of Moonlighting Policy

Please initial each of the following statements.

_____ I understand that moonlighting activities are 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 moonlighting activity, my performance will be monitored for the effect moonlighting activities have upon patient care responsibilities and education performance related to ACGME requirements, and if the moonlighting activities adversely affect either of these areas of care or learning, then permission to moonlight may be withdrawn.

_____ I understand that time spent in internal/external moonlighting 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 activity hours in my institution's work hour tracking mechanism. Failure to do so could result in corrective action and suspension of moonlighting privileges.

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

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

_____ I have obtained a malpractice insurance policy that will cover the moonlighting activity being performed outside of my training program.

_____ I understand that should I have a professional liability claim while moonlighting, I will notify the UAMS Director, Insurance and Claims Management within 30 days of notice.

_____ I understand that I must receive approval from GME before agreeing to work any supplemental clinical activity shifts. I understand that I am not approved for supplemental clinical activity until I receive an approval email from the GME Accreditation Manager.

Resident/Fellow Signature:

Name _____ Signature _____ Date _____