



FRANCISCAN MISSIONARIES OF OUR LADY  
HEALTH SYSTEM

<b>RESPONSIBLE DEPARTMENT:</b> SFMC GME		<b>SUBJECT:</b> Resident Moonlighting
<b>PAGES:</b> 3		<b>REPLACES POLICY DATED:</b> N/A
<b>ORIGINAL EFFECTIVE DATE:</b> 10/13/20	<b>REVISION EFFECTIVE DATE:</b> N/A	<b>POLICY NUMBER:</b> GME-ADM-20

**PURPOSE:**

To establish criteria for SFMC sponsored residents participating in Moonlighting activities.

**DEFINITIONS:**

Moonlighting: Professional activities outside of the scope of the residency program, which includes volunteer work or service in a clinical setting, or employment that is not required by the residency program.

**POLICY:**

- A. Residency training is a full-time educational endeavor. It will be the responsibility of the Program Director to ensure that the resident's moonlighting activities do not interfere with the ability of the resident to achieve the goals and objectives of the program, the resident's educational performance, nor the resident's opportunities for rest, relaxation, and independent study. It is the sole discretion of each Program Director to determine whether outside activities interfere with the responsibilities, duties and assignments of the residency program. Should adverse effects be noted, the Program Director may withdraw approval for and/or restrict the resident's moonlighting activities.
- B. Each residency program will develop written policies and procedures concerning moonlighting and other professional activities outside the program. These policies and procedures will comply with ACGME Institutional Requirements and RC requirements for the specialty. These will be submitted to the GMEC for review and approval.
- C. Residents cannot be required to engage in moonlighting activities.
- D. Moonlighting is not permitted for residents in their first year of training.
- E. Residents requesting approval for moonlighting must:
  - 1. Complete and submit to the Program Director an SFMC Resident Moonlighting Request form indicating the nature, duration and location of the outside activity. Approved requests must be signed by the Program Director and maintained as a part of the resident's permanent record.
  - 2. The Program Director will notify the Graduate Medical Education Office of approved moonlighting activities by forwarding a copy of the application to the Graduate Medical Education Office. If the resident does not comply with this request for permission to moonlight, it is grounds for disciplinary action/dismissal.
- F. Internal and external moonlighting activities will be counted toward the 80-hour weekly limit on duty hours.
- G. It is the responsibility of the resident to obtain and provide professional liability insurance (malpractice) coverage for all moonlighting/other professional activities which are not an official part of the resident's training program. Internal moonlighting coverage will be provided by the organization in the same manner as the resident's professional liability.
- H. Residents must use their individual DEA numbers for moonlighting activities. The institutional number cannot be used for moonlighting activities.
- I. It is the responsibility of the resident who plans to moonlight to obtain licensure for unsupervised medical practice in the state where moonlighting will be done.

J. Documentation of resident moonlighting is part of all annual program evaluations and the annual institutional review.

**ACGME STANDARD: IV.J.1.**

**STATUTORY/REGULATORY AUTHORITY: GMEC**

## St. Francis Medical Center

### Resident Moonlighting Request Form

#### Application Instructions

Fill out the entire application and forward to your Program Director for approval/signature.

#### Personal Information

\_\_\_\_\_  
Resident Name

\_\_\_\_\_  
PGY Level

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
State Medical License Number

\_\_\_\_\_  
Issue Date

\_\_\_\_\_  
Federal DEA Number

#### Moonlighting Information

Separate from my responsibilities as a Resident at St. Francis Medical Center, I request to be employed for the period of:

\_\_\_\_/\_\_\_\_/\_\_\_\_ through \_\_\_\_/\_\_\_\_/\_\_\_\_

(Approval is granted for 12 month periods or less depending on the current academic year)

#### CONTINUED ON NEXT PAGE

Moonlighting Employer: \_\_\_\_\_

Contact Person: \_\_\_\_\_

\_\_\_\_\_  
Contact Person's Email

\_\_\_\_\_  
Contact Person's Phone Number

Type of Activity: \_\_\_\_\_

\_\_\_\_\_

Estimated number of hours per week devoted to moonlighting: \_\_\_\_\_

Professional Liability Insurance (please also provide a copy):

_____	_____
Insurance Company	Policy Number
_____	_____
Limits of Coverage	Effective Date

<b>Resident Attestation</b>
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**I understand the following:**

- St. Francis Medical Center assumes no responsibility for my actions in connection with external moonlighting.
- All moonlighting is voluntary.
- All moonlighting must be documented (including days, hours and location).
- This activity is not to interfere with my training, including my learning and/or patient care. If it contributes to undue fatigue, I will immediately cease all moonlighting activities.
- There will be a periodic review of my training performance and if it is less than expected, permission to moonlight will be withdrawn.
- Moonlighting activities are prohibited during regular duty hours.
- St. Francis Medical Center professional liability insurance does not cover moonlighting activities that are unapproved or outside of the organization.
- While employed in the activity below, I will not use or wear any items which identify me as affiliated with St. Francis Medical Center, nor will I permit the organization by which I am employed to represent me as so affiliated.
- Any Resident who moonlights without permission will be subject to disciplinary action.

*By signing and dating this form, I acknowledge that I have carefully read and fully understand the foregoing regarding moonlighting activity.*

Resident Signature: \_\_\_\_\_ Date: \_\_\_\_\_

<b>Program Director Approval</b>
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Please obtain the signature of your program director before returning this form.

*I agree to monitor this Resident, for the effect of this activity on his/her residency performance, and may withdraw this permission if adverse effects are noted.*

I approve this activity: \_\_\_\_\_ \*I do not approve this activity: \_\_\_\_\_

\* Please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Program Director: \_\_\_\_\_ Date: \_\_\_\_\_

*\*\*\*Program Directors: A copy of all approved applications should be forwarded to the GME Office.*