

**EXTERNAL** MOONLIGHTING

Housestaff Name: Click or tap here to enter text.

Training Department and Subspecialty Program Name: Click or tap here to enter text.

Post Graduate Year (PGY) Level: Click or tap here to enter text.

Location of Moonlighting Activity: Click or tap here to enter text.

Date(s) of Moonlighting Activity: Click or tap here to enter text.

Description of Moonlighting Activity: Click or tap here to enter text.

Provider of Medical Liability Insurance Coverage: Click or tap here to enter text.

Liability Coverage Limits: Click or tap here to enter text.

I understand that I may not engage in any moonlighting activity outside of this approval process. Any such activity may be grounds for my immediate termination from the program. I further attest that I understand that this activity, if approved, is apart from my assignment as a graduate medical resident/fellow of the University of Florida. I understand that the University of Florida is not responsible for and does not provide medical professional liability coverage, disability insurance, or workers compensation coverage for external moonlighting activity. I will finish my outside employment at least 12 hours prior to beginning of residency duties. I further understand that all external moonlighting activities, if approved, must be logged, counted towards, and compliant with the 80 hours per week clinical experience and education hours limit, and institutional and program policies.

I expressly and unequivocally understand and agree that this external moonlighting activity is in no way related to my employment with the University of Florida, and that the University of Florida has no obligation, responsibility, or liability whatsoever for any injury or harm which may occur or which may befall me during my performance of or as a result of outside activity. Accordingly, I hereby release, forever, discharge, and waive any all claims I may have now or in the future arising out of or connected with my outside employment activities against the University of Florida Board of Trustees, the State of Florida, the Department of Education for the State of Florida, or the Board of Governors for the State of Florida, and any and all officers, agents, employees, underwriters and insurers, all individually and in their respective official capacities.

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

APPROVAL BY PROGRAM DIRECTOR AND/OR CHAIRMAN OR ASSOCIATE CHAIRMAN

I have reviewed this request and certify that this activity, when combined with the numbers of hours or work per week required of this individual by our program, will not exceed the guidelines established by the Residency Review Committee of our program.

Approved: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If approved by the department, approval by the Associate Dean for Graduate Medical Education, Designated Institutional Official (DIO) must be obtained.

Approved: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_