

**INTERNAL** MOONLIGHTING

Housestaff Name: Click or tap here to enter text.

Training Department and Subspecialty Program Name: Click or 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.

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

I understand that I may not engage in any internal moonlighting outside of this approval process. I further understand that this moonlighting activity, if approved, must be counted towards and compliant with the clinical experience and education hours’, and institutional and program policies. This moonlighting activity must have associated and documented goals, objectives, and evaluations. I also understand that the compensation for internal moonlighting is processed by the University of Florida College Of Medicine. The Self Insurance Program (SIP) and Workers Compensation provide coverage for all approved internal moonlighting activities.

Participation in internal moonlighting requires that the participating resident/fellow to be in good academic standing. Internal moonlighting must not interfere with the ability of the resident/fellow to achieve the goals and objectives of the educational program. Permission for participation in internal moonlighting activity may be revoked at any time by the Program Director. Participation in internal moonlighting for supplemental compensation without formal approval of the University of Florida College of Medicine as outlined, may result in disciplinary action, which may include dismissal from the program.

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

APPROVAL BY PROGRAM DIRECTOR AND/OR CHAIR OR ASSOCIATE CHAIR

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Note: Please retain a copy of approval in the resident’s personnel file.