OLIVE VIEW - UCLA MEDICAL CENTER

MOONLIGHTING REQUEST FORM (MRF)

PROGRAM NAME:	PROGRAM DIRECTOR:
TRAINEE'S NAME:	LEVEL OF TRAINING:
CALIFORNIA LICENSE NUMBER:	NUMBER OF HOURS PER WEEK DEVOTED TO THIS ACTIVITY:
NAME OF CONTACT AT MOONLIGHTING SITE:	CONTACT'S TELEPHONE NUMBER:
NAME OF CLINIC OR HOSPITAL:	CITY/STATE:
DESCRIBE THE MALPRACTICE INSURANCE COVERAGE THAT WILL COVER THE RESIDENT/FELLOW DURING THIS MOONLIGHTING ACTIVITY:	
STATE THE REASON(S) FOR THIS MOONLIGHTING REQUEST:	
DESCRIBE THE TYPE OF PROFESSIONAL ACTIVITY TO BE ENGAGED IN AND ITS EDUCATIONAL VALUE:	
LIST ALL OTHER CURRENT MOONLIGHTING SITES:	

ACKNOWLEDGMENT, AUTHORIZATION AND RELEASE:

I UNDERSTAND THAT IF THIS REQUEST IS APPROVED, THE APPROVAL IS FOR ONLY ONE (1) PROGRAM YEAR. I UNDERSTAND THAT THIS APPROVAL MAYBE REVOKED AT ANY TIME PURSUANT TO DEPARTMENT POLICY. I FURTHER UNDERSTAND THAT BY ENGAGING IN PROFESSIONAL ACTIVITY OUTSIDE THE TRAINING PROGRAM I DO SO AS A PRIVATE PRACTITIONER AND THAT NEITHER THE OLIVE VIEW - UCLA MEDICAL CENTER (OVMC) NOR MY PROGRAM DIRECTOR ACCEPT ANY RESPONSIBILITY FOR MY OUTSIDE PRACTICE. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL LIABILITY OR OTHER LEGAL MATTERS ASSOCIATED WITH SUCH OUTSIDE PROFESSIONAL ACTIVITY, INCLUDING OBTAINING AND MAINTAINING ADEQUATE MEDICAL MALPRACTICE INSURANCE. I ATTEST THAT I HAVE OBTAINED ADEQUATE MALPRACTICE INSURANCE TO COVER MY OUTSIDE PRACTICE. I UNDERSTAND THAT ALL OVMC AND DEPARTMENTAL RESIDENT DUTY HOUR POLICIES APPLY. IF MY COMMITMENT TO THIS MOONLIGHTING ACTIVITY CHANGES FROM WHAT IS SPECIFIED IN THIS MRF, I WILL NOTIFY MY PROGRAM DIRECTOR IMMEDIATELY.

I HEREBY AUTHORIZE OVMC, ITS CLINICAL STAFF AND REPRESENTATIVES TO CONSULT WITH MEMBERS OF THE ADMINISTRATION AND MEDICAL

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STAFF OF OTHER HOSPITALS FOR WHOM I HAVE ENGAGED IN MOONLIGHTING AND TO CONSULT WITH MALPRACTICE CARRIERS FOR PURPOSE OF VERIFYING THE NATURE, SCOPE AND SCHEDULE OF ANY PROFESSIONAL ACTIVITY.

I HEREBY RELEASE FROM LIABILITY THE OVMC, ITS CLINICAL STAFF AND ALL REPRESENTATIVES OF THE OVMC FOR THEIR ACTS PERFORMED WITHOUT MALICE IN CONNECTIONS WITH EVALUATING THIS APPLICATION AND MONITORING MY PROFESSIONAL ACTIVITIES. I HEREBY RELEASE FROM LIABILITY ANY AND ALL INDIVIDUALS AND ORGANIZATIONS WHO PROVIDE INFORMATION TO THE OVMC, OR TO MEMBERS OF ITS CLINICAL STAFF OR REPRESENTATIVES, WITHOUT MALICE, CONCERNING OUTSIDE PROFESSIONAL ACTIVITIES IN WHICH I ENGAGE INCLUDING BUT NOT LIMITED TO WORK HOURS, NATURE AND SCOPE OF DUTIES AND PERFORMANCE THEREOF, AND I HEREBY CONSENT TO THE RELEASE OF THIS INFORMATION.

MY MOONLIGHTING ACTIVITIES CANNOT INTERFERE WITH MY REGULAR TRAINING PROGRAM RESPONSIBILITIES. I MUST ACCURATELY REPORT MOONLIGHTING HOURS IN QUARTERLY WORK HOURS SURVEYS CONDUCTED BY THE OFFICE OF GRADUATE MEDICAL EDUCATION. MY TOTAL WORK HOURS MUST BE IN ACCORDANCE WITH OVMC AND ACGME STANDARDS. I CANNOT WORK MORE THAN EIGHTY (80) HOURS PER WEEK (AVERAGED OVER A ONE-MONTH PERIOD). I CANNOT WORK LONGER THAN 24 CONSECUTIVE HOURS (PLUS 3 HOURS OF TRANSFER OF CARE TIME). I SHOULD HAVE AT LEAST TEN (10) HOURS OF NON-WORK TIME BETWEEN SHIFTS. I MUST HAVE ONE 24-HOUR PERIOD FREE FROM CLINICAL DUTIES EACH WEEK. I WILL INFORM MY PROGRAM DIRECTOR OF MY MOONLIGHTING SHIFTS SO THAT THIS ACTIVITY MAY BE MONITORED BY MY PROGRAM. I WILL NOT REPORT ANY CASES DONE DURING MOONLIGHTING ON AN OVMC OR ACGME CASE LOG SYSTEM BECAUSE I UNDERSTAND THESE CASES TO HAVE BEEN DONE OUTSIDE OF MY STANDARD TRAINING PROGRAM.

I HAVE READ AND UNDERSTOOD THE *OVMC POLICY AND PROCEDURES REGARDING PROFESSIONAL ACTIVITY OUTSIDE THE TRAINING PROGRAM BY PHYSICIANS*, AND I UNDERSTAND THAT MY FAILURE TO ADHERE TO THIS POLICY AND THE PROCEDURES OUTLINED THEREIN CAN BE GROUNDS FOR MY IMMEDIATE DISMISSAL FROM THE TRAINING PROGRAM.

SIGNATURE OF HOUSE STAFF MEMBER _____ DATE _____

I APPROVE THIS REQUEST:

SIGNATURE OF PROGRAM DIRECTOR _____ DATE _____