EXTRACURRICULAR EMPLOYMENT REQUEST FORM

Resident must answer the following questions legibly on this form.

1. Name: ____________________________
2. Clinical PGY training level currently in your current program: ______________
3. Visa type (if applicable): ____________________
4. Program Name: Internal Medicine Department : Medicine
5. Is this considered moonlighting or extra sessions? (check one)__X____ EXTRA SESSIONS_______ MOONLIGHTING

Note: Moonlighting must have expertise in the field/service and an independent Maryland license; Extra Sessions require supervisory oversight (direct or indirect) and does not require independent license, but should be related to the current program training.

6. Institution where you will be working: Mercy Medical Center
7. Anticipated number of hours each week you plan to work on this activity: ____________hrs/week
8. Field/or Service for this activity: Inpatient Internal Medicine
9. Your clinical training in years in this Field/or Service: ________________________

Note: this answer may be different from your response to #2.

For Moonlighting please respond to these questions	For Extra Sessions, please respond to these questions
10. What entity is providing your malpractice coverage? ________N/A________________________________	**10.** Who will be providing direct/indirect supervision of you? Note: please provide supervising physician name(s) Kristi M. Moore, M.D.
11. What is the policy # _____N/A_______________ **12.** Does the policy include tail coverage? __N/A____ **Attach insurance rider as proof of coverage.**	

Medical Staff Services must confirm the following for Moonlighting only:

13. The resident(s) has(ve) appropriate insurance and licensure/training/skills for described activity:
______yes _______ no ____________________________________Medical Staff signature ______date

MMCIP (self-insurance trust) must confirm the following for Moonlighting and Extra Sessions:

14. Malpractice certificate has (have) been issued by UMMC ____ Yes ____ No

a) if No is checked, MMCIP has confirmed insurance coverage appears adequate for activity? ___ Yes ____ No

____________________________________ MMCIP signature ________date

Resident signature ________________________ date_________ (print name name)_________________________

Program Director signature ___________________ date________ (print name name) Susan D. Wolfsthal, M.D.