

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) 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: University of Maryland 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

10. What entity is providing your malpractice coverage?

N/A

11. What is the policy # N/A

12. Does the policy include tail coverage? N/A

Attach insurance rider as proof of coverage.

For **Extra Sessions**, please respond to these questions

10. Who will be providing direct/indirect supervision of you?

Note: please provide supervising physician name(s)

Neda Frayha, M.D./Leann L. Silhan, M.D.

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.