



GARDEN CITY HOSPITAL MEDICAL EDUCATION "MOONLIGHTING" REQUEST FORM

Name: _____ Residency Program: _____ Year: OGME-_____

Outside Professional Activity ("Moonlighting") Description

Nature of employment: _____

Requested date(s): _____

Estimated hours: _____

Name of Employer/Contact Person: _____

Contact telephone: _____

Liability/Malpractice Insurance Coverage (Include contractors, policy number, and expiration date)

NOTE: You must provide written proof of insurance coverage.

Acknowledgement:

This request is made within the guidelines of the GCH Medical Education Policy and Procedure, "Outside Professional Activities ('Moonlighting') For Residents". I have read and understand the GCH Policy/Procedure for "Outside Professional Activities ('Moonlighting') For Residents". I agree to comply with this Policy. I am aware that any violation of the "Outside Professional Activities ('Moonlighting') For Residents" Policy will result in disciplinary action up to and including discharge from GCH.

I hereby authorize the representatives of the GCH Medical Education Department to, at their discretion, contact the moonlighting services as indicated above and any others who may have information regarding my employment, hours, duties, and supervision and release from liability all representatives of the Medical Education Program Directors, the Medical Education Office, and GCH for their acts performed in good faith and without malice in connection with evaluating my request for moonlighting privileges. In addition, I release from any liability all individuals and organizations that provide information pertaining to my outside professional activities ("moonlighting") in good faith and without malice concerning my request for moonlighting privileges.

Resident Signature

Date

Residency Program Director Approval

Date

VP Medical Education Approval

Date

THIS FORM MUST INDICATE APPROVAL BY SIGNATURES OF ALL PARTIES PRIOR TO ANY "MOONLIGHTING" ACTIVITIES.