The George Washington University School of Medicine and Health Sciences
Institutional Policy on Resident Moonlighting
Appendix 1: Request to engage in moonlighting activity

Resident/Fellow Name: ___________________________________________

Training Program: ______________________________________________

Current PGY Level: ______________________________________________

Requested Moonlighting Site: ______________________________________

Is this moonlighting activity (check one):
   _____ Internal (to be performed within the GWU)
   _____ External (outside of GWU)

Estimated Hours per shift: _______  Estimated Hours per week: _______

Description of duties: _____________________________________________

____________________________________________________________________

I have attached the following:
   Ƒ Copy of full, unrestricted and current medical license
   Ƒ Copy of DEA license or attestation from program director certifying that this is internal
     moonlighting in my residency program and I am not writing prescriptions
   Ƒ Copy of insurance (malpractice) certificate showing coverage in force for outside
     employment

I certify that I understand and agree to the following:
   Ƒ Outside employment (moonlighting) will not be considered an excuse for poor job
     performance, absenteeism, tardiness, early departure, refusal to travel, or refusal to accept
     additional/altered assignments.
   Ƒ I have informed my outside employer that the residency or fellowship is of top priority.
     The outside employer has agreed to accommodate the residency or fellowship schedule
     and avoid conflicts with my educational program.
   Ƒ I will inform the program director of any changes, corrections or additions to
     moonlighting place, schedule, duties or total work hours. Additional moonlighting sites
     require an additional form.
   Ƒ I understand that ALL moonlighting hours count toward the duty hour limit, and I will
     not moonlight in excess of my program’s limits.
   Ƒ My approval to moonlight may be revoked if difficulties with learning, performance,
     patient care, fatigue or other issues arise.
   Ƒ This approval is time-limited and applies for the current academic year only.

Signed: _______________________  Date: ___________
   (Resident Signature)

Approved: _____________________  Date: ___________
   (Program Director Signature)

Approved: _____________________  Date: ___________
   (Associate Dean for Graduate Medical Education)