

MUSC OFFICE OF GRADUATE MEDICAL EDUCATION

MOONLIGHTING APPROVAL FORM

For the period: July 1, 2008 to June 30, 2009

PLEASE COMPLETE ONE FORM FOR EACH EMPLOYER or FACILITY:

Resident: _____

Program: _____

SC License #: _____

Malpractice Insurance Company: _____

_____ **Policy #:** _____

Name and Address of Employer (i.e., Physician Office or Medical Facility):

Hours per week (est): _____ **or** **Hours per month (est):** _____

I agree to record my moonlighting hours using the E*Value system (Please Check One)

_____ ***INTERNAL*** moonlighting hours to be recorded ***WEEKLY***.

_____ ***EXTERNAL*** moonlighting hours to be recorded ***MONTHLY***.

Resident's Signature

Date

I approve this moonlighting activity *for the amount of time listed.*

**My residency program _____ DOES or _____ DOES NOT
have an affiliation agreement with this office or facility.**

Program Director's Signature

Date

ACGME Designated Institutional Official (DIO)

Date

(GMEC approved 8/12/04; modified 5/11/06; modified 6/13/07)