MOONLIGHTING AUTHORIZATION FORM INSTRUCTIONS

IF YOU DO NOT READ AND FOLLOW THESE INSTRUCTIONS,
YOU WILL NOT BE AUTHORIZED FOR EXTENDED EMPLOYMENT.
YOU ARE REQUIRED TO READ AND COMPLY WITH THE FULL
POLICY AND PROCEDURES!

1. SUBMIT A COMPLETE MOONLIGHTING AUTHORIZATION FORM (ATTACHED) WITH **ALL QUESTIONS FULLY ANSWERED** – INCLUDING YOUR ACLS AND BLS EXPIRATION DATES, SERVICE YOU WILL BE PROVIDING AND **THE NAME OF YOUR SITE SUPERVISOR (WHO MUST BE A PHYSICIAN AND CANNOT BE A RESIDENT OR FELLOW).** Partially completed applications will **NOT** be approved.

2. **PROVIDE THE OGME WITH A COPY OF A VALID MASSACHUSETTS FULL LICENSE AND COPY OF YOUR MOST RECENT LICENSE APPLICATION.**

3. **PROVIDE A COPY OF YOUR OWN STATE AND FEDERAL DEA NUMBERS.** The resident has 3 months from the date of receiving his/her full license to apply for State & Federal DEA numbers. The UMMMC hospital DEA number can be used on the UMass or Memorial campus ONLY for up to 3 months, after which time it will be deactivated. An individual DEA number will be required from that point forward.

4. **MOONLIGHTING IS LIMITED TO APPROVED SERVICES WITHIN APPROVED SITES.** (Note: Each approval is site and service specific). The Director of Claims Management must approve each moonlighting request.

5. **MOONLIGHTING IS NOT PERMITTED UNTIL YOU HAVE RECEIVED WRITTEN NOTIFICATION FROM THE OGME THAT YOU HAVE BEEN APPROVED!!** Residents who work **BEFORE** they receive written authorization **will not be paid** through the OGME and **will not have malpractice coverage** for shifts worked.

6. **THE TOTAL NUMBER OF HOURS WORKED PER WEEK INCLUDING PROGRAM ACTIVITY PLUS MOONLIGHTING MUST REMAIN IN FULL COMPLIANCE WITH UMMS AND ACGME DUTY HOURS REQUIREMENTS. THIS INCLUDES A MAXIMUM OF 80 HOURS PER WEEK, 24 HOURS OF CONTINUOUS PATIENT CARE, AND 10 HOURS OFF BETWEEN SHIFTS.**

7. **WRITTEN RENEWAL AUTHORIZATION IS REQUIRED FOR EACH ACADEMIC YEAR FOR EACH RESIDENT/FELLOW.**

AUTHORIZATION IS NOT EFFECTIVE UNTIL APPROVED BY CLAIMS MANAGEMENT!

UMMSOFFICE OF GRADUATE MEDICAL EDUCATION
AUTHORIZATION FORM FOR ADDITIONALCOMPENSATION FOR EXTENDED EMPLOYMENT
AUTHORIZATION WILL BE DENIED UNLESS ALL QUESTIONS ARE ANSWERED!
ACADEMIC YEAR JULY 1, 2019 THROUGH JULY 31, 2020

NAME OF RESIDENT/FELLOW: _____ **PGY LEVEL:** _____

VISA STATUS: _____* **RESIDENCY/FELLOWSHIP PROGRAM:** _____

*Federal Regulations prohibit moonlighting on a J-1 visa. H1B visa holders must have H1B petitions reviewed by the Immigration Services Office before moonlighting activities can be approved.
ISO signature is required for anyone on an H1B visa.

MASS FULL LICENSE NUMBER: _____**LICENSE EXPIRATION DATE:** ____/____/____
Current Copy of Full License AND most recent license application must be on file in OGME. Authorization expires with license expiration unless GME receives a copy of the renewal application AND license.

FEDERAL DEA NUMBER: _____ **MASS DEA NUMBER:** _____ **NPI#**_____

BLS EXPIRATION DATE : ___/___/_____ **ACLS EXPIRATION DATE :** ___/___/_____

HOSPITAL OR SITE: _____

SITE SUPERVISOR (MUST BE A PHYSICIAN): _____

TYPE OF SERVICE TO BE PROVIDED: _____

Please indicate whether _____**INPATIENT** _____**OUTPATIENT**
_____**IN-HOUSE** _____**BEEPER CALL FROM HOME**

PLEASE READ AND CONFIRM THE FOLLOWING:

____I hereby acknowledge that I have read the Extended Employment Requirements and the Reporting of Occurrence Requirements of the Office of Risk Management. I agree that I will strictly abide by the requirements.

____I hereby request that a letter be sent to the aforementioned site verifying my malpractice coverage for extended employment.

____I understand and agree that there will be no professional services billing submitted in my name to patients or third party payers for ***any inpatient services*** that I provide at UMass Memorial Medical Center.

____**I agree to fully comply with all ACGME Duty Hours Requirements and report all moonlighting hours to the OGME as requested. I understand that I am not permitted to use Personal Days to moonlight.**

PLEASE CONFIRM THE FOLLOWING FOR ANY OUTPATIENT MOONLIGHTING:

____**This represents an agreement for outpatient activity which is completely separate from my training program and for which I will be separately reimbursed in accordance with the requirements of the UMMS Extended Employment Program.**

RESIDENT SIGNATURE: _____**DATE:** _____

We hereby acknowledge that the above-named Resident/Fellow is authorized to receive additional compensation for the above services.

APPROVED SIGNATURES:
PROGRAM DIRECTOR: _____DATE: _____

SITE SUPERVISOR OR ADMINISTRATOR_____ DATE: _____

ISSO for H1B VISA HOLDER: _____ DATE: _____

OGME DIRECTOR: _____DATE: _____

APPROVED BY UMMMC CLAIMS MANAGEMENT _____ DATE: _____
Revised 10/7/2019 OGME will provide copy to site director. Resident MUST provide documentation as required by the site.