UNIVERSITY OF MASSACHUSETTS MEDICAL SCHOOL
OFFICE OF GRADUATE MEDICAL EDUCATION

EXTRA COMPENSATION REQUEST FORM
FOR ALL AFFILIATE RESIDENT/FELLOW MOONLIGHTING

SITE NAME (Hospital, Health Center, etc.): _____

TYPE OF SERVICE PROVIDED: _____

RESIDENT/FELLOW NAME: _____

RESIDENT/FELLOW PROGRAM: _____

RESIDENT/FELLOW ID NUMBER: _____

DATE & ACTUAL HOURS WORKED:

DATE	HOURS WORKED	TOTAL # HOURS

TOTAL HOURS FOR PAY PERIOD: _____

RATE OF PAY: $ _____ PER _____

TOTAL COMPENSATION DUE RESIDENT/FELLOW: $ _____

ADMINISTRATIVE CHARGE (3%): $ _____

TOTAL AMOUNT ENCLOSED: $ _____

SIGNATURES:

SITE AUTHORIZATION: _____ DATE: _____

OFFICE OF GME: _____ DATE: _____

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ACCOUNT # W103094 CHECK # _____

DISTRIBUTION: BLUE --- PAYROLL; YELLOW --- GRAD MED ED; PINK --- RESIDENT/FELLOW; GOLD --- SITE

NS GME 0102 Rev 3/08