UNIVERSITY OF MASSACHUSETTS MEDICAL SCHOOL
OFFICE OF GRADUATE MEDICAL EDUCATION

EXTRA COMPENSATION REQUEST FORM

FOR ALL 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
DATE	HOURS WORKED	TOTAL # HOURS
DATE	HOURS WORKED	TOTAL # HOURS
DATE	HOURS WORKED	TOTAL # HOURS
DATE	HOURS WORKED	TOTAL # HOURS

TOTAL HOURS FOR PAY PERIOD: ______________________________

RATE OF PAY: $ ____________ PER ____________

TOTAL COMPENSATION DUE TO RESIDENT /FELLOW: $ ______________

SIGNATURES:

SITE AUTHORIZATION: ______________________________ DATE: ____________

OFFICE OF GME: ______________________________ DATE: ____________

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ACCOUNT #: ______________

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