

MOONLIGHTING APPROVAL

Ventura Family Medicine Residency

NAME: _____

LOCATION/S OF MOONLIGHTING:

1) _____

2) _____

DATES and HOURS YOU EXPECT TO BE MOONLIGHTING:
(Provide specific dates and shift times)

(1) _____ (2) _____ (3) _____ (4) _____

(5) _____ (6) _____ (7) _____ (8) _____

ROTATION/S YOU WILL BE ON:

(1) _____ (2) _____ (3) _____ (4) _____

(5) _____ (6) _____ (7) _____ (8) _____

OF HOURS PER WEEK OF MOONLIGHTING:

(1) _____ (2) _____ (3) _____ (4) _____

(5) _____ (6) _____ (7) _____ (8) _____

MALPRACTICE COVERAGE: YES NO (Circle)

If not covered by the organization where you are working, please explain how you will ensure coverage.

I attest that the combined hours of my residency duties and moonlighting will not exceed 80 hours per week.

I attest that my medical records are up to date and will be up to date at all times prior to any moonlighting shifts

Signature of Resident Physician/Date

Approval Signature of Program Director /Date