Email Form

INTERNAL MEDICINE-PEDIATRICS RESIDENCY PROGRAM
MONTHLY MOONLIGHTING FORM

Resident Name: _____

Date Submitted: _____

Please list the location, dates and shifts this month you would like to moonlight:

DATE	SERVICE MOONLIGHTING	SHIFT HOURS

Will you still have 4 days off in the month? ☐ Yes ☐ No

Will you work more than 80 hours per week? ☐ Yes ☐ No

Please remember that moonlighting shifts must be included in your duty hours. (Example: If you only have 4 days off during the month and you would like to spend one of them on MICU moonlighting, this would be a duty hour violation.)

_____

Resident Signature Date

_____

Chief Resident Signature Date