

Appendix D – MOONLIGHTING

Request to Moonlight at a facility outside the Grady Healthcare system or EMORY HEALTHCARE

- I submit this request to be approved to moonlight during the period _____
(The period may not be longer than six months);
- I agree to have a signed contract to moonlight at _____ (Name of
hospital(s) or other facility). The contract must state that the facility will provide professional
liability insurance coverage with respect to the services that I provide during my moonlighting
assignment or that I have my own personal professional liability insurance to cover this moonlighting.
- I am fully licensed to practice medicine in the state where the moonlighting will occur;
- I am NOT in training on a J-1 visa;
- I agree NOT to wear anything identifying me as a trainee in the Emory training program
(including, but not limited, to Emory photo ID cards, uniforms, lab coats);
- I agree not to exceed any restrictions the training program has regarding the total number of hours
I may work per week;
- I acknowledge any activities, including moonlighting, which interfere with residency training or
impact on my performance in the training program may be grounds for disciplinary action up to and
including my dismissal from the residency program;

By signing below, I attest to the completeness and accuracy of the above information.

Signature of resident requesting permission to moonlight

Date

Print name of resident/ PGY

Request for moonlighting **is** **is not** (circle one) approved

Signature of Program Director

Date

Request to Moonlight in the EMORY HEALTHCARE system

- I submit this request to be approved to moonlight during the period _____
(The period may not be longer than six months);
- I agree to have a valid contract to moonlight at _____ (Name of Emory Healthcare facility). The contract must state that the facility will provide professional liability insurance coverage with respect to the services that I provide during my moonlighting assignment.
- I am fully licensed to practice medicine in the state where the moonlighting will occur;
- I am NOT in training on a J-1 visa;
- I agree not to exceed any restrictions the training program has regarding the total number of hours I may work per week;
- I acknowledge any activities, including moonlighting, which interfere with residency training or impact on my performance in the training program may be grounds for discipline up to and including my dismissal from the residency program;
- I understand I may moonlight only in outpatient settings or in the Emergency Department;

By signing below, I attest to the completeness and accuracy of the above information.

Signature of resident requesting permission to moonlight

Date

Print name of resident/ PGY

Request for moonlighting **is** **is not** (circle one) approved

Signature of Program Director

Date