



Policies and Procedures

Policy MFMR06	Moonlighting
Effective Date:	10/22/2022
Reviewed/Revised Date:	
PEC Approval Date:	10/22/2022; 10/13/2023
References:	GMEC Moonlighting

Purpose: To establish guidelines for resident moonlighting in Methodist Medical Center ACGME-accredited residency and programs.

Definition: Moonlighting is defined as any activity, outside the requirements of the residency program in which an individual performs duties as a fully licensed physician or duties in any other capacity whether the resident receives financial remuneration or not. This includes, but is not limited to:

- Providing direct patient care
- Providing care via telemedicine
- Conducting "wellness" physical examinations
- Reviewing medical charts, EKGs, or other information for a company or an agency
- Teaching in a medical school or other educational programs involving clinical skills
- Providing medical opinions or testimony in court or to other agencies
- Serving or volunteering as a sports team physician or a medical official for an event
- Volunteering in a clinic where medical care is provided
- Working in any other capacity which requires after-hours work

Any moonlighting by a resident must be reported to the Program Director in writing using the Moonlighting Permission form and will be included as part of the ACGME 80-hour weekly duty-hour limit.

Policy:

- Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program. Time spent by residents in Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour weekly duty-hours limit.
- PGY-1 residents are not permitted to moonlight.
- Residents must be in good standing with the program to moonlight.
- Residents are informed that Methodist Medical Center or Covenant Health does not provide professional liability insurance for any moonlighting.

Moonlighting:

Moonlighting requires:

- the resident must be fully licensed by the State of Tennessee to practice medicine independently when moonlighting as a physician
- residents must provide proof of malpractice coverage to the Program Director along with the request for permission to moonlight
- the additional work respects the policy on limitations on duty hours and relief from duty when patient care might be compromised
- time spent by residents in moonlighting must be counted towards the 80-hour weekly duty-hours limit

Procedure:

- If a resident plans to engage in moonlighting, the resident is required to receive prior written approval from the Program Director and the DIO.
- Residents should complete the required Moonlighting Permission Form. It is incumbent upon the resident to ensure changes to their moonlighting status are reported to and approved by the Program Director.
- The Program Director shall maintain one copy of approval in the resident's file and return one copy to the resident.
- The resident's performance will be monitored for the effect of moonlighting activities upon performance and adverse effects may lead to withdrawal of permission.

Failure of a resident to comply with this policy shall result in disciplinary action up to and including termination.

The moonlighting request form is attached.

Methodist Medical Center
REQUEST TO ENGAGE IN EXTRAMURAL PROFESSIONAL ACTIVITIES
(EXTERNAL MOONLIGHTING)

APPLICATION INSTRUCTIONS

1. Complete the entire application.
2. Obtain signature from your Program Director and DIO
3. Return completed form to your Program Coordinator for inclusion with your file.

UNDERSTANDING THE APPLICATION PROCESS

1. You must obtain approval for moonlighting PRIOR to engaging in any outside activity.
2. The decision to allow moonlighting is solely at the discretion of the Program Director.
3. Moonlighting privileges may be revoked at any time.

PERSONAL INFORMATION

Resident Name: _____ PGY Level: _____

Department/Division: _____

State Medical License Number: _____ Issue Date: _____

Federal DEA Number: _____

MOONLIGHTING INFORMATION

SEPARATE FROM MY RESPONSIBILITIES AS A RESIDENT AT METHODIST MEDICAL CENTER; I REQUEST TO BE EMPLOYED FOR THE PERIOD OF:

___/___/___ THROUGH ___/___/___ Moonlighting Employer: _____
(NOTE: One employer per form only)

Contact Person: _____ Address: _____

MOONLIGHTING INFORMATION CONTINUED

Type of Activity: _____ Approximate Hours per Month: _____

Professional Liability:
Insurance: _____ Policy Number: _____

Limits of Coverage: _____ Effective Date: ___/___/___

I understand that Methodist Medical Center assumes no responsibility for my actions in connection with this activity. I will so inform the organization by which I am employed, and I will make no representation which might lead that organization or its patients to believe otherwise. While employed in the requested activity, I will not use or wear any items which identify me as affiliated with Methodist Medical Center, nor will I permit the organization by which I am employed to represent me as so affiliated.

I understand that moonlighting activities are prohibited during regular Methodist Medical Center clinical and education work hours, as defined by the Program Director and ACGME.

I further understand that Methodist Medical Center professional liability insurance does not cover moonlighting activities. I hereby certify that I have professional liability insurance which covers any liability which may result from the activity.

I acknowledge that my performance will be monitored for the effect of this activity, and adverse effects on my residency performance may lead to rescinding of this permission.

Resident Signature: _____ Date: ___/___/___

PROGRAM DIRECTOR/DIO APPROVAL

PLEASE OBTAIN THE SIGNATURE OF YOUR PROGRAM DIRECTOR AND DIO BEFORE RETURNING THIS FORM TO THE PROGRAM OFFICE.

With my signature, I

- 1) Approve this moonlighting activity,*
- 2) Agree to monitor this resident for the effect of this activity on his/her residency/fellowship performance, and*
- 3) May withdraw this permission if adverse effects are noted.*

Program Director: _____ Date: ___/___/___

Designated Institutional Official: _____ Date: ___/___/___