

PM&R MOONLIGHTING POLICY

TO: PM&R Residents

FROM: Samuel Bierner, M.D.

SUBJECT: Moonlighting and Permission Form

Because residency education is a full-time endeavor, it is my responsibility, as program director, to ensure that moonlighting does not interfere with the ability of the resident(s) to achieve the goals and objectives of the educational program.

MOONLIGHTING POLICY

1. Moonlighting is permitted at the sole discretion of the Residency Program Director.
2. No PGY-2 resident may moonlight. Exceptions to this would be rarely, if ever, given.
3. Any PGY-3 or PGY-4 resident who wishes to moonlight must submit the request in writing to the Residency Program Director at least 30 days prior to the start of such employment. The Residency Program Director will require proof of professional liability insurance coverage, and that the hours and days of the week do not interfere with the academic training of the resident. Any type of work experience that may adversely affect the reputation of the University of Texas Southwestern Medical Center, this department, or the field of PM&R will not be permitted. Any resident who is granted permission to moonlight must have previous clinical evaluations at the level of 7 or above (superior) on his/her past 12 months of rotation evaluations.
4. The resident cannot leave work early or come in late, or miss in-house call, because of the moonlighting schedule.

Attached is the moonlighting permission form needed before granting privileges. Permission will be granted on 6-month intervals. You will be required to resubmit the permission form 6 months after starting. Your satisfactory performance during the previous six month time period will be reviewed.

Please return the completed form, a copy of the professional liability insurance coverage, copy of Texas Medical License, DPS and DEA to Terri Isbell at least 30 days in advance. Once the form as been approved, you will be notified and a copy will be provided to you for your records.

Please do not hesitate to contact me should you have questions regarding this information.

SB:tli
Attachment



**Physical Medicine & Rehabilitation Department
Permission Form for Moonlighting**

Resident Name: _____

Date of Request: _____

Approximate Start Date	
Direct Supervisor Name:	
Name of Facility: Department:	
Address City, State, Zip	
Phone Number: Fax Number:	
Scheduled Days (Monday, Tuesday, etc)	
Hours of Duty (excluding residency) (8:00 am – 5:00 pm)	
Total Number of Hours Per Shift	
# Days Per Week (specify which week days or weekends)	
Type of Work (inpatient, ED, outpatient, etc.)	
Are you current ACLS certified? (show proof)	

