Request to Moonlight at one of the Emory Healthcare facilities

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).

I am fully licensed to practice medicine in the state where the moonlighting will occur;

I am NOT in training on a J-1/H1B 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