MOONLIGHTING INSTRUCTIONS:

Please Complete and Send the Forms on the Following 6 Pages to the Medical Staff Office at Box URMFG 278911.

1) URMC Moonlighting (extra work shift) Request Form, p. 1 of 6
2) URMC System Credentials & Privilege Review, p. 2 & 3 of 6
3) DEA or DEA Statement. If you are using SMH’s or HH’s DEA number, submit the DEA Statement with the suffix #, otherwise a copy of your own DEA, p. 4 of 6
4) Consent to Release of Information, p. 5 & 6 of 6

Please Send to the Medical Staff Office the Following Additional Items:

1) Your CV (curriculum vitae)
2) Health Assessment/TST (PPD) form
3) Your Delineation of Competencies listing
URMC MOONLIGHTING (extra work shift) REQUEST FORM

I, ________________________________, am requesting permission to moonlight.

I recognize the following:
1. My moonlighting activities cannot interfere with my regular training program responsibilities.
2. I must accurately report moonlighting hours in semiannual work hours surveys conducted by the Office of Graduate Medical Education.
3. My total work hours must be in accordance New York State Health Care Code, Section 405 and ACGME standards.
   • I cannot work more than eighty (80) hours per week. I understand that NYS further defines the weekly time limit to be a maximum of 84 hours.
   • I cannot work longer than 24 consecutive hours (plus 3 hours of transfer of care time).
   • I should have at least ten (10) hours of non-work time between shifts.
   • I must have one 24-hour period free from clinical duties each week.
4. I will inform my Program Director of my moonlighting shifts so that this activity may be monitored by my program.
5. I understand that professional liability insurance provided to me for my residency program duties will only cover moonlighting activities at Strong Memorial Hospital or Highland Hospital.
6. I possess a current unrestricted New York State medical or dental license.
7. I understand that if I do not have my own Federal DEA number that I can use the institutional DEA number assigned to the hospital at which I am moonlighting and use my assigned suffix.
8. For activities that will take place at Strong Memorial or Highland Hospital, I will secure Medical Staff privileges (at each hospital) before I begin any outside work.
9. I will not report any cases done during moonlighting on an ACGME case log system because I understand these cases to have been done outside of my standard training program.
10. I understand that approval to moonlight is granted through the end of the current academic year and must be requested for each subsequent year.

Failure to comply with the above may result in withdrawal of permission to moonlight or other disciplinary actions. I further understand that if I am placed on probation by the residency program, or if my program director is concerned that my clinical performance has been negatively affected I will no longer be allowed to moonlight.

I understand the number of hours that need to be reported to the program and will not knowingly put myself and my program in violation of the New York State Health Care Code, Section 405 or ACGME regulations.

Signature of Resident          Date

I have reviewed with the trainee his/her plans to moonlight. The planned activities will not violate the New York State Health Care Code Section 405 and ACGME regulations, and I approve of this trainee’s request. I will monitor and maintain records of these activities.

Signature of Program Director          Printed Name of Program Director          Date

cc: Departmental File
    Office for Graduate Medical Education
    Credentialing Office (SMH, HH)
**Strong Memorial Hospital/Highland Hospital System Credentials & Privilege Review**

Non-curricular Graduate Assistant Staff Activity

**APPLICANT**

I, ____________________________________________________ (please print name) am requesting privileges at:

- [ ] Highland Hospital
- [ ] Strong Memorial Hospital
- [ ] Other ______________________ (please specify)

in the Department(s) of ___________________________________________ for the purpose of providing patient care as a dependent practitioner from ___/___/___ through ___/___/____. My Social Security Number is ______________________, my date of birth is ____________, and my New York State License number is ______________________. I am a citizen of ___________________.

Signature ___________________________________________          Date ___________________ Sex: M / F

Email __________________________________________________________________________

**TRAINEE PROGRAM DIRECTOR**

_____________________________________ (applicant’s name) is currently a ____-year [ ] resident [ ] fellow in the ________________________ Training Program. I will be responsible for assuring that this trainee does not exceed New York State 405 code and ACGME regulations regarding work hours for trainees, and for notifying the Medical Staff Office if this trainee receives an unsatisfactory semi-annual evaluation. I have reviewed the attached Delineation of Competencies form(s) for the Department(s) of ________________________ and verify that the above-named trainee is qualified and capable of assuming these privileges as a dependent practitioner.

Signature ___________________________________________          Date ___________________

Program Director

**EMPLOYING DEPARTMENT CHAIR**

Signature ___________________________________________          Date ___________________

SMH Department Chair

Signature ___________________________________________          Date ___________________

HH Chief of Service

**CREDENTIALS AND PRIVILEGE REVIEW**

Based on the above assurances from the applicant’s Program Director, review by the Chief of Service employing the trainee, and upon review of the appointment information, in accordance with the Medical Staff Bylaws, the Chair of the Credentials Committee approves the request for non-curricular privileges:

- [ ] with no objections noted
- [ ] with restrictions as noted on page 3 of this form.

Chief Medical Officer / Designee Signature ___________________________          Date ___________________

**For Moonlighting Outside of Training Program:**

Chief Medical Officer / Designee Signature ___________________________          Date ___________________
1. Have any professional liability suits been filed against you that are currently pending in this or any other state? __ Yes __ No

2. Have any professional liability judgments and/or settlements been made against you or on your behalf? __ Yes __ No

3. Have you ever been the subject of a National Practitioner Data Bank adverse action report? __ Yes __ No

4. Has your employment, medical staff appointment, affiliation, or clinical privileges ever been voluntarily or involuntarily suspended, diminished, revoked, refused, or limited in any hospital or health care facility, including to avoid disciplinary action? __ Yes __ No

5. Has your license to practice your profession in any jurisdiction ever been limited, suspended, revoked, denied, or subject to probationary conditions? __ Yes __ No

6. Have you ever voluntarily or involuntarily relinquished your license to practice your profession in any state? __ Yes __ No

7. Have you ever been subject to disciplinary action proceedings by a state or professional body, e.g. OPMC? __ Yes __ No

8. Do you have any pending misconduct proceedings against you in this or any other state? __ Yes __ No

9. Have you ever been convicted of, or are you currently under investigation for a misdemeanor or felony in any jurisdiction? __ Yes __ No

10. Have you ever been cited for violation of patient rights as set forth by the NYS Department of Health or any other state department of health? __ Yes __ No

11. I attest that the information provided on this form is true and accurate. __ Yes __ No

12. I understand that any misrepresentation, misstatement, or omission from this form could result in the immediate rejection or revocation of this request. __ Yes __ No

13. I am currently able to perform the clinical privileges that I have requested. __ Yes __ No

14. I am not currently using any illegal drug, nor have I during the past two years. __ True __ False

____________________________________       _________________
Signature of Applicant                        Date

* * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * *

Restrictions from Credentials Committee:

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

_______________________________
Signature of Applicant

Date

* * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * *

Restrictions from Credentials Committee:
DEA Certification Statement

Required for any provider without a current New York State (NYS) DEA with a current NYS address

I have applied for Medical Staff Membership and privileges and am providing information regarding DEA Certification. You must check off one of the following, complete the information within that selection and sign below.

- I will not be pursuing my own DEA Certificate.
  - Must provide reason and URMC practitioner name below (if applicable).
    - Reason:  __________________________________________________________
    - __________________________________________________________
  
  Name of URMC practitioner with a valid DEA certificate in New York State that will write all controlled substance prescriptions on your behalf *:
    - __________________________________________________________

- I am a trainee and will be using the Institutional DEA# listed below:

<table>
<thead>
<tr>
<th>Institution</th>
<th>DEA#</th>
<th>Suffix #</th>
</tr>
</thead>
<tbody>
<tr>
<td>HH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SMH</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: DEA is required for billing fellows, unless you are in the specialty/professional designation listed below. Billing fellows cannot use the Institutional DEA.

- My degree/professional designation or specialty does not qualify for a DEA certificate.
  - (CSW, L.Ac, LMT, OD, PhD, PsyD, DC, CRNA, Pathology)

If you select one of the following three responses, you must provide the name of the URMC practitioner with a valid DEA certificate in New York State that will write all controlled substance prescriptions on your behalf until you have a valid NYS DEA certificate.*:  ____________________________________________

- I have a DEA in another state and I attest to changing my DEA address to New York State within 30 days of relocating to New York State. I understand and agree to send a copy of my address change form to the Medical Staff Office by faxing to 585-276-0097. (Must provide practitioner name above)

- I have a DEA in another state that I will retain, and have applied for an additional DEA in New York State. I will notify the Medical Staff Office on receipt, and fax the New York State DEA certificate to 585-276-0097. (Must provide practitioner name above)

- I have applied or will apply for my NYS DEA Certificate. (Must provide practitioner name above)

- I have a NYS DEA with my current NYS address.

* If you are unsure of this information, please contact your department administrator.

_________________________   ________________
Signature                  Date

_________________________
Printed Name
URMC Credentials Verification Organization

Consent to Release of Information

Please read carefully before signing on the next page.

I, _______________________________________, (name), have applied for appointment or reappointment (the “Application”) to the University of Rochester Medical Center entity/entities (the “Entity/ies”) or any contracted Entity/ies listed on my Application. I understand that the University of Rochester Medical Center, Department of Credentials & Privilege Review (hereafter referred to as the “University of Rochester Medical Center Credentials Verification Organization” or the “URMC CVO”) administers a centralized credentialing verification service on behalf of the member entities of the University of Rochester Medical Center or any contracted Entity/ies. I agree to the URMC Entity/ies checked on my Application using URMC CVO’s centralized credentialing verification services to process my Application.

In connection with my Application, I consent to the URMC CVO, the Entity/ies and all entities where I have privileges or have made application for privileges to report, release, and exchange information among themselves and with or to (a) the Secretary of the Department of Health and Human Services; (b) the Medical Board of the State of New York; or (c) any other person or entity required by law related to the following: (1) any payments made for my benefit under a policy of insurance, self-insurance, or otherwise in settlement or partial settlement of, or in satisfaction of a judgment in, a medical malpractice action or claim; (2) any professional review action or formal disciplinary procedure that adversely affects my clinical privileges, including the reduction, restriction, suspension, revocation, denial or failure to renew such privileges, for a period longer than 30 days for reasons relating to my professional competence or conduct; (3) any surrender of clinical privileges accepted by a healthcare entity relating to possible incompetence or improper professional conduct, or any surrender of clinical privileges accepted by a health care entity in return for not conducting such investigation or proceeding; (4) any professional review action of a professional society which adversely affects my membership in the society; (5) any surrender of my license(s) or censure, reprimand, or probation by the board of Medical Examiners of any state for reasons relating to my professional competence or professional conduct and (6) any other information which may be required by law.

I further consent to the URMC CVO, the Entity/ies and their representatives to consult with administrators and members of the medical staffs of hospitals or institutions with whom I have been associated and with other entities or persons, including past and present malpractice carriers, who may have information bearing on my professional training, competence, character, mental and physical health status, and ethical qualifications. I also consent to the URMC CVO, the Entity/ies and their representatives, inspecting all documents that may be material to an evaluation of my professional qualifications and competence to carry out the clinical privileges requested, as well as my moral, mental health, and ethical qualifications for membership and/or participation. I hereby waive my right to review any physician references or other similar documents that may be requested and included in my credentials file.

I agree to subject my clinical performances to, and faithfully participate in, the Entity/ies Quality Assurance programs; and I agree to hold members of the Medical Staff and other authorized representatives of the Hospital engaged in these Quality Assurance activities free of all liability for their actions performed in good faith in connect therewith.

At applicable teaching facilities, I agree that the care of my patients will support the teaching mission of the Entity/ies. I and my patients will cooperate in furthering the instruction of students. I understand that the exact methods by which this is done are under the control of the Chief of each Service.

I agree to appear for interviews in regard to this Application if requested to do so.

I authorize the Hospital to release information concerning me to any other hospital or professional association to which I may make application. I agree that all agreements in connection with this application shall also be fully applicable in connection with reappointment, corrective action, hearings, and other reviews or appraisals as provided for in the Bylaws of the Medical Staff or in the Rules and Regulations of the Hospital.

I have provided complete information about any malpractice claims, professional disciplinary proceedings and actions, and felony criminal convictions, and authorize inquiry into those matters. Except as noted on my application, I am not aware of any health impairment that would adversely affect my professional performance and
judgment in the management of my patients. I agree to exhaust internal review processes prior to seeking judicial review of any adverse determination regarding my Medical Staff Membership.

I believe that I am qualified to perform all procedures for which I have requested privileges. Furthermore, I realize that certification by a Board does not necessarily qualify me to perform certain procedures.

I understand and agree that this consent is irrevocable (a) for so long as I am an applicant for privileges at any of the Entity/ies or any entity affiliated with the Hospital which has an agreement with URMC CVO to perform such entity’s credentialing verification or, if later in time, (b) for as long as URMC CVO or any Entity/ies may be under duty to report information regarding me pursuant to the Health Care Quality Improvement Act of 1986, Pub. L.99-660 or any other applicable law.

All information submitted by me in the URMC CVO Application Form (“Application”) signed and dated by me is true to the best of my knowledge and belief. I fully understand that any misstatement in, or omission from, the Application may constitute cause for denial of appointment or reappointment, or cause for summary dismissal from the medical staff.

By applying for appointment or reappointment to the medical staff of any entity listed on the Application, I acknowledge that I have received and have the responsibility to read the medical staff bylaws and rules and regulations of each entity or panel of participants. I agree to be bound by the terms of such documents and all other applicable policies of such entities as may from time to time be in effect, if I am granted membership or clinical privileges. I agree to conduct my practice in accordance with the ethical principles of the American Medical Association or other applicable professional association, and I pledge to provide continuous care for my patients. I agree to observe all the ethical standards of my profession, to provide continuous care and supervision of my patients, and to accept consultation assignments when appropriate. I agree to accept committee assignments.

I hereby release from liability all representatives of URMC CVO, the Entity/ies and any other persons providing information for their acts performed in good faith, without malice and in reasonable belief that any information gathered, exchanged, or released is warranted by the facts known to them.

I accept the obligation of informing the Hospital should my professional liability insurance coverage be canceled or should lapse and further agree to indemnify and compensate the Hospital for any damages which it may incur because of my failure to so act.

I understand and agree that I, as an applicant for Medical staff membership, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications.

Applicant’s Name  (Please print)     Date

Applicant’s Signature  ____________________________________________