

POLICY ON MOONLIGHTING

This document can also be found at <http://extranet.urmc.rochester.edu/urmc-mso/credentialing/MoonlightingApplication.pdf>.

Moonlighting is defined as clinical activities outside of a residency or fellowship training program, for which the trainee is paid on an hourly or other rate, in addition to the approved salary for a trainee at his/her training level.

Professional activities outside the training programs are prohibited to the extent that they may interfere with training program responsibilities. Each department must have its own policy on outside activities, which may be more restrictive than that of the institution. No resident may be required to moonlight.

Prior to seeking such employment, Residents and fellows who wish to engage in outside activities (moonlighting):

1. are required to have written approval from the Chairman or Program Director using the Moonlighting (extra shift) Request Form and the Credentials & Privilege Review forms (pages 1-7)
2. must be in good standing in the training program in full time status
3. should seek written assurance of malpractice and workers' compensation coverage from any outside employer
4. must have a valid New York State medical license
5. may use the institutional DEA number assigned to the affiliated hospital at which the resident is moonlighting as well as your own suffix; alternatively, obtain your own Federal DEA number
6. must hold a MD, DO, DDS or DMD degree
7. MDs and DOs clinical training shall include completion of at least one year in an approved residency training program, which may include a Transitional Year or a year in a designated subspecialty
8. must have a primary appointment in an accredited residency or fellowship program sponsored by the University of Rochester
9. must have his/her performance monitored to ensure that he/she remains in good standing in his/her training program as documented by satisfactory evaluations (semi-annually). If the trainee receives an unsatisfactory evaluation at any time or is terminated from his/her program, the moonlighting appointment will be immediately terminated. If a trainee receives an unsatisfactory evaluation, moonlighting may not be renewed for the remainder of the training program. The Medical Staff Office will be notified in any event.

Approval to moonlight (assume extra shifts) is granted through the end of the current academic year and must be requested for each subsequent year.

If a Resident or Fellow engages in professional activities outside of the training program, the hours devoted to that activity must be added to the training program work hours and must be reported on the Office for Graduate Medical Education work hours survey, and to the Chair and Program Director on any departmental work hours surveys. The trainee is responsible for reporting all moonlighting activity to the program director. The program director is responsible for monitoring the trainee's moonlighting (extra shift) activity and maintaining records of the activity in the trainee's departmental file. The total hours must comply with the number of hours a resident may work as detailed in the University's duty hour policy. Usual trainee duty hours plus moonlighting (extra shift) hours added together must not cause trainees to violate duty hour limits. (See Institutional Policy on Resident/Fellow Duty Hours.)

Residents/fellows must be supervised by a member of the attending staff at SMH and Highland Hospital for all Strong Health moonlighting (extra shift) activities. That attending physician will be the physician of record for all patients cared for by the moonlighting trainee. Supervision will be comparable to that required when residents/fellows engage in activities which are part of the training program. The moonlighting (extra shift) activities may be under general supervision if the resident/fellow has been appropriately credentialed to perform the specific activities under general supervision; if not, the resident/fellow must be directly supervised by the attending physician.

Residents/fellows may moonlight (take on extra shifts) in their own or other Departments at SMH and HH. The employing Department is responsible for maintaining records that the trainee has been appropriately credentialed (see Policy on Credentialing for All Clinical Activities) and privileged to perform the relevant moonlighting activities under general supervision. The employing Department is also responsible for (extra shift) monitoring the status of the appointment through the Credentials & Privilege Review Office,

CATEGORIES OF MOONLIGHTING at Strong Health Facilities

Supervised Extra Work Shifts

Works **dependently** as credentialed, supervised by the attending of record. Payment is by extra compensation. Professional liability insurance provided by Strong Health covers these activities. Requires privileges through the Credentials & Privilege Review Office. Services rendered by residents under general supervision may not be billed. However, attending physicians may bill for services when the Teaching Physician regulations for rendering and documenting services are followed. For questions related to billing for clinical services in these settings, please contact the Compliance Office (5-1609).

Credentials & Privilege Review Office

Request for moonlighting (extra shift) privileges requires completion of packet, which includes:
Completion of *Non-Curricular Resident Activity Form* (including all signatures as required)
Copy of current valid New York State License to practice Medicine
Copy of Current CV
Completed Health Assessment Form
Signed SMH Statement of Assurances

Supervised Extra Work - (elective part of program)

Paid electives coordinated by the program result in additional annual stipend in an equal amount for all residents at the same level of training. This arrangement must be approved by the Graduate Medical Education Committee. No additional appointments are required, as this is part of the program. Professional liability insurance for residency training covers these activities. (If all residents in the program do not pursue the electives, then the experience must be done as above). Services rendered by residents under general supervision may not be billed. However, attending physicians may bill for services when the Teaching Physician regulations for rendering and documenting services are followed. For questions related to billing for clinical services in these settings, please contact the Compliance Office (5-1609).

MOONLIGHTING AND VISA ISSUES

Those training with a J-1 or H-1B visa are not eligible. Trainees must be a US citizen or have a permanent residency card.

Approved by GMEC 4/13/98

Updated by GMEC 2/12/01, 4/21/03

Updated by Medical Staff Office 0806

MOONLIGHTING INSTRUCTIONS:

Please Complete and Send to the Medical Staff Office the Forms on the Following 7 Pages:

- 1) Strong Health Moonlighting (extra work shift) Request Form, p. 1 of 7
- 2) Strong Health System Credentials & Privilege Review, p. 2 and 3 of 7
- 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 7
- 4) SMH SOA and/or HH SOA(Statement of Assurances), p. 5/ 6 of 7
- 5) Consent to Release of Information, p. 7 of 7

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

- 1) Your CV (curriculum vitae)
- 2) Health/PPD form
- 3) Your Delineation of Competencies listing
- 4) New York State License, a copy of the original license and original registration with expiration date

STRONG HEALTH 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

c: 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 _____

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 Department Chair

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 2 of this form.

 Director, Medical Staff Office 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
1. 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:



Strong Memorial Hospital – Golisano Children's Hospital at Strong – Highland Hospital
The Highlands – Eastman Dental Center – Visiting

STATEMENT REGARDING DEA CERTIFICATION

I, _____ have applied for Medical Staff Membership and privileges.
As stated on my application I do not have a DEA Certificate.

1. () I applied for my own DEA certificate on ____/____/____.

I will provide a copy to the Medical Staff Office upon receipt.

2. () I have an institutional DEA _____ Suffix _____.

3. () Please define how patients you treat will obtain prescriptions for controlled substances:

_____.

4. () I will not be pursuing my own DEA Certificate because _____

_____.

5. () Other _____

Applicants Signature

____/____/____ Date

STRONG MEMORIAL HOSPITAL

STATEMENT OF ASSURANCES - SMH

If my application for membership and privileges is approved, I agree to abide by the Bylaws of the Medical Staff, and the Rules, Regulations, and Policies of Strong Memorial Hospital, the University of Rochester, and of the Clinical Services(s) to which I am appointed. 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 agree to subject my clinical performance to, and faithfully participate in Strong Memorial Hospital's 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 connection therewith.

I agree that the care of my patients will support the teaching mission of the School of Medicine and Dentistry. 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 Services.

I authorize the Chief of the Service of my appointment(s), any designated reviewing committee(s), and the Strong Memorial Hospital Medical Staff Office to contact any institution or individual who may have information material to this application. I release Hospital and its staff members from any liability for acts and written or oral statements made in good faith in connection with an evaluation of this application. I release from any liability all individuals and organizations who in good faith provide the Hospital information materials to this application. I agree to appear for interviews in regard to this application if requested to do so.

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 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 page 1, 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 certify all information in this application is true and complete and that any misstatement or omission constitutes cause for withdrawal of privileges.

SIGNATURE

DATE

PLEASE PRINT NAME

HIGHLAND HOSPITAL

STATEMENT OF ASSURANCES - HH

I fully understand that any significant misstatement in or omission from this application constitutes cause for denial of appointment to the Medical Staff. All information by me in this application is true to the best of my knowledge and belief.

In making this application for appointment to the medical staff of this Hospital, I acknowledge that I have received and read the Medical Staff Bylaws including the Rules and Regulations for the department(s) to which I am applying, and I agree to be bound by the terms thereof without regard to whether or not I am granted membership or clinical privileges in all matters relating to the consideration of my application for appointment to the Medical Staff, and I further agree to abide by such Hospital and Staff rules and regulations as may be from time to time enacted.

By applying for appointment to the Medical Staff, I hereby signify my willingness to appear for interviews in regard to my application, authorize the Hospital, its Medical Staff, and their representatives to consult with administrators and members of medical staffs of other hospitals or institutions with which I have been associated, and with others who may have information bearing on my professional competence, character, and ethical qualifications.

I hereby further consent to the inspection by the Hospital, its Medical Staff, and its representatives of all records and documents, including medical records at other hospitals 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 and ethical qualifications for staff membership.

I hereby release from liability all representatives of the Hospital and its Medical Staff for their acts performed in good faith and without malice in connection without malice in connection with evaluation of my application and my credentials and qualifications; and I hereby release from any liability any and all individuals and organizations who provide information to the Hospital, or its Medical Staff, in good faith without malice concerning my professional competence, ethics, character, and other qualifications for staff appointment and clinical privileges; and I hereby consent to the release of such information.

I hereby further authorize and consent to the release of information by this Hospital, or its Medical Staff, to other hospitals and medical associations on request regarding any information the Hospital and the Medical Staff may have concerning me as long as such release of information is done in good faith and without malice; and I hereby release from liability this Hospital and its staff for so doing.

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.

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.

Name _____ *(please print)*

Signature _____ **Date** _____

Strong Health Credentialing Verification Office

Consent to Release of Information

Please read carefully before signing

I, _____, (name), have applied for appointment or reappointment (the "Application") to the Strong Health System entity/entities (the "Entity/ies") listed on my Application. I understand that the University of Rochester Medical Center, SMH Department of Credentials & Privilege Review (hereafter referred to as the "Strong Health Credentialing Office" or the "SH CVO") administers a centralized credentialing verification service on behalf of the member entities of the Strong Health System. I agree to the SH Entity/ies checked on my Application using SH CVO's centralized credentialing verification services to process my Application.

In connection with my Application, I consent to the SH 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 SH 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 SH 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 hereby release from liability all representatives of SH 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 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 Strong Health System which has an agreement with SH CVO to perform such entity's credentialing verification or, if later in time, (b) for as long as SH 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 Uniform Application Form ("Application") signed by me and dated _____ 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.

Applicant's Name (Please print)

Date

Applicant's Signature