

Wichita
RESIDENT RURAL HEALTH MOONLIGHTING REQUEST
(To be submitted no less than 2 weeks prior to planned activity.)

1. Approval is requested for _____ to
Name of Resident PGY-level
participate in a moonlighting activity (for compensation) during time that he/she
is not required to participate in his/her residency program sponsored by the KUSM-W.

2. This moonlighting will occur for:

Name of Physician Location of Physician's Office, Clinic or Hospital Date(s) Time(s)

3. Reason for physician's absence (illness, vacation, CME, etc.)

4. Reason why resident coverage via moonlighting is more appropriate than coverage via
another community physician. (Use a separate sheet if necessary.)

5. The resident has a full license issued by the Kansas State Board of Healing Arts and has
an individual DEA registration number.

License # DEA registration # DEA expiration date

6. The resident is covered by a personal malpractice insurance policy in an amount no less
than one million dollars per occurrence/three million dollars annual aggregate. A copy
of the certificate of insurance must be attached to this form submitted to the WCGME
office.

Policy Number Effective Date Expiration Date

7. As Program Director, I verify the resident is in good standing and recommend that the
resident is approved for such moonlighting.

Program Director's Signature Date

8. I request permission to participate in the moonlighting activity identified above. I
understand that it constitutes an extracurricular activity falling outside the confines of
my formal residency program. I understand these hours count toward the 80hour/week
duty hour maximum.

Resident's Signature Date

FORWARD ALL COPIES TO: Wichita Center for Graduate Medical Education
1010 N. Kansas
Wichita, KS 67214-3199

Approved by:

Chief Operating Officer Date Executive Vice Chancellor – KUMC Date