YALE-NEW HAVEN HOSPITAL
YALE UNIVERSITY SCHOOL OF MEDICINE

Moonlighting Compliance Attestation

I, _____, understand that it is the policy of the _____ Residency/Fellowship Program at Yale-New Haven Hospital to comply with the ACGME Moonlighting Requirements for all residents and fellows. I understand the policy requires the following:

- I shall not be required to moonlight.
- I will receive signed permission for moonlighting from my Program Director via the appropriate departmental document for all moonlighting.
- All moonlighting hours performed must be counted towards my 80 hour weekly work limit.
- My performance will be monitored for the effect of these activities upon performance and that adverse effects may lead to withdrawal of permission to moonlight.
- Residents are not permitted to bill for professional services provided within the scope of their training program and during working hours.
- Yale-New Haven Hospital will not provide liability coverage to residents while on professional activities (moonlighting) outside of the training program.

The requirements of the policy have been explained to me by Program Director _____, who has requested that I comply with the directives of this policy.

I understand that if I fail to adhere to this policy, it may result in my suspension from clinical duties, failure to be promoted to the next level of training and/or termination from the _____ Residency/Fellowship Program.

Signed: _____
Resident/Fellow

Signed: _____
Program Director

Department: _____

Date: _____

YALE-NEW HAVEN HOSPITAL
YALE UNIVERSITY SCHOOL OF MEDICINE

Moonlighting Compliance Attestation

I, _____, understand that it is the policy of the _____ Residency/Fellowship Program at Yale-New Haven Hospital that moonlighting **is not allowed in this program.**

This policy has been explained to me by Program Director _____, who has requested that I comply with the directives of this policy.

I understand that if I fail to adhere to this policy, it may result in my suspension from clinical duties, failure to be promoted to the next level of training and/or termination from the _____ Residency/Fellowship Program.

Signed: _____
Resident/Fellow

Signed: _____
Program Director

Department: _____

Date: _____

YALE-NEW HAVEN HOSPITAL
YALE UNIVERSITY SCHOOL OF MEDICINE

Moonlighting Compliance Attestation
J-1 Visa Holders Only

I, _____, understand that as a resident/fellow in the _____Residency/Fellowship Program at Yale-New Haven Hospital, and on a J-1 visa, that I am not permitted to moonlight.

I understand that if I fail to adhere to this policy, it may result in my suspension from clinical duties, failure to be promoted to the next level of training and/or termination from the _____ Residency/Fellowship Program.

Signed: _____
Resident/Fellow

Signed: _____
Program Director

Department: _____

Date: _____