Moonlighting Approval Form

Non training professional activities (Moonlighting) approval for UNR Med Psychiatry Residents

Date _____

I, _____ have read the UNR Med Psychiatry manual and the institutional policy manual and agree to adhere to the practice requirements in both documents.

I will be moonlighting at: _____
Location

I will be moonlighting at: _____
Location

I will be moonlighting at: _____
Location

I agree to file a Review of Activities form every 4 months, per ACGME requirements.

Signature _____ Date _____

Program Director _____ Date _____

Department Chair _____ Date _____

University of Nevada, Reno
School of Medicine
Psychiatry and Behavioral Sciences