Stanford HEALTH CARE
STANFORD MEDICINE

Residents and Fellows On Call Coverage or Moonlighting
Stanford Hospital and Clinics/Lucile Packard Children's Hospital
(Requests are valid for a maximum of one academic year and must be renewed annually)

I certify that I have read and agreed to follow the Stanford Hospital and Clinics/Lucile Packard Children's Hospital Policy on "Payment for extra services by residents and fellows." I understand that approval of this request is only for duties outlined below.

Program Director Name _____ **Program Director Signature**_____
Name of Protocol: (Must appear on all invoices)_____

Moonlighting:_____ On Call Coverage:_____

Name of Program:_____ Administrative Contact:_____

Contact email:_____ Contact telephone:_____

Description of Duties:

1) If on call –attach a copy of your program curriculum and highlight the applicable section.
2) If moonlighting, attach a copy of the CPT codes billed for and explain how the billing is not part of the training program.

2. Please list the hourly wage to be paid and describe **how the prevailing wage was determined**.
_____

3. Please list **ALL** names and estimated number of hours per month of all residents/fellows who are expected to receive payment under this on call coverage process.

Resident Name	Employee Number	Sub-Acct	Cost Center	HRS/Month

PTA to charge if applicable: _____

Please allow 60 days for review and approval of this request.
Approved by GMEC: _____

Signature: _____Date:_____