Attachment #12

STANFORD UNIVERSITY SCHOOL OF MEDICINE

DEPARTMENT OF DERMATOLOGY

REQUEST FOR MOONLIGHTING

Please submit this request to your Mentor and the Residency Program Director for approval.

Resident Name:

Dates (inclusive):

Institution/Practice:

Hours of Moonlighting: _____

Description of Moonlighting:

Please provide the Residency Program Coordinator the original of your signed form, as well as proof of malpractice coverage.

_____ _____

Signature of Resident Date Submitted

APPROVAL:

_____

Faculty Mentor Director of Residency Program