

# MOONLIGHTING VERIFICATION FORM

Resident

Fellow

Name: \_\_\_\_\_

Moonlighting Date: \_\_\_\_\_

Address: \_\_\_\_\_

Hours worked: \_\_\_\_\_

\_\_\_\_\_

Baylor ID: \_\_\_\_\_

\_\_\_\_\_

**Department:** \_\_\_\_\_

I verify that I was scheduled and worked on the date listed above at the following location:

\_\_\_\_\_ **TCH Main Campus**

\_\_\_\_\_ **TCH West Campus**

Rotation to which resident is assigned during the requested time of ECEP (be specific).

**If on elective, specify which elective** \_\_\_\_\_.

I verify that despite taking this extra call, I will still have an average of 4 days without clinical duties during this 4-week period, and that my total work hours will not exceed 320 hours for this 4-week period, (80 hours per week).

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

It is the moonlighter's responsibility to complete this form and email to **Andrea Fletcher or Sara Moser**.

**Verification form must be submitted within two weeks of the moonlighting shift for which you are requesting payment. Payment will not be processed until the verification form is received.**

Thank you! ☺

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**To be completed by TCH:**

Payment amount: \$ 618

I, M Tyson Pillow, MD, MEd, certify that the services mentioned above were performed as scheduled.

\_\_\_\_\_  
**M Tyson Pillow, M.D., MEd**

\_\_\_\_\_  
**Date**