Extended Medical Professional Liability Insurance for Moonlighting

Medical professional liability insurance coverage applies on behalf of physicians, dentists, and podiatrists, who are named on the *Expanded Coverage Schedule of Insureds*. The insurance described in this confirmation is subject to the terms and conditions of any applicable CRICO house officer medical professional liability policy ("Policy").

The insurance provided by the Policy is hereby extended to the resident or fellow named herein to cover "Professional Services," as defined in the Policy, outside the scope or course of his/her professional employment with a "Named Insured" or program of approved medical instruction by a "Named Insured."

Note: Per the MA Board of Registration in Medicine, any resident or fellow moonlighting is required to have a full license.

Coverage is for *(check one)* ❑ Fellow ❑ Resident, PGY 3–10 ❑ Resident, Emergency Medicine *(See Emergency Room Required Certification below.)*

Name of Resident or Fellow _____ Social Security No. ☐☐☐ ☐☐ ☐☐☐☐

Sponsoring Institution

The resident/fellow named above is provided coverage by the "Named Insured" institution checked below:

❑ Beth Israel Deaconess Medical Center, Inc.
❑ The Brigham & Women's Hospital, Inc.
❑ Cambridge Health Alliance
❑ Children's Medical Center Corporation
❑ Dana-Farber Cancer Institute, Inc.
❑ Harvard School of Dental Medicine
❑ Harvard T. H. Chan School of Public Health
❑ Harvard University Health Services
❑ Joslin Diabetes Center, Inc.
❑ Massachusetts Eye and Ear Infirmary
❑ Massachusetts Institute of Technology
❑ The Massachusetts General Hospital
❑ The McLean Hospital Corporation
❑ Mount Auburn Hospital
❑ New England Baptist Hospital
❑ Newton-Wellesley Health Care Systems, Inc.
❑ North Shore Medical Center, Inc.
❑ Spaulding Rehabilitation Hospital

Non-CRICO institution(s) where resident/fellow will be moonlighting _____

Coverage as described in this confirmation terminates as respects the medical or dental resident or fellow at the earliest of:
1. The date upon which the individual elects to cancel such coverage, or
2. The date the resident or fellow is no longer provided coverage by the "Named Insured" institution issuing this confirmation, or
3. The date the moonlighting ends.

Resident's/Fellow's Moonlighting Dates

_____ Moonlighting Begins _____ Moonlighting Ends

Emergency Room Required Certification

Coverage requires Advanced Cardiac Life Support (ACLS) or Pediatric Advanced Life Support (PALS) and Advanced Trauma Life Safety (ATLS) certifications.

Will the resident or fellow be practicing part-time in an Emergency Room outside the Harvard Medical Institutional System?
❑ No ❑ Yes If "yes," state when and where the resident or fellow received certifications. PGY 3 and PGY 4 residents may **NOT** moonlight in an emergency room outside the Harvard Medical Institutional System, unless enrolled in the Harvard-affiliated Emergency Medicine Residency Program.

_____ Date _____ Agency Granting ACLS or PALS Certification

_____ Date _____ Agency Granting ATLS Certification

Signatures

_____ Signature of Resident/Fellow

_____ Signature of Chief of Service (Approved by Named Insured)

_____ Name of Chief of Service (please print)

Controlled Risk Insurance Company of Vermont, Inc.

_____ Duly Authorized Representative

Please review and complete the checklist on the last page of this form.

crico

Extended Medical Professional Liability Insurance for Moonlighting

INSURED RESIDENT/ FELLOW

Name: _____
Please print

❑ Fellow ❑ Resident, PGY 3–10 ❑ Resident, Emergency Medicine *(Complete Emergency Room Required Certification.)*

EVALUATION FACTORS

Checklist must be completed by insured resident/fellow

		True	False	Not Applicable
1	I have a full Massachusetts medical license.	☐	☐	☐
2	There is congruence among my education, training, prior experience, current program, and competence and the patient care responsibilities of the requested clinical extension(s).	☐	☐	☐
3	I have confirmed that I will *not* be the sole physician on duty in the area(s) in which the clinical extension is requested.	☐	☐	☐
a	If "false," I have ascertained that arrangements have been made for back-up physician availability, including consultation and anesthesia and radiology services, if applicable.	☐	☐	☐
4	I have assessed the adequacy of the support services, the physical plant, and equipment for safe patient care at the site(s) for the requested clinical extension.	☐	☐	☐
5	I have confirmed that the amount of overtime work planned will *not* adversely impact my clinical performance in either my current program or the requested clinical extension.	☐	☐	☐
6	I have confirmed that my moonlighting activities will *not* exceed the maximum number of hours per week that my hospital has approved for insureds to do work.	☐	☐	☐
7	**If the clinical extension requested is for emergency services**, please refer to the "Guidelines for Credentialing and Delineation of Clinical Privileges in Emergency Medicine" developed by the American College of Emergency Physicians. These guidelines list potential clinical situations that a resident or fellow might face in an unsupervised Emergency Room setting.			
a	I possess the credentials to perform special procedures that may be required at the facility where I will be practicing part-time.	☐	☐	☐
b	I have confirmed that I will *not* be providing in-house services, e.g. response to cardiopulmonary arrests, insertion/replacement of lines.	☐	☐	☐
i	If "false," I have confirmed that arrangements have been made for physician coverage of the emergency services in my absence while on the units.	☐	☐	☐
c	**I possess current ACLS or PALS *and* ATLS certification.**	☐	☐	☐
8	The requested clinical extension site(s) will provide malpractice liability coverage for me.	☐	☐	☐

9 If this requested clinical extension is for an out-of-state site, my medical license number in that state is: _____

10 The name of my supervising clinician(s) at the moonlighting institution: _____
Attach additional pages if necessary

SIGNATURES

_____ _____
Signature of Resident/Fellow Date

_____ _____
Signature of Chief of Service Date

_____
Name of Chief of Service (please print)