Policy of the Graduate Medical Education Committee
Section: Institutional Responsibilities
Subject: Supplemental Clinical Activities
Number: 3.400
Date Developed: 2/99
Last Review/Revision: 10/04, 10/07, 7/10, 7/2011, 10/2012, 10/2013, 5/2014
Replaces: previous policy of same name, dated 7/2010
ACGME Requirement: Institutional IV.J.1.a); Common VI G.2.

Purpose
The policy will define supplemental clinical activities (internal moonlighting) resulting in additional financial support, the procedure for approval of such activities, and approval for the participation of residents in these activities.

The policy should also serve as a guideline against inappropriate use of resident service, in activities that residents may have covered previously as part of the educational program, occurring in teaching institutions.

Definition
Supplemental clinical activities are voluntary, compensated, medically-related work performed within any institution in which the program has required or elective rotations.

Policy
Development of a supplemental clinical activity is made by a request from the Departmental Chairperson and/or Training Program Director to the Associate Dean for GME and must be approved by the Dean.

Supplemental clinical activities are covered by the housestaff malpractice insurance and count toward the 80 hour week.

PGY-1s may not engage in these activities.

A resident must obtain a prospective written statement of permission of his/her Program Director for supplemental clinical activity.

The Program Director and the individual resident must closely monitor the activity to ensure it does not interfere with the resident's ability to achieve the goals and objectives of the educational program. If a resident is no longer performing satisfactorily in the program, the Program Director may withdraw the permission to participate in the supplemental clinical activity.

Procedure
1. The Departmental Chairperson and/or Training Program Director submits a written request to the Associate Dean for GME describing the clinical activity using the Supplemental Clinical Activity Approval Form and the Supplemental Clinical Activity Yearly Participant form at the end of this policy.
2. If the Associate Dean for GME has questions, the GME Office will investigate. If there are no questions, the Associate Dean for GME submits the request to the Dean and Risk Management for signatures.
3. Written documentation of approval is provided to the Program Director, Departmental Chairperson and the Assistant Dean for Housestaff Records.
4. The Associate Dean for GME maintains a file(s) on descriptions of approved supplemental clinical activities as well as persons who participate in supplemental clinical activities. These files will be updated yearly in August

Supplemental Clinical Activity Approval Form

Supplemental clinical activities are voluntary, compensated, medically-related work performed within any institution in which the program has required or elective rotations.

Date of Request: _____

Program: _____

Is resident/fellow participation in this activity ongoing from year to year? Yes or No

If not ongoing, list the date range of the activity. _____

Name of activity: _____

Location of activity: _____

*List the average number of hours/week resident(s) will participate in this activity_____

*List the average number of times/week resident(s) will participate in this activity_____

How many residents will participate in this activity? _____

Description of Activity:

Responsibilities of Resident:

Who supervises this activity? (*Please include both the name and title of the individual(s))*

Sources of additional financial compensation to the resident(s) (if applicable):

Program Director: Name _____ Signature_____ Date_____

GME Office will obtain signatures below:

Director of FGP Risk Mgt: Name _____ Signature_____ Date_____

Associate Dean for GME: Name _____ Signature_____ Date_____

College of Medicine Dean: Name _____ Signature_____ Date_____

*If more than one person participates in this supplemental clinical activity, the time commitment reflects all residents combined.

Reference: GMEC policy 3.400 Supplemental Clinical Activities

Supplemental Clinical Activities (SCA) Yearly Participant Form

Program name: _____

Date range of activity: _____

Activity: _____

Supervisor of activity: _____

List below the name of each resident in the program who has participated in the above named SCA during the time frame listed.

Resident names and PGY year:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

If anything regarding this activity has changed since initial approval (i.e., who supervises, resident responsibilities, etc) please describe below.