Independent Clinical Practice Plan

Name and address of Resident:

Name of service: _____

Location of service:_____ (Name of Hospital/Clinic, City)

Job Description:

Dates of approval: November 1 – April 30 _____
May 1 – October 31 _____

I acknowledge and accept the terms of the College of Medicine Moonlighting and Independent Clinical Practice Policy (specifically numbers 8, 9 and 10) and the PAIRS Collective Agreement surrounding Maximum Hours and Limitations on Work Periods (Article 9).

_____ _____

Date Signature of Resident