Application for Resident Extracurricular Clinical Practice
(Edwardical licence - “Moonlighting Endorsement”)

☐ Moonlighting Request
(supervised practice)

Name of Resident Applicant: __________________________________________________________

Program: __________________________________________________________________________

Failure to meet deadlines for renewal may result in loss of moonlighting privileges for the next six month period.

New Application: Cannot exceed 6 months. Expires at closest of Expiry Dates. Application for renewal must be submitted as per timelines outlined in “Renewal Application” box below. New application requests MUST be received a minimum of 2 weeks prior to requested start date.

Start Date: ___________________________                     Expiry Date: ☐ April 30 ☐ October 31

Renewal Application: Cannot exceed 6 months. Note timelines.

Renewal Terms:
☐ May 1 to October 31 (Deadline for submission to Postgraduate Medical Education Office no later than March 15)
☐ November 1 to April 30 (Deadline for submission to Postgraduate Medical Education Office no later than September 15)

Please provide name of person responsible for scheduling your moonlighting shifts.

Scheduler Name ___________________________ Phone Number ___________________________ Email Address ___________________________

I have reviewed the Moonlighting Policy and hereby accept the terms and limitations of the Moonlighting Policy and of the attached practice plan. I acknowledge that any change requires a revised practice plan and new approval. I am responsible for seeking permission from the individual whom I identify as my supervisor (as required by the College of Physicians and Surgeons of SK (CPSS) for licensing purposes). The supervisor should be someone other than my Program Director. I further agree that I will take responsibility for ensuring that all moonlighting activities are reported on a monthly basis to the Postgraduate Medical Education Office.

_________________________________________ ___________________________ ___________________________
Scheduler Name Phone Number Email Address

Resident ___________________________ Date ___________________________

I have reviewed this application, the attached practice plan and the CPSS Moonlighting Endorsement Form. I am satisfied that undertaking such moonlighting is not anticipated to interfere with this resident’s education.

_________________________________________ ___________________________ ___________________________
Program Director Phone Number Email Address

Date

+ I have reviewed this application and attached practice plan and approve this submission based on the recommendation by the Program Director.

_________________________________________ ___________________________ ___________________________
Associate Dean, Postgraduate Medical Education Phone Number Email Address

Date

Must attach to new and renewal applications: (1) Resident’s moonlighting practice plan; (2) Completed CPSS Moonlighting Endorsement Form; 3) proof of LMCC; (4) proof of CMPA type of work code needed for moonlighting (5) copy of job description with list of competencies.

Submit to: Associate Dean, c/o Jennifer Dybvig, Postgraduate Medical Education, Room 411 St.Andrew’s College, 1121 College Drive

Once approved: Resident is responsible for obtaining the appropriate moonlighting license, reporting the moonlighting license number to CMPA, obtaining appropriate approval/privileges with the appropriate health region, and reporting moonlighting activities on a monthly basis to the Postgraduate Education Office.