

**NONPROGRAMMATIC PROFESSIONAL ACTIVITY\***

Name of housestaff member: \_\_\_\_\_  
Department and subspecialty program: \_\_\_\_\_  
Location of employment: \_\_\_\_\_  
Date(s) of Employment: \_\_\_\_\_  
Description of professional activity: \_\_\_\_\_  
Medical liability insurance coverage: \_\_\_\_\_  
Occurrence coverage preferred to claims coverage: \_\_\_\_\_  
Provider: \_\_\_\_\_  
Liability Limits: \_\_\_\_\_

I understand that I may not engage in any nonprogrammatic activity outside of this approval process. Any such activity will be grounds for my immediate termination from the program in

(\_\_\_\_\_). I further attest that I understand that this activity, if approved, is apart from my assignment as a graduate medical student of the University of Florida. I understand that the University of Florida is not responsible for and does not provide medical professional liability coverage, disability insurance or workers' compensation coverage for nonprogrammatic professional activity. I will finish my outside employment at least 12 hours prior to residency duties unless given explicit permission by my program director.

I expressly and unequivocally understand and agree that this nonprogrammatic activity is in no way related to my employment with the University of Florida and that the University of Florida has no obligation, responsibility, or liability whatsoever for any injury or harm which I may incur or which may befall me during my performance of or a result of this outside activity. Accordingly, I hereby release, forever discharge, and waive any and all claims I may have now or in the future arising out of or connected with my outside employment activities against the University of Florida, the State of Florida, the Department of Education for the State of Florida, or the Board of Regents for the State of Florida, and any all officers, agents, employees, underwriters and insurers, all individually and in their respective official capacities.

Signature \_\_\_\_\_

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**CERTIFICATION BY PROGRAM DIRECTOR AND/OR CHAIRMAN OR ASSOCIATE CHAIRMAN:**

I have reviewed this request and certify that this activity, when combined with the numbers of hours or work per week required of this individual by our program, will not exceed the guidelines established by the Residency Review Committee for our program.

Approved: \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_  
Disapproved: \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

If approved by the department, approval by the Director of Graduate Medical Education must also be obtained.

Approved: \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_  
Disapproved: \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

**\*This form is for Housestaff only and serves in lieu of University of Florida Outside Activities Report, Form OAA-GA-L-267**