

ACKNOWLEDGEMENT

I HEREBY ACKNOWLEDGE RECEIPT OF THE UNIVERSITY HOSPITALS CLEVELAND MEDICAL CENTER RESIDENT MANUAL (THE "MANUAL"). BY SIGNING BELOW, I FURTHER ACKNOWLEDGE AND AGREE THAT I READ AND UNDERSTAND THE MANUAL AND AGREE, AS A CONDITION OF MY RESIDENCY, TO BE BOUND BY AND COMPLY WITH THE MANUAL.

I SPECIFICALLY AGREE THAT I HAVE READ AND UNDERSTOOD THE TERMS IN SECTION 3.9, LICENSURE. IT IS MY RESPONSIBILITY TO OBTAIN AND MAINTAIN OHIO STATE MEDICAL BOARD LICENSURE.

FURTHER, I SPECIFICALLY AGREE THAT I HAVE READ AND UNDERSTOOD THE TERMS UPON WHICH I CAN MOONLIGHT OR PERFORM EXTRA DUTY FOR PAY AS DESCRIBED IN SECTION 5.3, AND UNDERSTAND THAT IF I AM WORKING ON VISA STATUS I AM NOT ELIGIBLE TO MOONLIGHT. I UNDERSTAND THAT MY FAILURE TO COMPLY WITH THE TERMS OF 5.3. CAN RESULT IN MY IMMEDIATE DISMISSAL FROM MY PROGRAM.

Name of Resident

Signature of Resident

Date

Department