NEW YORK CITY HEALTH + HOSPITALS
Housestaff Request

General Information

Facility: ______________________________ Clinical Service:______________________________

Housestaff Officer Information

First Name: _________________________________ Last Name:_________________________________

Employee ID: ___________________ Job Class: _______________

Date of Coverage: _____/_____/_____

Payment Information

*If you are claiming multiple payments, please complete a separate request form for each.

Please check one box only

Type of On-call/coverage	Code	Amount
☐ Weeknight	OCE	$418
☐ Weekend/Holiday	OCW	$558
☐ Short Call	OCS	$210
☐ Critical Care Coverage Weekday - (Non COVID-19)	CCC	$418
☐ Critical Care Coverage Weekday - COVID Emergency Preparedness	CC1	$418
☐ Critical Care Coverage Weekday - COVID General Activities	CC2	$418
☐ Critical Care Coverage Weekend/Holiday - (Non COVID-19)	CCC	$558
☐ Critical Care Coverage Weekend/Holiday - COVID Emergency Preparedness	CC1	$558
☐ Critical Care Coverage Weekend/Holiday - COVID General Activities	CC2	$558

☐ Scheduled Holiday Worked Pilot (More than 50% of shift) $200/per Shift

Holiday Worked: ____________________ (New Year's Day, Martin Luther King Jr. Day, Washington's Birthday, Memorial Day, Labor Day, Independence Day, Thanksgiving Day, Christmas Day).

If requesting on-call compensation, please complete the following for absent housestaff officer:

First Name:____________________________ Last Name:_____________________________

Dates of Absence: ___/___/___ to ___/___/___

If I am claiming compensation for critical care coverage, I hereby certify that such hours are in addition to my regular residency hours

Housestaff Officer Signature:____

Approval
(to be completed by Program Director/Chief Resident)

Name:_________________________________ Title: _______________________________

Signature:______________________________

Date: __/___/__

Note A copy of department/service on-call schedule must be attached for payment to be made.