

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
<input type="checkbox"/> Weeknight	OCE	\$418
<input type="checkbox"/> Weekend/Holiday	OCW	\$558
<input type="checkbox"/> Short Call	OCS	\$210
<input type="checkbox"/> Critical Care Coverage Weekday - (Non COVID-19)	CCC	\$418
<input type="checkbox"/> Critical Care Coverage Weekday - COVID Emergency Preparedness	CC1	\$418
<input type="checkbox"/> Critical Care Coverage Weekday - COVID General Activities	CC2	\$418
<input type="checkbox"/> Critical Care Coverage Weekend/Holiday - (Non COVID-19)	CCC	\$558
<input type="checkbox"/> Critical Care Coverage Weekend/Holiday - COVID Emergency Preparedness	CC1	\$558
<input type="checkbox"/> 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, Juneteenth, Independence Day, Labor 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.