**NEW YORK CITY HEALTH AND HOSPITALS CORPORATION**

**Housestaff On-Call Coverage Pool Reimbursement Request**

## General Information

Facility

Clinical Service

## Covering Housestaff Officer Information

Last Name

First Name

Job Class

Employee ID ___ - ___ - ____ - ___

Date of Coverage ___ - ___ - ___

## Payment Information

Please check the appropriate box:

| | Type of Call | Code | Amount |
|---|---|---|---|
| ☐ | Weeknight/Night Float/ER | OCE | $418 |
| ☐ | Weekend/Holiday/ER | OCW | $558 |
| ☐ | Short Call | OCS | $210 |

## Absent Housestaff Officer Information

Last Name

First Name

Dates of Absence ___ - ___ - ___ to ___ - ___ - ___

Reason for Absence _____

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

Name _____

Title _____

Signature _____

Date ___ - ___ - ___

NOTE Top copy to Payroll Department. Clinical service or department retains duplicate copy.
*A copy of department/service on-call schedule must be attached for payment to be made.*

HHC 799 (May 07)