TIMESHEET No

For Internal Use only

WEEK COMMENCING Monday __/__/20__

Timesheets can be emailed to timesheets@europeanbizhealthcare.co.uk no later than Monday 12:00 (lunch time) to be paid the same week.

****All timesheets must be signed daily****

(Block capital)

CONTRACTOR NAME:

Professional Registration Number:

HOSPITAL NAME:

							Please tick		*Person In Charge*				
Day	Date	Start Time	Finish Time	No of Hours	Break Time	Hours Payable	Day Shift	Night Shift	WARD DEPARTMENT	Name	Signature	Grade	Reference No
Monday													
Tuesday													
Wednesday													
Thursday													
Friday													
Saturday													
Sunday													

To prevent delay in payment, this timesheet must authorised/signed by your Line Manager at the end of your shift.
Any travel expenses will only be payable if authorised at the time of the booking.

Induction ○ I can confirm that I undertook the Client induction training prior to commencement of my shift at the Client's premisses as stated on this timesheet.

Declaration I declare that the information I have given on this form is correct and complete and that I have not claimed elsewhere for the hours/shift detailed on this timesheet. I understand that if I knowingly provide false information, it may result in disciplinary action and I may be liable for prosecution and civil recovery proceedings. I consent to the disclosure of information from the form to third parties and if applicable by the NHS body and the NHS CFSMS for the purpose of verification of this claim and the investigation, prevention, detection and prosecution of fraud.

PRINT NAME: DATE: SIGNATURE:

Client Authorisation I am an authorised signatory for the Client/Ward/Department as stated above. I am confirming that the grade of the agency worker and the hours worked are accurate and I approve payment. I understand that if I knowingly provide false information, it may result in disciplinary action and I may be liable for prosecution and civil recovery proceedings. I consent to the disclosure of information from the form to third parties and if applicable by the NHS body and the NHS CFSMS for the purpose of verification of this claim and the investigation, prevention, detection and prosecution of fraud.

PRINT NAME: DATE: SIGNATURE: