

Weekly TimesheetEmail: accounts@dream-medical.netTimesheet Ref NoWeek Ending DateTel: 01189255335Fax: 01189195119

All entries must be in <u>black ink and block capitals</u> . No correction fluid must be used on the timesheet. Any timesheet that is incomplete or illegible will result in the form being returned back to you and a delay in the payment. Any corrections or alterations made on the timesheet by the agency worker must be initialed by the authorised signatory. Before the timesheet is submitted for authorisation, any uncompleted boxes must be crossed through. Time of hoursworked should be entered in the twenty-four hour clock format.	
Candidate Name	Client Name
NMC/HcPC No.	Location
Grade/Specialty	Department
Booking Ref No.	Reporting to

## **CANDIDATE SECTON ONLY**

	Date	Start Time	End Time	Start Break	End Break	Total Break Deduction	Total Hours		Candidate Declaration		
e.g.	01/01/2013	09:00	18: 00	13:00	14:00	1:00	8:00		ormation I have given on this form is correct and complete and ed elsewhere for the hours/shifts detailed on this timesheet. I		
Monday	1 1 : : : : :		understand that if I knowingly provide false information this may result in disciplinary								
Tuesday	/ /	:	:	:	:	:		the disclosure of info	action and I may be liable for prosecution and civil recovery proceedings. I consent to he disclosure of information from this timesheet to and by the NHS body and the NHS Counter Fraud and Security Management Service for the purpose of verification of this claim and the investigation, prevention, detection and prosecution of fraud. By		
Wednesday	/ /	:	:	:	:	;					
Thursday	/ /	:	:	:	:	;		signing this timesheet I have accepted the terms and conditions of the agency and also confirm that I have received a suitable client induction prior to commencing the assignment.			
Friday	/ /	:	:	:	:	;					
Saturday	/ /	:	:	:	:	:		Please sign and date below to confirm that the information you have submis correct. Please provide supportive evidence for all expenses claimed.			
Sunday	/ /	:	:	:	:	:		Locum Signature			
						Total		Date			

## **CLIENT SECTION ONLY**

Placement assessment Please complete	N/ A	Unsatisfactory	Borderline	Satisfactory	Good	Excellent	Client Authorisation			
Clinical Skills in line with need of position							"I am an authorised signatory for my ward/department/NHS body and I am sign-			
Relationships with patients & staff							ing below to confirm both the grade of agency worker and the hours/shift I am authorising are accurate and I approve payment. I understand that if I knowingly			
Timekeeping							authorise false information this may result in disciplinary action and I may be liable			
Managing workload							for prosecution and civil proceedings. I consent to the disclosure of information from this timesheet to and by the NHS body and the NHS Counter Fraud and			
Reliability							Security Management Service for the purposes of verification of this claim and the investigation, detection and prosecution of fraud" Any questionable timesheet must			
Communication skills							be immediately brought to the attention of the Local Counter Fraud Specialist or you			
Supervisory skills							may report any case of fraud, in confidence to NHS Protect Reporting on 08 4060.			
Organisational ability							Print Name			
Sickness/absence record							Client Signature			
Overall clinical& professional performance							Date			