No Correction fluid should be used on this timesheet

Timesheet No.

Workers Name (print)

Name: ____________________

Worker No: ____________________

Job Title/Specialisation: ____________________

Grade/Brand: ____________________

Client Details (complete name and address)

Hospital/Organisation: ____________________

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____

Ward/Department: ____________________

Any incomplete or illegible timesheets will result in the form being returned to the agency worker and delay in payment

Travel Expenses Claim
(requires separate authorisation)

Miles:______________

Pence per mile: _______

Authorisation Signature:

____

IMPORTANT NOTE:

1. Leave pink copy of timesheet with Hirer.
2. Temporary Worker to retain yellow copy.
3. Return white copy to branch by Monday following week worked at the latest.

	Please use 24-hour clock and enter reference numbers									ON-CALL / SLEEPIN			
Day	Date	Start Time	Finish Time	No Of Hours	Break Start Time	Break Finish Time	Hours Worked	Reference Number	Client Signature	Start Time	Finish Time	Actual Hours Worked	Total Time
MON													
TUE													
WED													
THU													
FRI													
SAT													
SUN													

Total hours worked: [ ] [ ]

Total number of hours worked (written in words): ____________________

Workers declaration and confirmation of hours

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/shifts detailed on this timesheet. I understand that if I knowingly provide false information this may result in termination of assignment and I may be liable to prosecution and civil recovery proceedings. I consent to the disclosure of information from this form to and by the Hirer for the purpose of verification of this claim and the investigation, prevention, detection and prosecution of fraud. Also, by signing this timesheet I can confirm that I am in good health and fit to practice.

PRINT NAME:		SIGNED:		DATE:

Client declaration, approval of hours and payment

I am an authorised signatory for my ward/department of the Hirer. I am signing to confirm that the Job Profile Title and Band of Nurse and the hours/shift that I am authorising are accurate and I approve payment. I understand that if I knowingly provide false information this may result in disciplinary action and I may be liable to prosecution and civil recovery proceedings. I consent to the disclosure of information from this form to and by the Hirer in England for the purpose of verification of this claim and the investigation, prevention, detection and prosecution of fraud. By signing this timesheet you are confirming acceptance of Servoca Nursing and Care Limited terms and conditions. Hours are charged to the nearest quarter, unless otherwise agreed in writing. In the event of any workers are employed on a permanent basis after being introduced by Servoca Nursing and Care, the Hirer will pay a fee based on 20% annualised Remuneration paid to the worker.

PRINT NAME:		SIGNED:		DATE:		POSITION HELD:

Company address: Kingston House, Towers Business park, Wilmslow Road, Manchester, M20 2LD.