

Please email to timesheets@focusmed24.co.uk by 10am Monday to receive payment Friday

Worker Name	Hospital
Week Commencing	Department/Ward

Day	Start Time	Finish Time	Breaks	Total Hours (Less break)	On-call Hours	On-call Hours Worked	Signature / Booking Number
Monday							
Tuesday							
Wednesday							
Thursday							
Friday							
Saturday							
Sunday							
PLEASE USE 24HR CLOCK				TOTALS			

Feedback / End of Placement Form (for client use)

Please tick the box which reflects your views on the worker	Excellent	Good	Average	Poor
Relationship with patients				
Relationship with colleagues				
Communication skills				
Appearance				
Professionalism & conduct				
Punctuality & attendance				
Were there any issues or concerns with the worker?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Would you be happy to have the worker back?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		

I have received onsite induction Yes No

<p>Please tick appropriate profession:</p> <p><input type="checkbox"/> ODP <input type="checkbox"/> RGN <input type="checkbox"/> RMN <input type="checkbox"/> HCA</p> <p>Please tick employment status:</p> <p><input type="checkbox"/> PAYE Umbrella <input type="checkbox"/> Direct PAYE</p>	<p>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 provide false information this may result in formal action and I may be liable to prosecution and civil recovery proceedings. I consent to the disclosure and information from this form to and by the NHS body and the NHS CFMS for the purpose of verification of this claim and the investigation, prevention, detection and prosecution of fraud.</p> <p>Worker's Signature</p>
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NHS/Authorised signatory

I am an authorised signatory for my ward/department/NHS body. I am signing to confirm that the grade of the agency worker and the hours/shifts that I am authorising are accurate and I approve payment. I understand that if I knowingly provide false information this may result in formal action and I may be liable to prosecution and civil recovery proceedings. I consent to the disclosure and information from this form to and by the NHS body and the NHS CFMS for the purpose of verification of this claim and the investigation, prevention, detection and prosecution of fraud. I understand that you will invoice me for this within the next seven days. I also confirm my acceptance of the terms and conditions of business, a copy of which I have received.

Signed Print

Position Date

Timesheet No

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Office use only

Entered on vendor portal date

Paid date

