Care Supreme

TimeSheet

Timesheets can be emailed to info@caresupreme.org digitally or posted to us. They must reach us by Monday 12pm to be paid that week.

For internal use only

TIMESHEET:

SECTION 1: Please write in BLOCK LETTERS

Your Name

Client Name

Grade

SECTION 2: TIMESHEET (use the 24hr clock)

	Date	Ordinary Time (Hrs/Mins)				On Call Time (Hrs/Mins)				Ward/Unit/Visits (If applicable)	Admin/Reference	Client Shift Appraisal
		START	BREAK	FINISH	TOTAL HRS Excl. breaks	START	BREAK	FINISH	TOTAL HRS Excl. breaks			
Monday	/ /											1 2 3 4 5
Tuesday	/ /											1 2 3 4 5
Wednesday	/ /											1 2 3 4 5
Thursday	/ /											1 2 3 4 5
Friday	/ /											1 2 3 4 5
Saturday	/ /											1 2 3 4 5
Sunday	/ /											1 2 3 4 5
			TOTAL HRS Excl. breaks				TOTAL HRS Excl. breaks			AGREED EXPENSES: (Please attach a receipt for all expenses). NOTE TO CANDIDATE: Please can you ensure that you ask the authorising signatory to complete the shift appraisal. Please circle as applicable: 1 = Unsatisfactory 2 = Poor 3 = Satisfactory 4 = Good 5 = Excellent		

SECTION 3: AUTHORISATION

Nurse/Doctor/Carer

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 this may result in desciplinary action and I may be liable to prosecution and civil recovery proceedings. I consent to this disclosure of information from this form to an by any Caresupreme authorised body for the purpose of verification of this claim and the investigation , prevention, detention and prosecution of fraud. I can confirm that induction and orientation training and fire safety have been provided by the client. By signing this, you agree to our candidate terms and conditions found on our website at www.caresupreme.org.uk

Name Signature

Speciality/Position Date

Authorised by: (senior member of staff)

I am an authorised signatory of the above named client. I am signing to confirm that the Job Profile Title and Band of Agency Worker and the hours/shif that I am authorising are accurate and I approve payment. I understand that if I knowingly provide false information this may resullt in desciplinary action and I may be liable to prosecution and civil recovery proceedings. I consent to this disclosure of information from this form to an by any Caresupreme authorised body for the purpose of verification of this claim and the investigation , prevention, detention and prosecution of fraud. Il understand and agree to Caresupreme's current terms of business at www.caresupreme/terms. A standard document fee will be charged if the Nurse/Doctor/Carer is taken on full time or engaged through a different agancy. Note to client: Please can you ensure you appraise the performance of the candidate using the client shift appraisal above.

Name Signature

Position Date