

**** TIME SHEETS MUST BE COMPLETED USING BLACK INK AND BLOCK CAPITALS ****

OFFICE USE ONLY
Job No. _____ Card No. _____

**a: 40-42 Parker Street, London,
WC2B 5PQ, UK.
t: +44 (0) 20 7025 0093**



Client Name/Hospital: _____ **Ward/Dept:** _____

Agency Worker Name (First & Surname as on Professional register) _____

Grade: _____ **Speciality:** _____

Date	Start	Break Start	Break Finish	Break Start	Break Finish	Finish	Total Hrs Worked (less breaks)	Ward/Dept Authorised Signature & Print Name	Ref Number	Travel Expenses N.B car 40p per mile (ONLY IF APPLICABLE)
Mon										
Tues										
Wed										
Thur										
Fri										
Sat										
Sun										

Any questionable timesheet must be immediately brought to the attention of the Local Counter Fraud Specialist (within England) or you may report any case of fraud, in confidence, to the NHS Fraud and Corruption Reporting Line on 0800 028 4060 (within England) or 0800 015 1628 (within Scotland)	Total Hours for Week	Total Hours (in words)	Total for Week
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<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 knowingly provide false information this may result in disciplinary action and I may be liable for prosecution and civil recovery proceedings. I consent to the disclosure of information from this form 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”</p> <p>Agency Worker Signature: _____</p> <p>“I am an authorised signatory for my ward/department/NHS body. I am signing below to confirm that both the grade of agency worker and the hours/shift that I am authorising are accurate and I approve payment. I understand that if I knowingly authorise false information this may result in disciplinary action and I may be liable for prosecution and civil recovery proceedings. I consent to the disclosure of information from this form 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, detection and prosecution of fraud”</p> <p>Client Signature: _____ NAME: _____ DATE: _____</p>	<p>Hospital Stamp (if required)</p>
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**** PLEASE SEND TO 020 7025 0091 BY MONDAY 5pm ** PLEASE TELEPHONE PAYROLL 020 7025 0093 TO CONFIRM FAX IS LEGIBLE ****

White – post to Geneva Health International Yellow – Client copy Pink – Agency Worker copy