

Fax this completed form to 01908 810 390

When completing this form please: Only use black ink. Obtain authorised signatures for all the shifts you have worked. Complete one timesheet for each week worked. If the hospital deducts breaks and breaks are worked, this must be signed off by an authorised signatory on each line. **Please fully complete this form, obtain an authorised signature and return to ID Medical.** After completing your shift(s) please return this completed form to: ID House, 1 Mill Square, Wolverton Mill South, Milton Keynes, MK12 5ZD e: payroll@id-medical.com t: 01908 810 290 f: 01908 810 390

Personal Information

First name Surname

Hospital name

Grade and speciality Contract Reference

Candidate number

Timesheet

Day	Date	Start time (24 hours)	Finish time (24 hours)	On call hours	Minutes taken for breaks	Approved signature for breaks not taken	Total hours after breaks deducted (hours/minutes)
Monday							
Tuesday							
Wednesday							
Thursday							
Friday							
Saturday							
Sunday							
Weekly totals							

Can you confirm the hospital induction was completed on arrival? Yes No

If not, please specify why

To be completed by the agency worker (you)

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 details on this timesheet. 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 time to time to and by the NHS body and the NHS CFSMS for the purpose of verification of this claim and the investigation, prevention, detection and prosecution of fraud.

Agency worker signature

Date

Assessment Form (Trust/hospital - please complete below if you are happy or in a position to assess this doctor)

Period of Employment

As part of our follow-up after care programme, we would greatly appreciate it if you could provide us with a follow-up assessment for the doctor's time spent at this hospital. Please note that this information may be used as a reference for future locum placements. Please tick the box which most reflects your view on the candidate.

	Excellent	Good	Average	Poor
ATTITUDE				
CLINICAL SKILLS				
COMMUNICATION				
KNOWLEDGE				

	Excellent	Good	Average	Poor
PROFESSIONALISM				
RELATIONSHIPS				
RELIABILITY				
TIMEKEEPING				

Additional Comments

Future Employment
Would you be happy to receive this doctor again for a locum position?
Yes No

Authorised Trust/hospital signatory

I confirm that I am an authorised signatory for my ward/department/NHS body. I am signing 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 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 NHS body of the NHS CFSMS in England (or NHS CFS in Scotland) for the purpose of verification of this claim and the investigation, prevention, detection and prosecution of fraud.

Authorised signature

First name

Surname

Position

Date

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).