# Timesheet - To be completed by agency worker

**Fax this completed form to 01908 552 298**

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 and return to ID Medical. Payment is made 2 working days following receipt of corresponding timesheet submitted by 2.30pm.** After completing your shift(s) please return this completed form to: ID House, 1 Mill Square, Wolverton Mill South, Milton Keynes, MK12 5ZD **e: payrollnursing@id-medical.com t: 0845 180 1133**

## Personal Information

First name

Surname

Candidate number

Band

PO number/Contract ref.

Hospital

Ward

| Day | Date | Start time (24 hours) | Finish time (24 hours) | Total hours (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

## Client Feedback Form (Trust/hospital - please complete below if you are happy or in a position to assess this agency worker)

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 agency worker's time spent at this hospital. Please note that this information may be used as a reference for future temporary positions. Please tick the box which most reflects your view on the candidate.

| | Excellent | Good | Average | Poor |
|---|---|---|---|---|
| **General Clinical Skills** | | | | |
| **Specialty Clinical Skills** | | | | |
| **Clinical knowledge** | | | | |
| **Attitude towards other professionals** | | | | |
| **Attitude towards patients** | | | | |

| | Excellent | Good | Average | Poor |
|---|---|---|---|---|
| **Relationship with patients** | | | | |
| **Relationship with colleagues** | | | | |
| **Appearance** | | | | |
| **Professionalism and conduct** | | | | |

**Additional Comments**

**Future Employment**

Would you be happy to receive this agency worker again?

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

Cost centre

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).