ID MEDICAL PRIMARY CARE

Timesheet - To be completed by agency worker

Fax this completed form to 01908 774 174

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: **e: payroll@id-medical.com f: 01908 774 174 p:** ID House, 1 Mill Square, Wolverton Mill South, Milton Keynes, MK12 5ZD. For any issues please call **01908 552 820**

Personal Information

First name

Surname

Practice Name

Location

Designation

Candidate number

Timesheet

Day	Date	Start time (24 hours)	Finish time (24 hours)	Home Visits	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				

Please confirm whether the hospital induction has been completed ☐ 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 Practice 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.

First name

Surname

Position

Authorised signature

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).