

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. After completing your shift(s) you can return this completed form to the above email address, directly to your recruitment consultant or fax to **01908 774 174**.

Timesheets should be submitted within 7 working days of shifts completed to support the timely approval and payment.

Personal Information

First name	Surname
<input type="text"/>	<input type="text"/>
Hospital name	Grade and specialty
<input type="text"/>	<input type="text"/>

Standard Hours

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

On Call Hours (please complete if applicable)

Day	Date	On call start time	On call finish time	Resident on call hours total	Non resident on call hours total	On call hours total
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Saturday						
Sunday						
Weekly totals						

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.	Authorised signature	<input type="text"/>
	Date	<input type="text"/>

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.	
First name	<input type="text"/>
Surname	<input type="text"/>
Position	<input type="text"/>
Date	<input type="text"/>
Authorised signature	<input type="text"/>