

AGENCY WORKER NAME				WEEK ENDING DATE				/ /	
SPECIALITY				GRADE					
HOSPITAL NAME				DEPARTMENT / WARD					
STANDARD HOURS		PO / REF NUMBER	DATE	START TIME	END TIME	TOTAL HOURS Prior to break deduction	BREAK TAKEN	TOTAL HOURS After break deduction	
	MONDAY								
	TUESDAY								
	WEDNESDAY								
	THURSDAY								
	FRIDAY								
	SATURDAY								
	SUNDAY								

**TOTAL HOURS**

NON-RESIDENTIAL HOURS <small>(standby / offsite oncall)</small>		PO / REF NUMBER	DATE	START TIME	END TIME	TOTAL HOURS Prior to break deduction	TOTAL HOURS After break deduction
	MONDAY						
	TUESDAY						
	WEDNESDAY						
	THURSDAY						
	FRIDAY						
	SATURDAY						
	SUNDAY						

**TOTAL HOURS**

RESIDENTIAL HOURS <small>(Onsite / On Call)</small>		PO / REF NUMBER	DATE	START TIME	END TIME	TOTAL HOURS Prior to break deduction	TOTAL HOURS After break deduction
	MONDAY						
	TUESDAY						
	WEDNESDAY						
	THURSDAY						
	FRIDAY						
	SATURDAY						
	SUNDAY						

**TOTAL HOURS**

**If expenses are to be paid by the hospital and are approved please send receipts along with your timesheet.**

**TO BE COMPLETED BY THE AGENCY WORKER**

By ticking this box I confirm that I have received an induction and orientation at the start of this placement.

"I declare that the information I have given on this form is correct 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 to 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. I confirm that I have been inducted in line with the trust local procedures and that I have been made aware of given all relevant access to my Day 1 rights".

**PRINT NAME:** \_\_\_\_\_ **SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**TO BE COMPLETED BY THE TRUST**

"I am an authorised signatory for my ward/department/NHS Body. I am signing to confirm that the above grade and speciality of the agency worker and the hours/shifts that I am authorising are accurate and I approve for 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".

**PRINT NAME:** \_\_\_\_\_ **JOB TITLE:** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

GETTING THE TIMESHEET AUTHORISED IS THE AGENCY WORKERS RESPONSIBILITY. TIMESHEETS SHOULD BE SENT TO [timesheets@locumvision.com](mailto:timesheets@locumvision.com) OR BY FAX 01908 810233 BY 5pm ON TUESDAYS.