

NURSING TIMESHEET
Strictly one timesheet per shift - Bad copies and photos will be rejected
SUBMISSION DEADLINE – 6PM MONDAY

FAX: 0844 77 44 661
EMAIL: timesheets@medpure.co.uk

Candidate Name	<input style="width: 95%;" type="text"/>	Trust	<input style="width: 95%;" type="text"/>
NMC No	<input style="width: 95%;" type="text"/>	Hospital	<input style="width: 95%;" type="text"/>
Band/Speciality	<input style="width: 95%;" type="text"/>	Ward	<input style="width: 95%;" type="text"/>

Local Induction

I received an induction addressing professional practice / relevant health & safety issues either during my shift(s) or previously when I worked on this ward.

Please tick this box to confirm

To be completed by the agency worker (you)

Day	Date	Booking reference	Start Time	Breaks Hrs/Mins	Finish Time	Total Hrs Exc. Breaks	Print Name	Daily Signature	Candidate Declaration
Monday									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 and by the NHS body and the NHS CFSMS for the purpose of verification of its claim and the investigation, prevention, detection and prosecution of fraud.
Tuesday									
Wednesday									
Thursday									
Friday									
Saturday									
Sunday									
						Total Hours			Nurse signed
									Date

To be completed by the authorised Trust/hospital signatory

	Excellent	Very Good	Good	Poor	N/A	Client Authorisation
Clinical skills in line with the position requirements						I confirm that I am signing to confirm that both the grade of Agency Worker and hours/shift that I am authorising are accurate and I approve payment. I know 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.
Relationships with patients and staff						
Timekeeping						
Management of Workload						
Reliability						
Professional standards						
Communication skills						
Sickness/absence records						
						Print Name
						Client Signature
						Date

Feedback by Print Name _____ Sign _____