TIMESHEET

1ST Eastview Healthcare | 2nd Copy – Client | 3rd Copy – Worker

Please Email or Fax your Timesheet by Monday 12PM

Email: timesheets@eastviewhealthcare.com

Post: Eastview Healthcare, Regents Pavilion,4 Summerhouse Rd, Moulton, Northampton, NN3 6BJ

Fax: +44(0)1604 217404 / +44(0)1865 910416

T: 0333 012 4743/ 01604 641129

First Name	
Surname:	
Client Name:	

Please minus your breaks when adding your total hours worked & ensure you use the 24hr clock. If no break was taken, write **NB** in the space provided

Booking Ref Number:

DAY	DATE	START	BREAK	FINISH	MILEAGE	TOTAL HRS	SIGNATURE
Monday							
Tuesday							
Wednesday							
Thursday							
Friday							
Saturday							
Sunday							
TOTAL HOURS (MINUS BREAKS)							

Feedback/Reference Form (For Client Only) Poor-1 Satisfactory-2 Good-3 Excellent-4

Type	1	2	3	4	Unable to comment
Clinical Skills					
Organisational Skills					
Communication Skills					
Willingness to learn					
Team Player					
Flexibility					

Were there any concerns with the worker?	Yes	No
Would you be happy to rebook the worker?	Yes	No

Please ensure your timesheet is fully completed and send before Monday 12pm Failure to do so may result in your payment being delayed and/ or amended

Worker:
I declare that the information I have given on this form is correct and complete and that I have no 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.

Name:	**Signature:**
Position:	**Date:**

Authorized by: (Senior Member of Staff):
I am an authorized signatory of the above named client. I am signing to confirm that the Job Profile Title and Band of Agency worker and the hours/shift that I am authorizing 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 the information from this form to and by any Eastview Healthcare Services Ltd authorized body for purpose of verification of this claim and the investigation, prevention, detection and prosecution of fraud. I understand and agree to Eastview Healthcare's Terms of Business – A standard introductory fee will be charged if the worker is taken on full time or allowed to change agencies.

Name:	**Signature:**
Position:	**Date:**