nlg Health

Timesheet – To be completed by agency worker only

E-Fax this completed form to 01482 420054

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 where at the same client and location. 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 and return a copy to NLG Health (e-fax: **01482 420054** / email: **timesheets@nlgroup.co.uk**).

Agency Worker Details

First name

Last name

Job title

Band

Timesheet no

Hospital

Ward/Dept

	Date	Shift start time	Shift end time	Break start time	Break end time	Break total	Total hours	Shift approval
Monday	dd mm yy	hh : mm	hh : mm	hh : mm	hh : mm	hh : mm	hh : mm	
Tuesday	dd mm yy	hh : mm	hh : mm	hh : mm	hh : mm	hh : mm	hh : mm	
Wednesday	dd mm yy	hh : mm	hh : mm	hh : mm	hh : mm	hh : mm	hh : mm	
Thursday	dd mm yy	hh : mm	hh : mm	hh : mm	hh : mm	hh : mm	hh : mm	
Friday	dd mm yy	hh : mm	hh : mm	hh : mm	hh : mm	hh : mm	hh : mm	
Saturday	dd mm yy	hh : mm	hh : mm	hh : mm	hh : mm	hh : mm	hh : mm	
Sunday	dd mm yy	hh : mm	hh : mm	hh : mm	hh : mm	hh : mm	hh : mm	
						Weekly Total	hh : mm	

☐ Please tick to confirm the hospital induction was completed on arrival

If not, please specify why

☐ Where applicable, ward register signed

To be completed by the agency worker (you)

I declare that the information on this form is correct and complete 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 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 dd mm yyyy

Client **Feedback** Form

(Trust/hospital - please complete below if you are happy or in a position to assess this agency worker)

As part of my IPR I would greatly appreciate it if you could provide me with a follow-up assessment for my time spent at this hospital.
Please note that this information may be used as a reference for future temporary positions. 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 worker again?

☐ Yes ☐ No

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.

Cost centre

First name

Last name

Position

Authorised signature

Date

Any timesheet under question or suspicion 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).