

Mental Health Timesheet

Timesheet Fax: 020 7993 9731

The Placement Group Nursing Ltd t/a Mediplacements Mental Health,
 110 Brooker Road, Waltham Abbey, Essex, EN9 1JH
 Tel: 0345 230 6666
 Timesheet must be received by midday MONDAY via FAX or POST.



Full name: _____

Position: _____

Ward / Department: _____

Name of Trust / Hospital: _____

Reporting to: _____

I declare that the information on this time sheet is true. In the event of a dispute regarding claimed hours, the locum will be liable to repay any overstated amount unless the time sheet has been duly authorised by the client. Any over payments should be repaid immediately as failure to do so may result in legal proceeding. 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 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 CFSMS for the purpose of verification of this claim and the investigation, prevention, detection and prosecution of fraud.

Locum Signature:

	DATE D M Y	START TIME	FINISH TIME	TIME OF BREAK	LENGTH OF BREAK	HOURS WORKED	CLIENT SIGNATURE	CLIENT NAME & POSITION	DATE
MONDAY	: :								
TUESDAY	: :								
WEDNESDAY	: :								
THURSDAY	: :								
FRIDAY	: :								
SATURDAY	: :								
SUNDAY	: :								

PLEASE USE 24 HOUR CLOCK
 We recommend that you retain copies of all your completed timesheets for further reference.

Total Hours Worked

By signing you are confirming:
 a) Our agreement to the terms of business, and b) That the claimed hours are correct.

I confirm I am an authorised signatory for my ward/department/NHS body. I am signing to confirm that the AFC Job title, band and spine point 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 and the NHS CFSMS in England for the purpose of verification of this claim and the investigation, prevention, detection and prosecution of fraud.

Booking Reference Numbers

Monday: _____

Tuesday: _____

Wednesday: _____

Thursday: _____

Friday: _____

Saturday: _____

Sunday: _____