Timesheet – To be completed by Agency Worker

Email to payroll@247lifeline.co.uk or Fax to 0346484984945

*USE BLOCK CAPITALS WITH BLACK INK ONLY

PERSONAL INFORMATION

First Name **Surname**

Job Title **Band**

Hospital **Ward**

Day	Date	Shift Start Time	Shift Finish Time	Break Time Start	Break Time Finish	Break Total (Hrs/Min)	Total Hours (Hrs/Min)
Monday		____ : ____	____ : ____	____ : ____	____ : ____	____H ____M	____H ____M
Tuesday		____ : ____	____ : ____	____ : ____	____ : ____	____H ____M	____H ____M
Wednesday		____ : ____	____ : ____	____ : ____	____ : ____	____H ____M	____H ____M
Thursday		____ : ____	____ : ____	____ : ____	____ : ____	____H ____M	____H ____M
Friday		____ : ____	____ : ____	____ : ____	____ : ____	____H ____M	____H ____M
Saturday		____ : ____	____ : ____	____ : ____	____ : ____	____H ____M	____H ____M
Sunday		____ : ____	____ : ____	____ : ____	____ : ____	____H ____M	____H ____M
						Total Hours	____H ____M

☐ **Please confirm that your hospital induction was completed upon arrival**

If not, please specify why? _____

I can confirm that all 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 can confirm that I have not carried out this role for any other Agency worker. 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 by 247 Lifeline Ltd. 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

Client Feedback Form – To be completed by the client (Please complete the below if you are satisfied or in a position to assess this agency worker)

As part of our post- customer service and worker support programme, we would greatly appreciate it if you could provide us with a post- assignment assessment for this 24/7 Lifeline agency worker for the work that was completed with you. We we may use this feedback as a reference for any future assignments.

	Excellent	Good	Average	Poor
Clinical Skills & Knowledge				
Time Keeping				
Communication				
Appearance & Dress Code				

	Excellent	Good	Average	Poor
Relationship with Patients				
Relationship with Colleagues				
Attitude & Professional Conduct				
Quality of Documentation				

Any Additional Feedback.

_____
_____
_____
_____

Client/ Trust Stamp

For Completion by the authorised Trust/ Ward/ Department Signatory

I can confirm that I am an authorised signatory for my Hospital/Ward/Department. I am signing below to confirm that I am authorising that both the grade of the agency worker and the hours/shifts that I am authorising are accurate and I approve 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 for the purpose of verification of this claim and the investigation, prevention, detection and prosecution of fraud. Any timesheet that is questionable must be immediately brought to the attention of your direct Manager. I certify that the above details are correct to the best of my knowledge and belief and approve the claim.

First Name

Surname

Position

Cost Centre

Authorised Signature

Date