Beacon Care Services Timesheet

Please complete all sections BLOCK CAPITALS. Failure to correctly complete a Timesheet could delay payment. Timesheets MUST be received by **10AM** on **Monday.**

Email: timesheet@beaconcare.com or Fax: 020 8896 9400

First Name:		Surname:	
Client:		Ward:	
Job Title:		Band:	

	Date	Start Time	Finish Time	Break	Total Paid Hrs *(figures)*	Total Paid Hrs *(words)*	Booking Reference No.	Authorised Signature
Monday								
Tuesday								
Wednesday								
Thursday								
Friday								
Saturday								
Sunday								

Please use 24 hour clock

Total Hours Worked

Agency Worker Feedback

(this section is to be completed by the service)

	Excellent	Good	Satisfactory	Unsatisfactory	Additional Comments
Overall Performance					
Overall Conduct/ Behaviour					
Timekeeping/ Reliability					

Authorised By: I am an authorised signatory for my ward/department/NHS body/organisation. I am signing to confirm that both the grade of Agency Worker and the hours/shift that I am authorising are accurate and 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. Where applicable I consent to the disclosure of information from this form to and by the NHS body and NHS Protect (NHS CFSMS) for the purpose of verification of this claim and the investigation, prevention, detection and prosecution of fraud.

Name

Position

Date

Signature

Agency Worker: 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. Where applicable I consent to the disclosure of information from this form to and by the NHS body and NHS Protect (NHS CFSMS) for the purpose of verification of this claim and the investigation prevention and prosecutions of fraud. By signing this declaration I agree to the following 1. I am fit to practice and will inform Beacon Care Services Limited if this changes 2.I have read and agreed to the Terms of Engagement and Handbook supplied to me by Beacon Care Services Limited. 3. If I have not opted out of WTR 48hr/wk I am responsible for monitoring my own hours 4. I received orientation and induction by the client for this booking

Signature

Date