DOCTORS SESSIONAL TIMESHEET

FAX NUMBER: 01908 810 202/payroll@txmhealthcare.co.uk Cut off for Timesheets is Tuesday 4pm. Please use black ink and ensure all necessary sections are completed. Failure to do so may lead to delay in payment. Please complete in BLOCK CAPITALS and only use black ink.

Full Name: _____ **Job Title:** _____

Hospital/Trust/Client: _____ **Ward/Department:** _____

GMC: _____ **Booking/PO Number:** _____ **Week Ending Date:** _____

Sessions Worked		Sessional Work		Hourly Work				Client Initials
Day	Date	Sessions Completed	Total	Start	Finish	Break	Total Hours	
Monday								
Tuesday								
Wednesday								
Thursday								
Friday								
Saturday								
Sunday								
		Total Weekly Sessions (Excluding breaks)				Total Weekly Hours (Excluding breaks)		

Can you confirm the Hospital/Trust/Client induction was completed on arrival? ☐ Yes ☐ No*

***If no, please specify why:** _____

To be completed by 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. I consent to the disclosure of information from this form to and by the Authority, other Public Sector body and Private entities who have a similar requirement and the Counter Fraud Services (or other similar organisation which operates in the same capacity for any other Public Sector organisation) for the purpose of verification of this claim and the investigation, prevention, detection and prosecution of fraud.

Signature:

Date:

Assessment Form - (Trust/Hospital – please complete the below section if you are happy to assess the agency worker)

As part of our supply of this agency worker we would be grateful to receive your feedback on the time the candidate has spent at your establishment. Please note we may use this information to assist us with finding future work for this candidate. Please tick the boxes below that reflect your view of the candidate.

Period of Employment: _____

	Excellent	Good	Satisfactory	Poor
Clinical Skills				
Relationships				
Timekeeping				
Knowledge				

	Excellent	Good	Satisfactory	Poor
Record Keeping				
Reliability				
Communication				
Sickness/Absence Record				

Additional Comments:

Further Employment

Would you be happy to receive this candidate again?

☐ Yes ☐ No

To be completed by the authorised Client/Trust/Hospital signatory:

I am an authorised signatory for my ward/department/NHS/Public Sector body/Private Sector body. I am signing to confirm that the Job Profile Title and Band/Grade of Temporary Workers 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 other Public Sector body and Private entities with similar requirements and the Counter Fraud Service (or other similar organisation which operates in the same capacity for any other Public Sector organisation) in England (Or NHS CFS in Scotland) for the purpose of verification of this claim and the investigation, prevention, detection and prosecution of fraud.

Name:

Position:

Signature:

Date:

Any questionable timesheet 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) 0800 015 1628 (within Scotland)