**Please send all timesheets to us as soon as you have finished your shift(s).**

* To ensure you are paid on time, please ensure the following:
* One timesheet is completed by agency worker each week in **BLACK INK** only.
* An authorised signature has been obtained.
* Timesheets are processed **weekly** so please ensure that we have received your timesheet by 12:00pm on Tuesday each week.

**Once completed please return to:** admin@brandnewdayhealthcare.co.uk

|  |  |
| --- | --- |
| **Forename** | **Surname** |
|  |  |
| **Hospital/ Organisation Name** | **Ward/ Unit** |
|  |  |

**PLEASE NOTE THAT IF THE HOSPITAL DEDUCTS BREAKS AND BREAKS ARE WORKED, THIS MUST BE SIGNED BY A CONSULTANT OTHERWISE PAYMENT FOR YOUR TIMESHEET WILL BE DELAYED.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Date** | **Start time****(24 Hours)** | **Finish time (24 Hours)** | **Hours Worked** | **Breaks Taken****Or Sleep In** | **Total hours after deducted****(Hours/ minutes)** | **Authorised Signature** |
| **Monday** |  |  |  |  |  |  |  |
| **Tuesday** |  |  |  |  |  |  |  |
| **Wednesday** |  |  |  |  |  |  |  |
| **Thursday** |  |  |  |  |  |  |  |
| **Friday** |  |  |  |  |  |  |  |
| **Saturday** |  |  |  |  |  |  |  |
| **Sunday** |  |  |  |  |  |  |  |
| **Weekly Totals** |  |  |  |  |  |
| **Client Feedback form** | **1** | **2** | **3** | **4** | **Comments** |
| **General Skills** |  |  |  |  |  |
| **Engagement with YP** |  |  |  |  |
| **Clinical Knowledge** |  |  |  |  |
| **General Knowledge; towards other staff** |  |  |  |  |
| **General Attitude; towards young people** |  |  |  |  |
| **General Attitude; towards other staff** |  |  |  |  |
| **Professional Relationships; with clients/ staff** |  |  |  |  |
| **General Attributes; appearance** |  |  |  |  | **Staff Signature** |
| **Punctuality and Dependability** |  |  |  |  |  |

**To be completed by the agency worker 1.Excellent 2.Good 3.Average 4.Poor**

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/ shift’s details 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 proceedings. I consent to the disclosure of information from time to time to Brand New Day/ CLIENT for the purpose of verification of this claim and the investigation, prevention, detection and prosecution of fraud.

|  |  |  |
| --- | --- | --- |
| **Staff Position:** | **Staff Signature:** | **Date:** |
|  |  |  |

**To be completed by the authorized trust/ hospital signatory**

I declare that the information I have given above on this form is correct and complete and that both the 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 proceedings. I consent to the disclosure from this form to and by ORGANISATION and for the purpose of verification of this claim and the investigation, prevention, detection and prosecution of fraud.

|  |  |  |
| --- | --- | --- |
| **Forename:** | **Surname:** | **Position:**  |
|  |  |  |
| **Authorised Signature:** | **Date:** | **Cost Centre:** |
|  |  |  |