



PAYE & UMBRELLA COMPANY TIMESHEET

AGENCY WORKER:	HOSPITAL:
ADDRESS:	LOCATION:
POSTCODE:	POSTCODE:

GRADE WORKED:	SPECIALITY WORKED:
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DAY	DATE	START TIME	FINISH TIME	BREAKS	TOTAL
MONDAY					
TUESDAY					
WEDNESDAY					
THURSDAY					
FRIDAY					
SATURDAY					
SUNDAY					
TOTAL HOURS WORKED					

EXPENSES (Amount in words or total mileage) _____ £ _____

AGENCY WORKER

I declare that the information on this timesheet is true. In the event of a dispute regarding claimed hours, the Consultancy will be liable to repay any outstanding amount unless the timesheet has been duly authorised by the Client. Any over payments should be repaid immediately as failure to do so may result in legal proceeding.

Name (Print): _____

Signature: _____

Date: _____

"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 CFSMS for the purpose of verification of this claim and the investigation, prevention, detection and prosecution of fraud".

HOSPITAL

I certify that the above hours and expenses have been worked to my complete satisfaction and agree to Bluecross Locums Ltd invoicing in accordance with the contract.

Name (Print): _____ (Head of Department)

Signature: _____

Date: _____

The above named is contracted by Bluecross Locums Ltd and therefore cannot accept a permanent or temporary position on the staff of your organisation otherwise that arranged with Bluecross Locums Ltd and on payment of the normal introduction fee, such fee becoming due and payable by you immediately, should the above named enter your employment.

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