No correction fluid should be used on this timesheet. Any incomplete or illegible timesheets will result in the form being returned to the agency worker and delay in payment

Timesheet No.

FP

Workers Name (print)	Client Details (complete name and address)
Name: _____	Hospital/Organisation: _____
Job Title/Specialisation: _____	_____
Grade/Brand: _____	Ward/Department: _____

firstpoint HEALTHCARE

Registered address:

Solar House,1-9 Romford Road, London, E15 4LJ

ON-CALL / SLEEPIN

Start Time	Finish Time	Actual Hours Worked	Total Time

Total Hours worked:

Details of the NHS Fraud and Corruption Reporting line: "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)".

NHS TRUST ONLY

Placement assessment. Please ✓ as appropriate	N/A	Un-satisfactory	Satisfactory	Good	Excellent
Communication skills					
Organisational skills					
Supervisory skills					
Timekeeping					
Reliability					
Managing workload					
Clinical skills in line with needs of position					
Relationship with patients & staff					
Overall clinical & professional performance					

Workers declaration and confirmation of hours

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 termination of assignment 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 body and the NHS CFSMS for the purpose of verification of this claim and the investigation, prevention, detection and prosecution of fraud. Also, by signing this timesheet I can confirm that I am in good health and fit to practice. I will promptly inform Firstpoint if this changes. I can confirm that I am not claiming any sick pay from any employer.

Print Name:..... Signed..... Date .....

Client declaration, approval of hours and payment

I am an authorised signatory for my ward/department/NHS body. I am signing to confirm that the Job Profile Title and Band of Nurse 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 body and the NHS CFSMS in England for the purpose of verification of this claim and the investigation, prevention, detection and prosecution of fraud.

Print Name:..... Signed..... Date ..... Position Held.....