

AGENCY TIMESHEET



Surname: _____ Forename: _____

HEALTH BOARD _____

HOSPITAL _____ LOCATION _____

INVOICE NO
PO NO
IF POOL SHIFT - AREA ALLOCATED -

Date Worked	Booking Ref No.	SHIFT	Time Worked		Unpaid Breaks** In Mins	TOTAL HOURS WORKED	THIS SECTION MUST BE SIGNED BY SISTER OR NURSE IN CHARGE					
			From	To			Print Name	Signature	WARD	BAND	DATE	
SUN												
MON												
TUE												
WED												
THUR												
FRI												
SAT												

Total hours excluding unpaid breaks ➡

**** Please note that breaks will automatically be deducted in line with WTD unless specifically authorised and noted on this timesheet**

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 for prosecution and civil recovery proceedings. I consent to the disclosure of information from this form to and by Cardiff and Vale University Health Board and the NHS Counter Fraud and Security Management Service for the purpose of verification of this claim and the investigation, prevention, detection and prosecution of fraud.

Signature of Agency Nurse: _____

Did you receive an induction?	Yes	No
Do you need any further induction training?	Yes	No

PLEASE EMAIL YOUR TIMESHEET TO US BY 12.00PM ON A MONDAY TO AVOID LATE PAYMENT
EMAIL: timesheets@asa-medical.com