Precedo Healthcare Services Ltd.

Agency Worker Timesheet

Payroll Department, Precedo Healthcare, Hallam Business Centre, Stubley Lane, Dronfield, S18 1LS. *Fax: 01246 299701* *timesheets@precedohealthcare.co.uk*

Booking Reference Number: _____
(provided by your Healthcare Manager)

Ward and Department: _____
(where your assignments are carried out)

Worker Title & Band: _____

Full Name: _____
(please enter your name as it appears on the Regulatory Bodies Professional Register)

Authority: _____
(where your assignments are carried out i.e. trust/establishment name)

I have received an on-site induction *(please tick box)* ☐

	DATE	START TIME	FINISH TIME	1ST BREAK		2ND BREAK		3RD BREAK		TOTAL HOURS	REF
				START	FINISH	START	FINISH	START	FINISH		
MONDAY											
TUESDAY											
WEDNESDAY											
THURSDAY											
FRIDAY											
SATURDAY											
SUNDAY											

AGENCY WORKER DECLARATION:

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 and 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.

SIGNED: _____ DATE: _____

Any questionable timesheet must be immediatley brought to the attention of the Local Fraud Specialist (within England) or you may report and case of fraud, in confidence, the the NHS Fraud and Corruption Reporting Line on 0800 028 4060 (within England)

AUTHORISED SIGNATORY DECLARATION

I am an authorised signatory for my ward/department/NHS body. I am signing to confirm that the Job Profile Title and Band of 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 for 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.

SIGNED: _____ DATE: _____

PRINTED NAME: _____ STAMP:

POSITION: _____