KOPE MEDICS

Delivering Quality Healthcare

WEEKLY TIMESHEET

DEADLINE: SAME DAY PAYROLL 10am, WEEKLY PAYROLL MONDAY 12.00 NOON

FAILURE TO DO SO WILL RESULT IN YOUR PAYMENT BEING DELAYED

Email: payroll@kope-medics.com

Telephone: +44 203 745 0470

Unit 41, Olav's Court, City Business Centre
25, Lower Road, London SE16 2XB

NAME		**Job Title**	
Client Initials		**Hospital**	
Ward Name		**Consultant**	

Please write your breaks when totalling your hours worked & ensure you use the 24hr clock. Unless NB (No Break) is written in the break column then the break will automatically be deducted if not included.

DAY	DATE	START	BREAK	FINISH	(Hours)	Shadowing Please tick	Client Comment/Appraisal/Compliments
Monday							
Tuesday							
Wednesday							
Thursday							
Friday							
Saturday							
Sunday							***Signature*** ***Date***
				TOTAL Hours			

Candidate 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/shift 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 the 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 persecution of fraud. I also confirm that induction and orientation training has been provided by the client. I also confirm that I am aware of the placement policies procedures; and I have received and induction within the clinical area.

Name		**Signature**		**Date**		**Position**	

Client Authorization:

I am an authorised signatory for my ward/department/NHS body or other relevant organization, I am signing to confirm that the Job Profile Title and band of the Nurse and the hours/shift that I am authorising the accurate and I approve payment. I understand that if I knowingly provide false information this may result in disciplinary action, and I 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 and other relevant organization for the purpose of verification of this claim and the investigation, prevention, detection, and prosecution fraud.

Name		**Signature**		**Date**		**Position**	
Note to the Client: ***We ensure we adhere to the NHS Framework requirements. Please ensure you appraise the performance of our worker using the Box provided above.***							