



WEEKLY TIMESHEET
DAILY PAYROLL DEADLINE MONDAY TO FRIDAY 10am
WEEKLY PAYROLL DEADLINE: MONDAY MIDDAY

Please email, Fax or Post: to arrive by Monday 12PM Midday
 Email: info@ultimatecareprofessionals.com
 Fax: Telephone: 01 708 533 562
 Post: Ultimate Care Professionals I 128 City Road, London, EC1V 2NX

(A photographic copy of this timesheet using a smartphone cannot be accepted)

Section 2: Please write in BLOCK CAPITALS your first name & surname on the topline, and client name on the second line e.g Hospital Name/Trust

First Name:	Surname:	
Other Name:	Ultimate Care Professionals Consultant	

Section 2: Please write your breaks when totally your hours worked & ensure you use the 24hr clock. Unless "NB" (Is written in a break column then breaks will automatically be deducted if not included)

NOTE: TOTAL CLAIMABLE HOURS = HOURS WORKED - BREAKS

DAY	DATE	START	BREAK	FINISH	TOTAL CLAIMABLE HOURS	BAND	WARD	BOOKING REF	CLIENT SHIFT APPRAISAL	AUTHORISED CLIENT SIGNATURE
MONDAY										
TUESDAY										
WEDNESDAY										
THURSDAY										
FRIDAY										
SATURDAY										
SUNDAY										
Agreed Expenses (Attach Separate Expenses From/Receipts)					TOTAL CLAIMABLE HOURS:				1 = Good 2 = Satisfactory 3 = Poor	

Section 2: Client Feedback - Please provide us with feedback for the agency worker's time spent at this organization. Please tick the box which most reflects your view on the candidate:

	Excellent	Good	Average	Poor	Would you be happy to receive this agency worker again?	
					Yes	No
Clinical Skill & Knowledge						
Work Performance						
Professionalism and conduct						
Relationship with patients and colleagues						
Attendance/Timekeeping						

Section 4: Please ensure your timesheet is completed and either emailed, faxed or posted to Ultimate Care Professionals; to arrive before Monday 12PM to ensure payment that week. Failure to do so will result in your payment being delayed.

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/shifts detailed on this timesheet. I understand that if I knowingly provide false

Information this may result in disciplinary action and I may be able to prosecution and civil recovery proceedings. I consent to the disclosure of information from this form to and by the NHS body (or otherwise) and the NHS CFSUS (CR

Otherwise) for the purpose of verification of this claim and the investigation, prevention, detection and prosecution of fraud. I also confirm that induction and orientation training has been provided by client.

Name:	Signed:	Position:	Date:
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Client Authorization: I am an authorized signatory for my ward/department/NHS Body or other relevant organization. I am signing to confirm that the job Profile Title and Band of Nurse and the hours/shifts that I am authorizing 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 able to prosecution and civil recovery proceedings. I consent to the disclosure of information from this form to and by the NHS body (or otherwise) and the NHS CFSMS for otherwise) for the purpose of verification of 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 (or otherwise) and the NHS CFSMS (or otherwise) in England (if applicable) or other relevant organization for the purpose of verification of this clam and the investigation, prevention, detention and prosecution of fraud.

Name:	Signed:	Position:	Date:
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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 on 0000 028 460 (within England). (Applicable to the NHS only). I understand and agreed to Ultimate Care Professionals Terms of Business.