



**PSYCHIATRY
PEOPLE**

TIME SHEET

Please fax to **+44(0)203 137 9992**

CLIENT: _____ DEPARTMENT: _____

LOCUM NAME: _____ GRADE & SPECIALITY: _____

WEEK ENDING DATE: _____ BOOKING REF (if applicable): _____

	DATE	START	FINISH	START	FINISH	ACTUAL HOURS WORKED
MONDAY						
TUESDAY						
WEDNESDAY						
THURSDAY						
FRIDAY						
SATURDAY						
SUNDAY						
TOTAL						

I confirm that I have worked

Write number of hours in words

hours

SUMMARY OF TRAVEL EXPENSES – Note: It must be assumed that travel is not paid unless authorised by Psychiatry People at time of booking. Transport receipts must be sent with travel claims. Standard mileage is paid at 23 pence per mile.	AMOUNT
TOTAL	

Note: Any questionable timesheet must be immediately brought to the attention of the Local Counter Fraud Specialist or you may report any case of fraud, in confidence, to the NHS Fraud and Corruption Reporting Line on 0800 028 4060.

"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 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 Counter Fraud and Security Management Service for the purpose of verification of this claim and the investigation, prevention, detection and prosecution of fraud"

LOCUM DOCTOR SIGNATURE: _____

"I am an authorised signatory for my ward/department/NHS body. I am signing to confirm that both the grade 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 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 Counter Fraud and Security Management Service for the purpose of verification of this claim and the investigation, prevention, detection and prosecution of fraud"

CLIENT SIGNATURE: _____ PRINT NAME: _____