Quality Care Cover

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Timesheet No: WQCC008571

PLEASE NOTE: DEADLINE FOR SUBMITTING TIMESHEETS IS MONDAY MIDDAY FOR PAYMENT FRIDAY

Worker's Full Name:	Induction completed: ☐ Client Signature:	
Institution worked at and Address:	WEEK ENDING: DD/MM/YY	SCANNED, FAXED OR POSTED TIMESHEETS ONLY – NO PHOTOS!
Department/Ward:		
Job Title and Band:	NMC/HCPC/GMC/GDC No:	Exp:

DAY RATES (MONDAY TO FRIDAY) PAID ON HOURS WORKED FROM 0600 TO 1959 HRS.
NIGHT RATES (MONDAY TO FRIDAY) PAID ON HOURS WORKED FROM 2000 TO 0559 HRS.
SATURDAY RATES ARE PAID ON HOURS WORKED FROM 0000 HRS SATURDAY TO 2359 HRS SATURDAY NIGHT.
SUNDAY RATES PAID ON HOURS WORKED FROM 0000 HRS SUNDAY TO 2359 HRS SUNDAY NIGHT.
BANK HOLIDAY RATES PAID ON HOURS WORKED FROM 0000 HRS ON THE START OF THE HOLIDAY TO 2359 HRS SAME DAY.
**BREAKS ARE DEDUCTED FROM THE LONGEST PERIOD OF THE SHIFT. IF NO BREAK IS TAKEN,
PLEASE STATE 'NOT TAKEN' IN THE 'BREAK TAKEN' FIELD AND REQUEST THE CLIENT TO SIGN THIS FIELD**

Day/insert Date below	Ref Number	Hours worked (use 24 hour clock)				
		Start Time	Finish Time	Break Taken	Total hours worked minus break taken	CLIENT'S SIGNATURE
Mon DD/MM/YY						
Tue DD/MM/YY						
Wed DD/MM/YY						
Thu DD/MM/YY						
Fri DD/MM/YY						
Sat DD/MM/YY						
Sun DD/MM/YY						

Please ensure this timesheet is completed correctly. Quality Care Cover reserves the right to not process timesheets completed incorrectly.

TOTAL MILEAGE CLAIM (where agreed by The Client)

TOTAL HOURS WORKED:

FEEDBACK FOR CLIENT USE ONLY How would you rate The Candidate's ability? (Please tick as appropriate)

	Excellent	Good	Average	Below Average	Further Comments
Clinical competency					
Punctuality					
Personal presentation					
Communication skills					
Teamworking ability					

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 detailed on this timesheet. I understand that if I knowingly provide false information this may result in action being taken and I may be liable to prosecution and civil recovery proceedings. I consent to the disclosure of the information on this form to and by Quality Care Cover, the Client named above and Law enforcement authorities including the NHS Counter Fraud Authority for the purposes of verification of this claim and the investigation, prevention, detection and prosecution of fraud.

SIGNED BY WORKER ..... PRINT NAME ..... DATE .....

I am an authorising signatory on behalf of the Client, I am signing to confirm that the role, time and date that I am authorising are accurate and that I approve payment. I understand that if I knowingly provide false information this may result in action being taken and I may be liable to prosecution and civil recovery proceedings. I consent to the disclosure of the information on this form to and by Quality Care Cover, the Client named above and Law enforcement authorities including the NHS Counter Fraud Authority for the purposes of verification of this claim and the investigation, prevention, detection and prosecution of fraud.

SIGNED BY CLIENT ..... PRINT NAME ..... DATE .....