BoL MCG

Breath of Life Medi-Care

Breath of Life Medi-Care Group
Supplying Health Care Professionals

Candidates Name:
Reporting to:
Job Title:
Band / Grade:
Name o f Trust / Hospital:
Ward / Department:
Reporting to:

Dept: . . . . . .

Email: info@bolmedi-caregroup.com

Fax: . . . . . .

Timesheet

★ **NB:** Timesheet must be received on Sunday by "WhatsApp, Fax or Email (Scan NOT photographs please)

	Date DD/MM/YY	Start Time	Finish Time	*BREAK TIME* Star	*Finish*	Hours Worked	Booking Refference Number	Authorised Signature
Monday								
Tuesday								
Wednesday								
Thursday								
Friday								
Saturday								
Sunday								
★ Please Use 24 hour clock				TOTAL HOURS WORKED				

CLINICAL/Character Assessment:	Complete using guide please: Good = **G** Satisfactory = **S** Unsatisfactory = **U**

Email feedback to: feedback@bolmedi-caregroup.com

Is able to provide a full range of care to patients and their family	
Ability to organise work within guidelines and professional boundaries	
Demonstrates clinical competence	
Uses initiative and experience to make the right decisions	
Maintains legible and accurate records	
Willingness to follow hospital procedure	
Punctuality and reliability	
Appearance	
Relationship with patients	
Relationship with colleagues	
Would you be prepared to have this healthcare worker back in the Ward/Dept ?	

To be completed by Head of Department/Authorised Signatory

TO BE READ BY ALL CLIENTS:

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 NHS Protect (NHS CFSMS) in England (or NHS CFS in Scotland) for the purpose of verification of this claim and the investigation, prevention, detection and prosecution of fraud. 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 Line on 0800 028 40 60 or email nhsfraud@nhsprotect.gsi.gov.uk.

Signature: . . . . . .

Print Name: . . . . . .

Position: . . . . . .

Date: . . . . . .

Declaration: We confirm that the hours and grade/band shown on this timesheet have been worked to our satisfaction and that this will form the basis of an invoice which will be paid on receipt. We agree to be bound by the terms and conditions of business.

To be completed by Agency Worker

TO BE READ BY ALL CANDIDATES:

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 NHS Protect NHS CFSMS) for the purpose of verification of this claim and the investigation, prevention, detection and prosecution of fraud.

SIGNATURE: . . . . . .

PRINT NAME: . . . . . .Date: . . . . . .

Declaration: I confirm I have worked the above hours. In addition, I declare that any travel and subsistence costs I have claimed have been necessarily incurred in the performance of my duties or travelling in order to perform my duties with Breath of Life Medi-care Group at a temporary workplace. I also declare that any laundry costs I have claimed have been incurred by me wholly, exclusively and necessarily in the performance of my duties.