Clover Healthcare Services – TIMESHEET

CLOVER CARE
QUALITY STAFFING SERVICES

SECTION 1 - Complete in BLOCK CAPITALS. First name on the top line, Surname on the second line and the Client name on the third line. E.g. Hospital name

First Name _____

Surname _____

Client Name _____

SECTION 2 - 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 breaks will automatically be deducted if not included

Email or Fax your TIMESHEET by Monday 5PM

Address: 8 Tennyson Avenue, Sowerby Bridge.
Halifax HX6 1BY
Telephone: 0142 264 8700
E-mail: info@clovercareuk.com
Web: www.clovercareuk.com

								ON CALL HOURS			
Day	**Date**	**Start**	**Break**	**Finish**	**Total Hrs (Excl. Breaks)**	**Reference number**	**Daily Signature**	**Start**	**Finish**	**Total Hrs**	**Signature**
Monday											
Tuesday											
Wednesday											
Thursday											
Friday											
Saturday											
Sunday											
Total Hours (Excl. Breaks)								Agreed Expenses (Attach Mileage form/receipts)			

SECTION 3 - Please ensure your time sheet is fully completed and either emailed or posted to Clover Healthcare Services before Monday 5PM to secure payment on that week. Failure to do so may result in your payment being delayed and/or amended

Agency Worker:
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 time sheet. 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 this disclosure of information from this form to and by any Clover Healthcare Services authorised body for the purpose of verification of this claim and the investigation, prevention, detection, and prosecution of fraud.

AUTHORISED BY: (SENIOR MEMBER OF STAFF)
I am an authorised signatory of the above named client. I am signing to confirm that the Job Profile Title and Band 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 the information from this form to and by any Clover Healthcare Services authorised body for the purpose of verification of this claim and the investigation, prevention, detection and prosecution of fraud. I understand and agree to Clover Healthcare Services current terms of business. A standard introductory fee will be charged if the Nurse is taken on full time or engaged through a different agency.

Name:	**Signature:**
Speciality:	**Date:**
Name:	**Signature:**
Position:	**Date:**