IMPACT
Believing Helping Achieving

TIMESHEET

Please ensure that this timesheet reaches us by **Monday 12PM**.

FAILURE TO DO SO WILL DELAY PAYMENTS

Email: impacttimesheet@gmail.com
FAX: 0845 6769 248
Website: www.impactcareservices.co.uk

FIRST NAME	
SURNAME	
CLIENT / TRUST	

JOB TITLE	
BAND	

Please indicate performance from 1-5 (5 being the best)

DAY	DATE	START	BREAK	FINISH	TOTAL HRS	WARD/UNIT	BOOKING REFERENCE NO	AUTHORISING NAME	AUTHORISING SIGNATURE	Punctuality	Dress Code	Attitude
Monday												
Tuesday												
Wednesday												
Thursday												
Friday												
Saturday												
Sunday												
				Total Hours of the week excluding breaks								

Notes to Candidate:

1. HAVE YOU RECEIVED HOSPITAL/NURSING HOME INDUCTION? Yes ☐ No ☐
2. Timesheets without Booking Reference and/or PO number (where applicable) WILL NOT be processed.
3. Timesheets which are not in a legible format or without an authorisation signature WILL NOT be processed for payment.
4. Please minus your breaks when totaling your hours worked & ensure you use the 24hr clock.
5. A photographic copy of this timesheet using a smart phone or other device will not be accepted.
6. Please use 1 Time sheet per client Per Week. For NHS Please use 1 time sheet per Shift.

Agency Staff: 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 this disclosure of information from this form to and by any Impact Care authorized body for the purpose of verification of this claim and the investigation, prevention, detection, and prosecution of fraud.	AGENCY STAFF NAME: SIGNATURE:	DATE: JOB TITLE:
AUTHORIZED BY: *(SENIOR MEMBER OF STAFF)* I am an authorized 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 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 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 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. I understand and agree to Impact Care Services. Terms of Business - A Standard introductory fee will charge if the Agency Staff is taken on full time or allowed to change agency.	AUTHORISED APPROVER NAME: SIGNATURE:	DATE: JOB TITLE: