AGENCY TIMESHEET

Surname:		Forename:	
HEALTH BOARD			
HOSPITAL		LOCATION	

INVOICE
PO NO
IF POOL SHIFT – AREA ALLOCATED -

Date Worked	Booking Ref No.	SHIFT	Time Worked		Unpaid Breaks** In Mins	TOTAL HOURS WORKED	THIS SECTION MUST BE SIGNED BY SISTER OR NURSE IN CHARGE				
			From	To			Print Name	Signature	WARD	BAND	DATE
SUN											
MON											
TUE											
WED											
THUR											
FRI											
SAT											
				Total hours excluding unpaid breaks →							

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 for prose caution and civil recovery proceedings. I consent to the disclosure of information from this form to and by Cardiff and Vale University Health Board 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.

Signature of Agency Nurse: _____