MSM Healthcare Ltd
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PLEASE REMEMBER TO EMAIL COMPLETED TIMESHEETS BY MONDAY 12:00 TO BE PAID ON FRIDAY.

Agency Worker Details:

Forename(s):	Job Title:	Client:
Surname:	Specialty:	Unit/Ward:

	Date	Start Time	Finish Time	Break	Sleep in (Client signature)	Worked Hours	Daily Authorised Signature
Mon							
Tue							
Wed							
Thu							
Fri							
Sat							
Sun							
					Total Hours		

Weekly Hours Authorised by the Client:

Print Name:		Position:	
Client Signature		Date:	

Client declaration: I am an authorised signatory for my ward/department/Company/NHS body. I am signing to confirm that 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. An introduction fee may be chargeable should a transfer of the Agency Worker either to direct/permanent employment or engagement by a third party occur. Please note that your signature confirms your acceptance of terms of business and authority to invoice the total hours.

Agency Worker Signature		Date:	

Agency Worker declaration: 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 confirm that I am responsible for monitoring my hours of work in relation to the Working Time Regulations. I have read, understood and agree to the Terms of Engagement supplied to me by the Company.