Concept Care Solutions LTD
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Staff name: _____ Week ending: _____

Specialty: _____ Hospital Name: _____

Grade: _____ Ward: _____

Day	Date	Start Time	Break	End Time	Total Hours	Reference Number	Client Signature
Monday							
Tuesday							
Wednesday							
Thursday							
Friday							
Saturday							
Sunday							
Total Hours (in words)							
Mileage							

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 Authority, other Public Sector body and Private entities who have a similar requirement and the Counter Fraud Services (or other similar organisation which operates in the same capacity for any other Public Sector organisation) for the purpose of verification of this claim and the investigation, prevention, detection and prosecution of fraud

Induction & Orientation training received (inc Fire Safety) on first assignment ? ☐**Yes** ☐**No**

Candidate has ID badge present? ☐**Yes** ☐**No**

Post Assignment Reference

Knowledge of Work	Excellent	Good	Satisfactory	Poor
Quality of work	☐	☐	☐	☐
Adaptability	☐	☐	☐	☐
Attitude and initiative	☐	☐	☐	☐
Reliability	☐	☐	☐	☐
Attendance	☐	☐	☐	☐
Courtesy/Congeniality	☐	☐	☐	☐
Personal Appearance	☐	☐	☐	☐

Locum Signature _____ Client Signature _____

Print Name _____ Print Name _____

Date _____ Date _____

Position _____

I am the authorised signatory for this placement. I am signing to confirm that the Job Title, Band Worked and the hours/shift, mileage/travel 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 the NHS CFSMS for the purpose of verification of this claim and the investigation, prevention, detection and prosecution of fraud.