DOCTORS TIMESHEET
PLEASE WRITE IN CAPITAL LETTERS
AND USE 24 HOUR FORMAT

Please email timesheets weekly to:
drtimesheets@carepro.co.uk or
FAX: +44 (0)20 8338 3044 T: 0208 518 0377

First Name:	Last Name:
Job Title:	Address:
Hospital/ Trust:	Ward/Dept:

DAY	DATE	START TIME	BREAK TAKEN	FINISH BREAK	FINISH TIME	TOTAL HOURS	BOOKING REF	AUTHORISED SIGNATURE	BREAK NOT DEDUCTED? Authorisation must be provded below
MON									Name: Signature
TUE									Name: Signature
WED									Name: Signature
THUR									Name: Signature
FRI									Name: Signature
SAT									Name: Signature
SUN									Name: Signature

Total Hours: Total Hours in Words:

Travel/ Mileage:

Induction and Orientation Training Completed? ☐ Yes ☐ No

I declare that the information given on this form is correct and complete, I have not claimed it elsewhere for the hours/ shifts declared on this timesheet. I understand that, if I knowingly provide false information this may result in disciplinary action and I will be liable to prosecution and civil recovery proceedings. I consent to the disclosure of the information from this form to and by NHS CFSMS for the purpose of the verification of this claim and investigation, prevention, detection and prosecution of fraud.

- To ensure payment on Friday,this timesheet must be received by 12pm Tuesday of the following week.
- Timesheets without booking reference/ PO will not be processed
- In order for the timesheet to be paid, an authorised signature and name MUST be present in the last column AND BOTTOM OF THE PAGE for the corresponding shifts. CarePro holds no responsibility if the trust refuses to pay despite the approval.

TRUST AUTHORISATION: I am an authorised signatory for my ward/ department/ NHS body. I am signing to confirm that both the grade of Locum and the hours/ shifts that I am authorising are accurate and I approve the 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 disclosue of information from this form to and by the NHS body and the NHS CFSMS in England (or NHS CFS for the purpose of verification of this claim and the investigation, prevention, detection and prosecution fraud.

Assessment	Poor	Satisfactory	Good	Notes
Scientific Knowledge & Clinical Skills				
Professionalism & Conduct				
Communication				
Leadership & Initiative				

Locum's Name Signature: Date:

Authorised Approver's Full Name: (IN BLOCK CAPITALS) Signature: Date: