

# AGENCY TIMESHEET



**Surname:** \_\_\_\_\_ **Forename:** \_\_\_\_\_

**HEALTH BOARD** \_\_\_\_\_

**HOSPITAL** \_\_\_\_\_ **LOCATION** \_\_\_\_\_

<b>INVOICE NO</b>
<b>PO NO</b>
<b>IF POOL SHIFT - AREA ALLOCATED -</b>

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 →

**\*\* Please note that breaks will automatically be deducted in line with WTD unless specifically authorised and noted on this timesheet**

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 prosecution 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:** \_\_\_\_\_

