interact medical
doctors + nurses + ahp's

N.B. PLEASE NOTE, PHONE CAMERA COPIES CAN NOT BE ACCEPTED

Timesheet:	Fax 01908 810235 or nursing.fax@interactmedical.co.uk

LOCUM DETAILS			
First Name:		**NMC Number:**	
Last Name:		**Week Ending Date:**	
Hospital:		**Ref:**	
Grade & Specialty:		**Ward:**	

	Date	STANDARD HOURS		ON-CALL HOURS		BREAKS		
		Start Time (24 hours)	End Time (24 hours)	Start Time (24 hours)	End Time (24 hours)	Breaks (minutes)	No Breaks (approved signature)	Total Hours (breaks deducted) E.g. "Forty hours and fifteen minutes"
Mon								
Tues								
Weds								
Thurs								
Fri								
Sat								
Sun								
				TOTALS				

Locum/Agency Worker Signature:
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 NHS body and the NHS CFSMS for the purpose of verification of this claim and the investigation, prevention, detection and prosecution of fraud.
The agency Worker / Locum consents to Interact Medical disclosing any information, including personal data and sensitive personal data, relating to the Assignment to HMRC or other such taxation authority, any medical regulatory authorities (such as the British Medical Association or the British Dental Association), any registered professional body (such as the Nursing Midwifery Council) and any investigatory body of the NHS, including the NHS Counter Fraud Services, upon demand.
Locum: - I confirm that I have worked/provided the services for the period as recorded above
- I confirm I have undergone a trust induction

Authorised Signature

Full Name ……………………………

Date …………………………………

Trust/Hospital Signature:
I am an authorised signatory for my ward/department/NHS body. I am signing to confirm that both the grade of Agency Worker and 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. I consent to the disclosure of information from this form to and by the NHS body and the NHS CFSMS in England (or NHS CFS in Scotland) for the purpose of verification of this claim and the investigation, prevention, detection and prosecution of fraud"
Any questionable timesheet must be immediately brought to the attention of the Local Counter Fraud Specialist (within England) or you may report any case of fraud, in confidence, to the NHS Fraud and Corruption Reporting Line on 0800 028 4060 (within England) or 0800 015 162+8 (within Scotland).Counter fraud declaration to be signed, with printed name and position of the Authorised Signatory, and dated by the Authorised Signatory of the Authority (and cost centre stamp if required by the Authority).

Authorised Signature

Full Name ……………………………

Position …………………………………

Date …………………………………

Please ✓ as appropriate, providing additional comments in support of the statements made	Unable to comment	Poor	Satisfactory	Good	Very Good	Excellent
Clinical skills demonstrated in line with the requirements of the position						
Relationships with patients, other healthcare workers and the public						
Timekeeping and management of workload						
Patient records and other records management						
Reliability						
Communication skills						
Supervisory skills						
Organisational ability						
Overall performance						
Overall conduct/behaviour						
Sickness/absence record						

Additional comments in support of the statements made

Would you be happy for this worker to be employed in the same role in the future?
☐ Yes ☐ No

Does this worker have any training needs that you have identified?
☐ Yes ☐ No

Do you believe the named applicant to be honest, conscientious and discreet? If no, please provide further details below.
☐ Yes ☐ No

Please tick the appropriate box.
Would you re-employ the named applicant? If no, please provide further details below. Please tick the appropriate box.
☐ Yes ☐ No