

FULL NAME		WEEK COMMENCING			ORGANISATION NAME		
DAY	START	FINISH	BREAK	TOTAL HOURS (Minus break)	WARD/DEPT	DATE	APPROVED SIGNATURE
MON							
TUES							
WEDS							
THURS							
FRI							
SAT							
SUN							
			TOTAL HOURS		TOTAL HOURS (IN WORDS)		

DECLARATION BY TEMPORARY WORKER I declare that the information on this timesheet 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 the Client or authorised officials.				AUTHORISED BY CLIENT We certify that the above-mentioned temporary worker has attended for work at the stated times and to our satisfaction. Only valid if signed by: Hospital Manager, Clinical Manager or Head of Care.			
TEMPORARY WORKER'S NAME:				FULL NAME:		POSITION:	
SIGN:		DATE:		SIGN:		DATE:	

A copy of this timesheet needs to be with us by 10am Monday, so that we can pay you on time. To send your time sheet, email a scan or photo to timesheets@beamishcare.com or come into the office. If you are going to email a scan or photo across, we recommend that you CC yourself on the email.