CAY HEALTHCARE
Compassionate Care Right In Your Home

TIMESHEET

PLEASE ENSURE THAT ALL SECTIONS ARE CORRECTLY FILLED BEFORE SIGNING

Staff Name:	**Client Name:**
Week Commencing:	**Address:**

DAY	DATE	START TIME	FINISH TIME	BREAK	HOURS DAY	HOURS NIGHT	Ward/ Dept	Grade	Clients Initial	Nurses Signature
SUN										
MON										
TUE										
WED										
THUR										
FRI										
SAT										
TOTAL HOURS EXCLUDE BREAKS										

I confirm that the information of hours is correct and agreed for payment

TOTAL HOURS (In Words)	
AUTHRORISED SIGNATURE:	**NAME: (Please print)**
POSITION HELD:	**DATE:**

Staff in charge Full Name:

Staff in charge Signature: **Date:**

I am authorised signatory for my ward, department/ Nursing home/ Residential Home. I am signing to confirm that the job profile, title and band of agency worker and the hours that l am authorising are accurate and l approve payment. I understand that if l knowingly provides false information this may result in legal action and l may be liable for prosecution and civil recovery proceedings.

Name of Worker: (print) **Signature of worker:**

Date:

I declare the information is correct and if l knowingly provide false information l may be prosecuted for fraud and civil recovery proceedings.

No Signed Time Sheet no pay.