Timesheets must be completed in BLACK ink
Photographs are not permitted.

EMAIL YOUR TIMESHEETS EVERY MONDAY BY 12PM

Please write in BLOCK CAPITALS

First Name		**Surname**	
Trust Name		**Hospital Name**	
Job Title		**Band**	
Recruitment Consultant			

Please confirm breaks taken when totaling your hours worked and ensure you use the 24hr clock - if a break is not recorded in the break column, then breaks will automatically be deducted according to trust policy.

Please note: TOTAL CLAIMABLE HOURS = HOURS MINUS BREAKS

Day	Date DDMMYY	Shift Start Time	Total Breaks Taken	Shift Finish Time	Total Claimable Hours	Ward Name	Booking Ref	Manager Signature
					Total Claimable Hours			

Candidate Declaration

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 Upwards Care ceasing to offer me further assignments 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 health body (or otherwise) and NHS Protect (or otherwise) or other relevant organisation for the purpose of verification of this claim and the investigation, prevention, detection, and prosecution of fraud. I also confirm that induction and orientation training has been provided by the client.

Name:	Signed:
Position:	Date

Client Authorisation:

I am an authorised signatory for my ward/department/NHS Body or other relevant organisation. I am signing to confirm that the Job Profile Title and Band of Nurse and the hours/shifts 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 for prosecution and civil recovery proceedings. I consent to the disclosure of information from this form to and by the health body (or otherwise) and NHS Protect (or otherwise) or other relevant organisation for the purpose of verification of this claim and the investigation.

Name:	Signed:
Position:	Date

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Please email your timesheets to info@upwardscare.com

Quality Assessment Form

Candidate's full legal name:				
When did the above-named work with you?	From:		To:	
Candidate's job title:			Band:	

How would you rate the candidate's performance in the following areas?				
CLINICAL ABILILTY	**Excellent**	**Good**	**Satisfactory**	**Poor**
Standard and quality of clinical work				
Medical record keeping accuracy				
CAPACITY & MOTIVATION				
Ability to work with initiative				
Ability to work as a team member				
Ability to manage staff (if applicable)				
RAPPORT BUILDING				
Ability to deal sensitively and politely with patients & relatives				
Rapport with other members of staff				
CHARACTER				
Adaptability				
Confidentiality / Trustworthiness				
Timekeeping				
Overall attitude				
Additional comments:				

Would you accept this candidate for future assignments?	Yes	No
Did you supervise the candidate's clinical practice whilst on shift?	Yes	No

Please note: This form will not be valid unless the below information is fully completed.

Referee's full legal name:	**Official Stamp: (If you do not have a stamp, please attach a signed compliment slip.)**
Referee's signature:	
Referee's job title: **Band:**	
Organisation name and ward name:	
Work email address:	
Mainline telephone number:	**Date completed:**