Marking Instructions — Using black or blue ink, please write CLEARLY and CAREFULLY inside the boxes using BLOCK CAPITALS, like this

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z 1 2 3 4 5 6 7 8 9 0

BNA — The British Nursing Association | grosvenor nursing | Mayfair SPECIALIST NURSES | **Nestor Healthcare Staffing**

Y0145708

Client / Hospital: GOSPORT WAR MEMORIAL HOSPITAL

Ward / Unit: DRYAD

Client / Hospital Address: BURY RD GOSPORT

Surname: Code A

Forenames: Code A

Member / Payroll No: S867078

Home Post Code: PO12RP

Qualification: NVQ3
Only Use One Qualification Relevant to Work

Shift Code:
1 = General 2 = Geriatric 3 = Psychiatric 4 = Specialist 5 = Sleeper Shift 6 = On Call Shift In Charge ☐ Y ☐ N
7 = Call Out 8 = Sitter Shift 9 = Acute & Primary 0 = Acute Child Specialist A= ICU B = Renal C = Midwifery

Client Internal Timesheet No:

Day	Date Month	Year	Hours Worked Start 24hr Clock Finish	Meal Break Start 24hr Clock Finish	Meal Break Hrs Mins	Total Hours Claimed	Grade	Shift Codes See Above	Booking Reference Number	Ward Signature	Financial Code (Client use only) or Ward Stamp
21	06	05	1300-2030	1630-1700	0030	0700	A	02	1351661	MO	

Total Miles ☐ **Total Claimed £** ☐☐.☐☐ **Expenses Claimed £** ☐☐.☐☐ Hours ☐☐ Minutes ☐☐ **Total Hours Claimed**

* It is the responsibility of the Member to ensure this timesheet is correct and complete before leaving the client.
* Timesheets must be submitted within two weeks of completing shift.

Agency Member Signature: Code A

CLIENT AUTHORISATION (MUST BE COMPLETED)

TOTAL HOURS TO BE PAID - IN WORDS
(To be completed by Client only) - DO NOT USE HYPHENS BETWEEN WORDS

HOURS SEVEN HOURS

MINUTES

Please Check the Following
1. The shift details claimed on this timesheet are correct.
2. The total hours claimed are correct and the breakdown of those hours are correct.
3. Do you need an internal timesheet? ☐ YES
4. Your timesheet has been signed by an authorised person in the Client Authorisation box.
5. You have stated the ward/unit worked on.

Please give your comments including the persons clinical performance during the shift(s)

Please (✔) ☐ Very Satisfactory ☐ Satisfactory ☐ Unsatisfactory

If unsatisfactory, please contact the local branch to discuss training needs.

Date: 210605

Name: Code A

Position: M. OSBORN S/N

Signature: Code A

Client Copy