| **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

**YO151805**

**Client / Hospital**

G O S P O R T M E M O R I A L

H O S P I T A L

**Ward / Unit**

D R A H A D

**Client / Hospital Address**

GOSPORT

**Surname:** Code A

**Forenames:**

**Member / Payroll No:**

**Home Post Code:** P O 5  Code A

**Qualification:** NVQ 3

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 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 16 | 06 05 | 2015 | 0745 — | — | | | A | | 137538 | | |
| | | | — | — | | | | | | | |
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| | | | — | — | | | | | | | |

**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

**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.

## 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** 1 0

**MINUTES**

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:** 17 06 05

**Name:** P. Mcweever

**Position:** Staff Nurse

**Signature:** Code A

**Client Copy**