

# INTER-COUNTY NURSING & CARE SERVICES

## TIMESHEET

78538

W/E  
Sunday

21/9/97

White - Head Office copy  
Pink - Nurse's copy  
Yellow - Client's copy

For H.O. use only

CLIENT POZZSWORTH HEDDLE

Address 60 POZZ SWORTH MEMORIAL

HOSPITAL .....

Ward Name NURSERY C  
(If NHS circle either GER or PSY or OTHER)

NURSE Membership Number EH130

Name THERESA HARRY

grade PAYABLE D

- Please ensure:**
- 1) Separate timesheet for each client per week
  - 2) the client signs below and retains yellow copy

### IF SOCIAL SERVICE DUTY

TICK

REF

EACH LINE to end of night duty	FROM HRS 00.00	TO HOURS 00.00	Time Taken for meals	HOURS ACTUALLY WORKED						TRAVEL Daily Mileage	EXTRAS e.g. NIGHT CALLS TRAVEL ON CLIENT BUSINESS ETC.
				DAY			NIGHT				
				W/D	W/E	P/H	W/D	W/E	P/H		
<del>10/9</del> MON	0700	1400		7							
TUES											
WED											
THURS											
FRI											
SAT											
SUN to end of night duty											
I certify that the total of				7						hours have been	

satisfactorily worked and that payment will be made in respect of these according to your terms and conditions of business which I have received and accept as the basis of the transaction.

Signature  
(Client please retain yellow)

**Code A**

Date 15.9.97

Position SIN



**We pay our members weekly.**  
Please be prompt with your settlement of the account  
I.C.N.S.  
90 High Street  
Burnham  
Bucks SL1 7TD  
Tel: Burnham (01628) 665271

Please tick if you require:

- Timesheets   
Address labels

**PORTSMOUTH HEALTHCARE NHS TRUST**  
**GOSPORT WAR MEMORIAL HOSPITAL**  
**AGENCY REQUEST FORM**

78538

A Request from: MURBERY WARD Date: 16/9/97

Class of Agency cover required: TRAINED D GRADE

Reason for use of Agency Staff: Sickness

Holiday \_\_\_\_\_

(Please tick)

Vacancy \_\_\_\_\_

Maternity Leave \_\_\_\_\_

Other \_\_\_\_\_

Grade or specific skills / experience required: TRAINED D GRADE

Location: MURBERY C

Date required from: 15/9/97 to 15/9/97

Hours and times to be covered daily: 0700 - 1400

To report to: MURBERY at \_\_\_\_\_

B Approved by: J CHERRY Date 16/9/97

Name of Agency supplying cover: INFER-COUNTY

Hourly rate (+details of any special payments) agreed: \_\_\_\_\_

Date booking confirmed with Agency: \_\_\_\_\_

Agency contact regarding this booking: YES

Name(s) of individual(s) being supplied by Agency \_\_\_\_\_

T HARDY

C Date Request form received 16.9.97

Date invoice received \_\_\_\_\_



The engagement of Agency Staff can only be undertaken by authorised Managers. If you are unsure as to whether you are authorised for this purpose then please contact your immediate Manager.

The following steps are to be adhered too when requesting the use of Agency Staff. (All questions must be completed).

1. Complete Section A and B of the Agency Request Form.
2. Notify Manager of relevant area of cover arranged.
3. Completed Agency Request Forms to be forwarded to General Office.  
Gosport War Memorial Hospital.

Please note when booking Agency Staff please inform the Agency in question to send their official invoices to:-

The General Office  
Gosport War Memorial Hospital  
Bury Road  
GOSPORT  
Hants  
PO12 3PW