

INTER-COUNTY NURSING & CARE SERVICES

TIMESHEET

74807

W/E
Sunday

24/8/97

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

For H.O. use only

CLIENT Warr Memorial Hospital
Address COBERT
HOSPITAL WARR MEMORIAL
Ward Name MURBERRY B
(If NHS circle either GEN or PSY or OTHER)

NURSE Membership Number HS/ 703
Name Code A
grade PAYABLE A
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		
MON											
TUES											
WED											
THURS											
FRI											
SAT											
SUN to end of night duty	1300	2100	8								
I certify that the total of				8						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 Code A Date 24.8.97 Position S/N.



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

74807

A Request from: MULBERRY WAD Date: 24/8/97

Class of Agency cover required: HCSW

Reason for use of Agency Staff: Sickness

Holiday

(Please tick)

Vacancy

Maternity Leave

Other

Grade or specific skills / experience required: HCSW

Location: MULBERRY B

Date required from: 24/8/97 to 24/8/97

Hours and times to be covered daily: 1300 - 2100

To report to: MULBERRY B at _____

B Approved by: J CHERRY Date 25/8/97

Name of Agency supplying cover: INTER-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 _____

Code A

C Date Request form received _____

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