EnR Healthcare Services

EnR HCA TIMESHEET

1st Copy: Send **one** to EnR - 2nd Copy: Leave with the Client - 3rd Copy: Keep for your records

Please either Email or Post your Timesheet by Monday 12PM:
Email: admin@enthcs.co.uk
Post: EnR Ltd, 39 Stukeley Road
Huntongdon, Cambridgehire
PE29 6HG
Telephone: 07733091550

Section 1: Please write in BLOCK CAPITALS your first name on the top line, your surname on the second line and the Client name on the third line. E.g. Hospital name

First Name

Surname:

Client Name:

Section 2: Please write your breaks when totaling your hours worked & ensure you use the 24hr clock. Unless "NB" (no break) is written in the break column then breaks will automatically be deducted if not included

		ORDINARY TIME				ON CALL HOURS				
DAY	DATE	START	BREAK	FINISH	TOTAL HRS (excl breaks)	START	FINISH	TOTAL HRS	WARD/UNIT	REFERENCE
Monday										
Tuesday										
Wednesday										
Thursday										
Friday										
Saturday										
Sunday										
		TOTAL HRS (MINUS BREAKS)				TOTAL HRS		AGREED	EXPENSES: (ATTACH MILEAGE FORM/RECEIPTS)	

Section 3: Please ensure your timesheet is fully completed and either emailed or posted to EnR before Monday 12PM to secure payment on that week. Failure to do so may result in your payment being delayed and/or amended

HEALTHCARE ASSISTANT:
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 disciplinary action and I may be liable to prosecution and civil recovery proceedings. I consent to this disclosure of information from this form to and by any EnR authorised body for the purpose of verification of this claim and the investigation, prevention, detection, and prosecution of fraud.

Name: Signature:

Specialty: Date:

AUTHORISED BY: *(SENIOR MEMBER OF STAFF)*
I am an authorised signatory of the above named client. I am signing to confirm that the Job Profile Title and Band of Agency Worker and the hours/shift 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 to prosecution and civil recovery proceedings. I consent to the disclosure of the information from this form to and by any EnR authorised body for the purpose of verification of this claim and the investigation, prevention, detection and prosecution of fraud. I understand and agree to EnR' current terms of business www.enrhcs.co.uk/agency-terms-conditions/ A standard introductory fee will be charged if the HCA is taken on full time or engaged through a different agency.

Name: Signature:

Position: Date: