

BMECP Center

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**PLEASE ENSURE THAT ALL SECTIONS ARE CORRECTLY FILLED BEFORE SIGNING**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **DAY** | **DATE** | **FROM** | **TO** | **HOURS****DAY** | **HOUSRS****NIGHT** | **Gen.** | **GTR** | **Psyc.** | **Ward/Dept** | **Grade** | **Clients****Signature** | **Nurses Signature** |
| **SUN** |  | ampm | ampm |  |  |  |  |  |  |  |  |  |
| **MON** |  | ampm | ampm |  |  |  |  |  |  |  |  |  |
| **TUE** |  | ampm | ampm |  |  |  |  |  |  |  |  |  |
| **WED** |  | ampm | ampm |  |  |  |  |  |  |  |  |  |
| **THUR** |  | ampm | ampm |  |  |  |  |  |  |  |  |  |
| **FRI** |  | ampm | ampm |  |  |  |  |  |  |  |  |  |
| **SAT** |  | ampm | ampm |  |  |  |  |  |  |  |  |  |
| **TOTAL HOURS EXCLUDE BREAKS** |  |  |  |  |  |

**I confirm that the name, hours ad and Grade are correct and agreed for payment**

|  |
| --- |
| **TOTAL HOURS (In Words)** |
| **AUTHRORISED SIGNATURE:** | **NAME: (Please print)** |
| **POSITION HELD:** | **DATE:** |

**Staff in charge Full Name Staff in charge Signature: Date** I am authorised signatory for my ward, department/ Nursing home/ Residential Home. I am signing to confirm that the job profile, title and band of agency worker and the hours that l am authorising are accurate and l approve payment. I understand that if l knowingly provides false information this may result in legal action and l may be liable for prosecution and civil recovery proceedings.

**Name of Worker** (print) …………. **Signature of worker……………….** Date ………… I declare the information is correct and if l knowingly provide false information l may be prosecuted for fraud and civil recovery proceedings.

No Signed Time Sheet no pay