

20A-30 Abington Street, Northampton, NN1 2AJ

**Tel:** 01604 660 663 | 07714 926 771 | **Email:** info@harcourthealthhub.co.uk | **Website:** www.harcourthealthhub.co.uk

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| **TIMESHEET** | | | |
| Candidate Name: |  | Week Ending: |  |
| Candidate Signature: |  | Reference Number: |  |
| Band: |  |  |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Date | Start Time | Finish Time | Break Duration | Hours Worked  (less break) | Ward  /Dept | Booking Ref | Authorised By |
| Monday |  |  |  |  |  |  |  |  |
| Tuesday |  |  |  |  |  |  |  |  |
| Wednesday |  |  |  |  |  |  |  |  |
| Thursday |  |  |  |  |  |  |  |  |
| Friday |  |  |  |  |  |  |  |  |
| Saturday |  |  |  |  |  |  |  |  |
| Sunday |  |  |  |  |  |  |  |  |
| Additional Hours | |  | | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Authoriser’s Name: |  | Total Hours Worked: |  |
| Authoriser’s Signature: |  | Ward Department: |  |
| Date: |  | Organisation: |  |

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| --- |
| I declare that I have read and accept the terms and conditions of Harcourt Health Hub. I can confirm that the above details are correct and accurate. I have approved this timesheet and provide authority for our organisation to be invoiced using the information provided on this timesheet.  I can confirm that I am an authorised signatory for my Ward/Dept. I can confirm that the Candidate’s Job Title, Band and Hours worked are correct and accurate. I am therefore authorising that payment be made to Harcourt Health Hub.  I understand that I am liable for disciplinary action, civil recovery proceedings or prosecution if I knowingly provide false and inaccurate information. I consent for the information on this timesheet to be disclosed to the NHS body and NHS CFMS for verification, investigation, fraud detection and prevention purposes.  Any suspicious timesheets will be reported and submitted to the Local Counter Fraud Specialist and in case of fraud to the NHS Fraud and Corruption Reporting Line on 0800 028 4060. |

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| All Timesheets Must Be Received By Us By 10am  Please Send Original Timesheet By Post If You Have Faxed Your Timesheet |

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| --- | --- | --- | --- |
| **ASSESSMENT FORM** | | | |
| Candidate Name: |  | | |
| Organisation: |  | Ward/Department: |  |
| Employment Dates- From: |  | Dates- To: |  |



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| --- | --- | --- | --- | --- | --- | --- |
| Please tick as appropriate | Unable To Comment | Poor | Satisfactory | Good | Very Good | Excellent |
| Clinical skills demonstrated in line with the requirements of the position. |  |  |  |  |  |  |
| Relationships with patients, other healthcare workers and members of the public. |  |  |  |  |  |  |
| Time keeping and management of work load. |  |  |  |  |  |  |
| Patient records and other records management. |  |  |  |  |  |  |
| Reliability. |  |  |  |  |  |  |
| Communication skills. |  |  |  |  |  |  |
| Supervision skills. |  |  |  |  |  |  |

In order to Validate Assessment Form, Please Provide Official Stamp, Signed Compliment Slip or Official Letter Head Paper.

|  |  |  |
| --- | --- | --- |
| Assessor’s Name: |  |  |
| Assessor’s Signature: |  |
| Position: |  |
| Date: |  |