Timesheet

Forename _____ **Surname:** _____ **Client:** _____

Please note that we can only accept one timesheet per week for each organisation that you work at. We advise that you have your timesheet completed on your last working day of the week (Monday - Sunday). To ensure payment, it is your duty to return a signed timesheet. **The below is to be completed by the clinician**.

Day	Date	Start / Finish Time (am)	Break Start / Finish Time (am)	Start / Finish Time (pm)	Hours	Days (½ or full)	On call days	Admin hours	Hours on call	Visit
Monday										
Tuesday										
Wednesday										
Thursday										
Friday										
Saturday										
Sunday										
					Total:					

To be completed by the client – Practice Manager of Lead GP to sign only

I authorise this timesheet and agree that the units stated are correct and I wish for you to send me an invoice for these units, without the need for another correspondence. 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 and by any Key Medical Services authorised body for the purpose of verification of this claim and the investigation, prevention, detection, and prosecution of fraud. I understand that Key Medical Services Terms of Business apply, and we will not book or employ this clinician directly or through any other organisation. Unless we have prior written permission from Key Medical Services Limited. If this occurs the standard introduction fee will apply.

Authorising signatory name		**Signature**		**Position**		**Date**	/ / 2024
Clinician signature		**Email:**	timesheets@keymedicalservices.co.uk	**Fax**	01582 647 773	**Deadline**	Sunday, 23:59