

TIMESHEET



CLIENT	MEMBER
Name:	Name:
Address:	Qualification: HCA / SNR / RGN
Postode:	Home Postcode:

	Date	Start Time	Finish Time	Breaks Deducted	Total Hours
MON					
TUE					
WED					
THU					
FRI					
SAT					
SUN					
TOTAL HOURS					

Office Use Only

Shift Notes:

Mileage Claim: **YES / NO**
FerryTransport: **YES / NO**

By signing this timesheet, I certify that the hours shown have been worked by the above-named Member of Ocean Healthcare and I have the authority to authorise the appropriate charges.

I confirm that breaks are paid
Initials: _____

Day Rate: 08.00 - 20.00
Night Rate: 20.00 - 08.00
Saturday Rate: 08.00 Saturday - 08.00 Sunday
Sunday Rate: 08.00 Sunday - 08.00 Monday

Signed: _____
Name: _____
Position: _____
Date: _____