



**Vostek Ltd**

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**Time Sheet**

Please ensure your timesheet is completed and submitted by email or posted to **Vostek Ltd's** address as above before Monday 12PM for prompt payment.

Candidate / Nurse Name:

Name of home/Hospital

Booking ref no:

Ward:

Address of home/Hospital

Qualification / Post

Week ending (Sunday)

Day	Date	Insert time			No of Hours work		Ward	Authorised By
		Start	Break	End	Day	Night		
Mon								
Tue								
Wed								
Thu								
Fri								
Sat								
Sun								
Total								

Total pay hours in words (excluding breaks): \_\_\_\_\_

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 the disclosure of information from this form to and by the NHS body and the NHS CFMS Service for the purpose of verification of this claim and investigation, prevention, detection and prosecution of fraud.

Candidate's name

Candidate's Sign

Date

**Feedback / Reference Form (For Client Only)**

Poor – 1, Satisfactory – 2, Good – 3, Excellent – 4, Unable to comment – n/a

Type	1	2	3	4	n/a	Comments
Clinical Skills						
Clinical Knowledge						
Organizational Skills						
Management Skills						
Willingness to learn						
Contribution to the department						
Punctuality						
Reliability						
Self Motivation						

Were there any concerns or issues with the worker? Yes / No

Would you be happy to have the candidate back? Yes / No

Induction completed by client (only applies to 1st shift) Yes / No

I am the authorised signatory to my ward/department/NHS body/nursing home. By signing below I confirm the accuracy of the agency worker, grade and hours/shifts and I approve payment. I understand that if I knowingly provide false information this may result in disciplinary action and I may be liable for prosecution and civil recovery proceedings. I consent to the disclosure of information from this form to and by the NHS body and the NHS Counter Fraud and Security Management Service for the purpose of the verification of this claim and investigation, detection and prosecution of fraud.

Authorised person's name

Authorised person's Sign

Designation

Date

Ward