

# MANU INTEGRITY SERVICES LTD

Your time sheet must be returned to Manu Integrity Services before 14:00 hrs to be included in our weekly payroll. After completing your assignment please return your signed form to: 58A, Birley Moor Road, Sheffield, S12 4WD

Email: [admin@manuintegrityservices.co.uk](mailto:admin@manuintegrityservices.co.uk)



## CANDIDATE INFORMATION

<b>CANDIDATE NAME:</b>	<b>BAND:</b>
<b>CANDIDATE SIGNATURE:</b>	<b>REFERENCE:</b>
<b>HOSPITAL NAME:</b>	<b>WARD:</b>

## TIMESHEET

	<b>Date</b>	<b>Start Time (24hrs)</b>	<b>Finish Time (24hrs)</b>	<b>Hours worked less break</b>	<b>Breaks taken</b>	<b>Authorised By:</b>
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Saturday						
Sunday						
						Weekly Totals:

<b>Authorisers First Name:</b>	<b>Surname:</b>
<b>Authorised signature:</b>	<b>Position:</b>
<b>Organisational Name:</b>	<b>Date:</b>

I am the authorised signatory for my ward/ Department /NHS body. I am signing to confirm that the job Profile Title and Band of worker and the hours/ shifts that I am authorising are accurate and I approve of the payment. 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 CFSMS in England for verification of this claim and the investigation, prevention, detection and prosecution of fraud. Any questionable timesheets will be brought to the attention of the Local Counter Fraud Specialist or reported to, in any case of fraud, to the NHS Fraud and Corruption reporting line on 0800 028 4060.

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## ASSESSMENT REPORT

CANDIDATE NAME:	DATE:
HOSPITAL NAME:	

Please assess the candidate worker on the following.

Please mark as appropriate	Poor	Satisfactory	Good	Excellent
Reliability				
Punctual				
Communication skills				
Management of work load				
Patient records and other management				
Relationships with patients and other members of the multidisciplinary team				
Clinical skills demonstrated in line with the requirements of their responsibilities				

ASSESSMENT COMPLETED BY: .....

SIGNATURE:

POSITION:

DATE:

**PLEASE PROVIDE A HOSPITAL  
STAMP, COMPLIMENT SLIP WITH  
SIGNATURE OR LETTERHEAD**

ADDITIONAL COMMENTS