ROYALE HEALTHCARE PRIVATE LIMITED

Agency Worker's Name	
Level/Grade	NURSE
Agency Worker's Address	

Client Name	
Department / Ward	
Client Address	

DAY	DATE	TIME – 24 HOURS		Worked Hours Minus Break Time	**AUTHORIZED SIGNATURE** Authorizing the specific shift. I declare that I am an authorized signatory to confirm that the shift(s) and time(s) below were worked by the named agency worker	
		FROM	TO			
Mon		:	:		Client Signature :	
Tue		:	:		Client Signature :	
Wed		:	:		Client Signature :	
Thu		:	:		Client Signature :	
Fri		:	:		Client Signature :	
Sat		:	:		Client Signature :	
Sun		:	:		Client Signature :	
			TOTAL HOURS		TOTAL HOURS IN WORDS	

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 knowingly provide false information this may result in action being taken against me which may include prosecution and/or civil recovery proceedings. I consent to the disclosure of information from this timesheet for the purpose of verification of this claim and the investigation, prevention, detection and prosecution of fraud.

Agency Worker's Signature		Print Name	