Fully completed, accurate & legible timesheets must be submitted to Care Network Ireland by 10am every Monday Morning to ensure payment in that week's payroll.

CLIENT/HOSPITAL: _____ LOCATION: _____

(Please use separate docket for each hospital)

DAY	DATE	WARD	START TIME	FINISH TIME	TOTAL HOURS	TOTAL 1st BREAK TIME (Hrs)	TOTAL 2nd BREAK TIME (Hrs)	WORKED HOURS (TOTAL HOURS – TOTAL BREAKS)	OVER TIME	HOLIDAY	AUTHORISED SIGNATURE*
Mon											
Tues											
Wed											
Thurs											
Fri											
Sat											
Sun											

**The authorised signature confirms the satisfactory of the hours as stated in this timesheet.*

I declare that the information I have given on this form is correct and complete and that I have 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 for prosecution and civil recovery proceedings. I consent to the disclosure of information from this form for the purpose of verification of this claim and the investigation, prevention, detection and prosecution of fraud. I wish to confirm that I have received all of my statutory break entitlements.

STAFF NAME (PRINT): _____ **SIGNATURE: _____**

CLIENT NAME (PRINT): _____ **SIGNATURE: _____**

Employment by the client within 12 months of completion of any of these placement will be subject to Permanent Conversion Fees as per Care Network Ireland Terms of Business.