Tel: 02037500790
Email: accounts@prime-healthcare.uk

Prime Healthcare Solutions Ltd.
147a High Street
Waltham Cross
Hertfordshire
EN8 7AP

This must be emailed to Prime Healthcare Solutions at the email address (above) by 12pm on Tuesday in order to facilitate payment. *

Hospital/Home:	
Address:	
Ward:	

Workers Full Name (Capitals)	

***All boxes on the below must be completed to ensure payment of shift - please follow format of the example given.**
If a mistake is made, please complete a new timesheet. Do not cross out entries.

	DAY	DATE	START TIME (24HH:MM)	FINISH TIME (24HH:MM)	NUMBER OF HOURS	BREAK (HH:MM)	HOURS WORKED	GRADE (HCA/RMN)
Example	*Monday*	*01/12/2025*	*09:30*	*19:30*	*10*	*01:00*	*9*	*HCA*
Actual Shift								

Approved Signatory

I agree to the above named person(s) worked hours shown above and by signing the timesheet we agree to pay your account in accordance with your terms of business. I understand that a further copy of your terms of business is available on request.

I am an authorised signatory for this Customer. I am signing below to con oth the pay point and the hours/days that I am authorising are accurate and I approve payment. I understand that if I knowingly authorise 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 Customer and the NHS Counter Fraud and Security Management Service for the purpose of veri cation of this claim and the investigation, detection and prosecution of fraud.

Before Signing - Ensure all the boxes above are completed. Failure to do so may result in delayed payment

Signed _____ Print Name _____ Date _____

Candidate Working

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/days 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 the civil recovery proceedings. I consent to the disclosure of information from this form to and by the Customer and the NHS Counter Fraud and Security Management Service for the purpose of tion of this claim and the investigation, prevention, detection and prosecution of fraud

Before Signing - Ensure all the boxes above are completed. Failure to do so may result in delayed payment

Signed _____ Print Name _____ Date _____