Healthcare Staffing Associates
Where Knowledge & Excellence Meet

Medical Timesheet

Send completed timesheets via:
Fax: 1(866) 480-9591
Email: StaffDoctor@gmail.com
www.MedicalDirectorStaff.com

Doctor's Name: ________________________________ Mobile Num: _______________

Week commencing Monday: ___ / ___ / ___ to: Sunday ___ / ___ / ___

Client / Clinic Name: ______________________________________

Location / Address: ____

Grade: ____

		Normal Hours			On-Site On Call			Off-Site On Call		
Day of the Week	Date	Start Time	End Time	Total Hours	Start Time	End Time	Total Hours	Start Time	End Time	Total Hours
EG:	D/M/Y	9am	5pm	8	5pm	8pm	3	8pm	9am	13
Monday										
Tuesday										
Wednesday										
Thursday										
Friday										
Saturday										
Sunday										
			Total Hours:							

Declarations:

Applicant Declaration (only to be signed if used for the purpose of an individual employee timesheet)

"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 relevant clients of Healthcare Staffing Associtės, Inc for the purpose of verification of this claim and the investigation, prevention, detection and prosecution of fraud. By submitting this timesheet I am agreeing to the terms and conditions of employment as outlined in the terms of engagement for the temporary worker."

Signature: ___________________________________

Authorised Signatory

"I am an authorised signatory for my ward/department/unit. I am signing to confirm that the above particulars that I am authorising are accurate and I approve same for payment. and billing purposes by Healthcare Staffing Associates to this organization. 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 relevant clients of Healthcare Staffing Associates, Inc for the purpose of verification of this claim and the investigation, prevention, detection and prosecution of fraud."

Signature: ____________________________ **Print Name:** _______________________ **Date:** __________