ALLHANDS CARE LTD

Timesheet (Please complete all fields)

Name of Temp: _____ **Week of Starting** _____

Client: _____

Client Address/Name of Hospital: _____

_____

DATE		Time Started	Time Finished	Total (hrs worked)	Client Signature	Temp Signature
	Mon					
	Tues					
	Weds					
	Thurs					
	Fri					
	Sat					
	Sun					
	Total Hours					

IMPORTANT NOTICE: TimeSheets received after 12no0n Saturday will not be included in the payroll that week. If the timesheets are not completed in full, they will not be processed. please make sure all alterations are countersigned. Please make sure al the week ending date and Client name are clearly printed. Scan and email to info@allhandscare.com any queries call: 07446019931 / 07532 748850

I confirm that the total hours worked are correct and agree to pay your account in accordance with Allhands Care Agency temporary and permanent staff terms which I have agreed with and also understand are available to me anytime at www allhandscare.com As the information on this timesheet is the sole basis for calculating your charge to me.

Client's signature _____

Position in company _____ Date ____ /____ /_____

_____

I confirm that the total hours worked are correct
Temporary worker's signature _____ Date _____

_____

We must have this timesheet back in the office by midday on a Monday for the previous week. Thank you.