**Doctors Name: Grade/Speciality:**

**Hospital: Week ending:­­­­­­­­­­­­­­­­­­**

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| --- | --- | --- | --- |
| **Shift** **Day**  | **Shift Date**  | **Standard Shift Start Time**  | **Standard Shift End Time**  |
| Mon  |   |   |    |
| Tue  |   |    |   |
| Wed   |   |   |   |
| Thurs   |   |   |   |
| Fri   |   |   |   |
| Sat   |   |   |   |
| Sun   |   |   |   |

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| --- |
| **For Completion by the Authorised Trust/Hospital/Client Signatory**  |
| I am an authorised signatory for my department/ward/HSE body. I am signing to confirm that both the grade of the Agency Worker and the hours/shift that I am authorising are accurate and I approve payment. 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 the HSE body for the purpose of verification of this claim and the investigation, prevention, detection and prosecution of fraud.  |
| **Authorised Name (Print)**  | **Authorised Position**  | **Authorised Signature**  | **Date**  |