



WANA HEALTHCARE SERVICES

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TIMESHEET

PLEASE COMPLETE TIME SHEET AND RETURN TO THE OFFICE BY MONDAY 12:00 NOON			
STAFF NAME:			
JOB TITLE:	BUSINESS LOCATION:	BAND:	ID NUMBER
CLIENT’S COMPANY NAME:			
LOCATION’S ADDRESS:			

Note to candidate: Please can you ensure that you ask the authorising signatory to complete the shift appraisal. Please circle as applicable: A = Excellent B = Good C = Satisfactory D= Unsatisfactory

DAY	DATE	START	BREAK	END	TOTAL HOURS (excl breaks)	Shift Reference	Client Shift Appraisal	Daily Authorised Client Initials
MONDAY							A B C D	
TUESDAY							A B C D	
WEDNESDAY							A B C D	
THURSDAY							A B C D	
FRIDAY							A B C D	
SATURDAY							A B C D	
SUNDAY							A B C D	
WEEK END								
Total Hours for the week excluding breaks								

Week End date is usually a Sunday
Please ensure you complete all fields on the timesheet correctly otherwise your timesheet will be rejected and may delay your payment. If you work on more than one location please print additional copies of your timesheet. You can also obtain copies from our website www.whcas.co.uk. Your timesheet must be submitted within 1 week of the shift date.

I CONFIRM THAT THE ABOVE HOURS HAVE BEEN SUCCESSFULLY WORKED BY THE STAFF NAMED ABOVE. I AM THE AUTHOURISED MEMBER OF THE ORGANISATION FOR WHICH I AM COMFIRMING THE ABOVE HOURS. THE HOURS WORKED AND EXPENSES WILL BE PAID IN ACCORDANCE WITH OUR TERMS OF BUSINESS.

PRINT NAME: _____SIGN: _____

DATE: ____/____/____

COMMENT: _____