**HUMBER TEACHING NHS FOUNDATION TRUST**

CLAIM FORM FOR EXCESS & ENHANCEABLE HOURS (NON-NURSING)

# NAME ASSIGNMENT NUMBER CONTRACT HOURS PER WEEK

|  |  |
| --- | --- |
| BASE/DEPARTMENT | MONTH ENDING |
| DATE | DAY | TIMES WORKED | **COLUMN A**TOTAL HOURS WORKED IN  EXCESS OF NORMAL WEEK | **COLUMN B**SAT/SUN/BANK HOL WORKED AS NORMAL HOURS |  |
|  |  | FROM | TO |
| 1 |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |
| 6 |  |  |  |  |  |  |
| 7 |  |  |  |  |  |  |
| 8 |  |  |  |  |  |  |
| 9 |  |  |  |  |  |  |
| 10 |  |  |  |  |  |  |
| 11 |  |  |  |  |  |  |
| 12 |  |  |  |  |  |  |
| 13 |  |  |  |  |  |  |
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| 20 |  |  |  |  |  |  |
| 21 |  |  |  |  |  |  |
| 22 |  |  |  |  |  |  |
| 23 |  |  |  |  |  |  |
| 24 |  |  |  |  |  |  |
| 25 |  |  |  |  |  |  |
| 26 |  |  |  |  |  |  |
| 27 |  |  |  |  |  |  |
| 28 |  |  |  |  |  |  |
| 29 |  |  |  |  |  |  |
| 30 |  |  |  |  |  |  |
| 31 |  |  |  |  |  |  |
| **TOTALS** |  |  |  |  |  |  |

For employees: 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 for prosecution and civil recovery proceedings. I consent to the disclosure of information from this form to and by the Trust and the NHS Counter Fraud Authority (NHSCFA) for the purpose of verification of this claim and the investigation, prevention, detection and prosecution of fraud.

For managers: I declare that I am an authorised signatory for my ward/department. I am signing below to confirm that both the grade and the shift 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 Trust and the NHS Counter Fraud Authority (NHSCFA) for the purpose of verification of this claim and the investigation, prevention, detection and prosecution of fraud.

SIGNATURE OF EMPLOYEE:

……………………………………………………………………

DATE: ………………………………………………………….

CERTIFIED FOR PAYMENT …………………………………………………………….

PLEASE PRINT NAME …………………………………………………………………...

DATE: ………………………………………………………………………………………