

Timesheet

PLEASE COMPLETE ALL SECTIONS IN BLOCK CAPITALS. Failure to correctly complete the timesheet accurately and clearly could delay payment. Timesheets must be received by **10AM on Monday.**

Email your completed timesheet in PDF format to: payroll@lustrohealth.com

STAFF NAME		CLIENT NAME	
JOB TITLE		CLIENT ADDRESS	

	DATE	START TIME	FINISH TIME	BREAK	TOTAL PAID HRS	EXPENSES	BOOKING REF.	STAFF SIGNATURE	CLIENT SIGNATURE
MONDAY									
TUESDAY									
WEDNESDAY									
THURSDAY									
FRIDAY									
SATURDAY									
SUNDAY									
				TOTAL HRS					

	Lustro Health Worker Feedback (this section is to be completed by the Client/service)			
	I am an authorized signatory for my service/client. I am signing to confirm that both the grade of the Lustro Health staff and hours /shift that I am authorizing are accurate and 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 proceeding			
	Excellent	Good	Satisfactory	Unsatisfactory
Overall Performance				
Overall Conduct/Behaviour				
Timekeeping/ Reliability				
	Name:			
	Position:			
	Signature:			
	Date:			

LUSTRO HEALTH STAFF	
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 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 proceedings. By signing this declaration, I agree to the following: a) I am fit to work. b) I have read and agreed to the Terms of Engagement and handbook supplied to me by Lustro Health. c) I have received orientation and induction by the client for this booking.	
	Name: _____ Band/Grade: _____ Signature: _____ Date: _____

A copy of this timesheet should be left with client.