

OFFICE USE ONLY:



ABN: 32 730 624 537

CARECHOICE TIMESHEET

CASUAL EMPLOYEE NAME

Name: _____

Address: _____

_____ P/Code: _____

CLIENT NAME

Company/Client: _____

Address: _____

_____ P/Code: _____

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WEEK 1	DATE	START TIME	FINISH TIME	BREAK	TOTAL HOURS	SLEEPOVER: HACC OR RESI	KMS	Authority Signature
Mon								
Tue								
Wed								
Thu								
Fri								
Sat								
Sun								
WEEK 2	DATE	START TIME	FINISH TIME	BREAK	TOTAL HOURS	SLEEPOVER: HACC OR RESI	KMS	Authority Signature
Mon								
Tue								
Wed								
Thu								
Fri								
Sat								
Sun								

CARECHOICE (AUST) PTY LTD EMPLOYEE ASSIGNMENT

I have worked the above hours and no injuries were sustained. I am aware that my hourly rate includes a loading for holiday and sick pay, and that I am only paid for actual hours worked. I also adhere to the policies and procedures as directed by CareChoice. I hereby acknowledge that if I do not submit timesheets within 3 months of the booked date of service, I will not receive payment.

CARECHOICE EMPLOYEE SIGNATURE: _____

NOTE: The timesheet must be signed by the client and yourself before payment may be made.

CLIENT AUTHORISATION

Please sign this form to confirm that the hours listed are correct and the work has been performed in a satisfactory manner. We / I have read and agree to the terms and conditions herein.

I acknowledge that the Temporary staff member on this timesheet is a valued employee of CareChoice and that in an event of the employee being offered a temporary, permanent, part time or casual position in this company / department, within a 12 month period of the last day of the temporary assignment with us, we are liable to pay a negotiated placement fee.

CLIENT NAME: _____ **CLIENT SIGNATURE:** _____

POSITION: _____

All timesheets MUST be submitted by 5:30pm Monday of pay week. Timesheets that are sent in late will not be paid in the corresponding pay cycle.

Send timesheets either via scan/e-mail: timesheets@carechoice.net.au or fax to 1300 737 943.

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