

Employee Name: _____ Designation: _____



GAIA
HEALTHCARE

Employee Number: _____ Week Ending: _____

Client	Dept / Ward	Date of Shift	Day	Start Time	Finish Time	Break Taken	Total Hours Worked	Mileage (if applicable)	Ward Managers or Team Leaders Name	Signature
			Mon							
			Tues							
			Wed							
			Thurs							
			Fri							
			Sat							
			Sun							

Please ensure your timesheet is accurately and completely filled out and signed by an authorised client representative.

All timesheets must be received by Gaia Healthcare no later than 10:00AM MONDAY. A separate timesheet is required for each client / ward.

Email timesheets to : timesheets@gaiiahealthcare.co.nz Website: www.gaiiahealthcare.co.nz PH: 03 599 9062

Notes:

Staff Declaration: (NB Fraudulent recording is a criminal offence and may lead to legal action being taken against you).

1. I declare that all above details are correct and accurate
2. I declare that I have advised Gaia Healthcare of my total hours worked in this pay period with all employers
3. I acknowledge all responsibilities undertaken by me as per the Gaia Healthcare Handbook.

Client Declaration:

1. I confirm that the above details are correct and the employee has completed these hours satisfactorily
2. I agree to all Terms of Business as per signed contract including payment for the above hours.

Signature: _____ Date: _____

Signature: _____ Date: _____