



Fixed Hours Time Sheet

STAFF NAME: _____ PAY NUMBER: _____

WEEKLY PERIOD COVERING MONDAY ____/____/200__ TO SUNDAY ____/____/200__

CLIENT NAME: _____

Staff Skill Level

Highest Client Care Level

Relief

Day	Date	Actual Time In	Actual Time Out	Actual Hrs Worked	Client Signature	Allocated Hrs <small>(by service co-ordinator)</small>	
Monday							
Tuesday							
Wednesday							
Thursday							
Friday							
Saturday							
Sunday							
TOTAL Hours Worked				<input type="text"/>	TOTAL Allocated Hours		<input type="text"/>

Staff Signature: _____

PAY OFFICE ONLY

Statutory Holiday Sick Pay Holiday / Lieu Pay

Home Management

Kitchen

Clean all surfaces	<input type="checkbox"/>
Wash dishes	<input type="checkbox"/>
Clean fridge	<input type="checkbox"/>
Clean oven	<input type="checkbox"/>
Wash floor	<input type="checkbox"/>
Clean inside cupboards	<input type="checkbox"/>

Bathroom

Clean Bath/Shower	<input type="checkbox"/>
Clean hand basin	<input type="checkbox"/>
Clean toilet	<input type="checkbox"/>
Wash floor	<input type="checkbox"/>

Lounge/Dining Room

Dust	<input type="checkbox"/>
Vacuum	<input type="checkbox"/>

Bedrooms

Dust	<input type="checkbox"/>
Vacuum	<input type="checkbox"/>
Make bed	<input type="checkbox"/>
Change bed linen	<input type="checkbox"/>

Laundry

Washing	<input type="checkbox"/>
Hanging out clothes	<input type="checkbox"/>
Drying	<input type="checkbox"/>
Ironing	<input type="checkbox"/>

Meal Preparation

Prepare meals	<input type="checkbox"/>
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Other

Clean interior windows	<input type="checkbox"/>
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Personal Cares

Showering	<input type="checkbox"/>
Put to Bed	<input type="checkbox"/>
Dressing	<input type="checkbox"/>
Skin care	<input type="checkbox"/>
Toileting	<input type="checkbox"/>
Suppositories	<input type="checkbox"/>
Transferring	<input type="checkbox"/>
Colostomy cares	<input type="checkbox"/>
Catheter cares	<input type="checkbox"/>
TED stockings	<input type="checkbox"/>
Cultural cares	<input type="checkbox"/>
Dementia cares	<input type="checkbox"/>

Money given for shopping \$ _____

Service user signature: _____

Support worker signature: _____

Receipt and change given and correct **YES / NO**

Signature of service user: _____
(Confirming receipt and correct change given)

Times Sheet Audited

Date _____ **by** _____

Client Notes: _____

