

Location of shift
(Delete as applicable)
Scarborough York

For Rota Co-Ordination
Team use:

**MEDICAL AND DENTAL STAFF
BANK LOCUM CLAIM FOR PAYMENT ON A LOCUM BASIS**

To Claimant

The purpose of this form is to allow hospital medical and dental staff to claim payments for duty performed on a locum basis with their own employing authority for which prospective agreement was not obtainable in time.

Please note it is advisable to retain a photocopy of this form for your records

PERSONAL DETAILS

Assignment Number	Email address:
Surname	Forename
Address	
Grade	Specialty
Type of pay (please highlight as appropriate)	Weekly / Monthly

CLAIM FOR PAYMENTS

Date	Time		No. of Hours	WTD	Pay Rate	Total Rate	Total Amount Claimed	Name of colleague covered and reason for duty	Specialty Covered	Cost Centre
	From	To		Rota team to complete	Rota team to complete	£	£			£
Total										

Rota Team:
Variation to contract form is required and has been completed: Yes / No
Pay through secondary contract: Yes / No

I have performed the above duties outside my regular contractual commitment. (Sign to confirm hours)

Signature of Claimant Date

Signature of Rota Co-Ordinator/Consultant Date
(Please delete as appropriate)

When completed this form needs to be sent to your Directorate/Divisional Manager for authorisation below:

To be completed by the Divisional/Directorate Manager

I agree to the locum terms that are determined above. Please pay the above named doctor the locum claim as detailed on this form.
Please charge tolocum budget

Signature:Directorate/Divisional Manager

Name of Directorate Manager/Budget Holder Date:.....

THIS FORM MUST BE RETURNED TO THE ROTA CO-ORDINATION TEAM