

In Home Care & Assistance

Weekly/Daily Timesheet and Client Card

Timesheets must be received by Monday each week no later than 11am.

Please email timesheets to: info@bpna.com.au or Fax: (02) 9588 – 2827. Each employee must sign the timesheet. Retrieve timesheet from www.bpna.com.au under 'Education and Forms'

EMPLOYEE NAME: _____ RN EEN EN AIN **Client Name:** _____

NOTE: Kilometres are paid from client to client only as per ATO

DAY	DATE	START TIME	FINISH TIME	KM's	BREAK TIME	TOTAL HOURS	CLIENT SIGNATURE (ALL SERVICES MUST HAVE A CLIENT SIGNATURE)	NOTES
MONDAY								
TUESDAY								
WEDNESDAY								
THURSDAY								
FRIDAY								
SATURDAY								
SUNDAY								

CLIENT REQUIREMENTS (✓) what applies to service

PERSONAL CARE	LIGHT HOUSEKEEPING	LAUNDRY	MEAL PREPARATION	PET CARE	TRANSPORT	POST HOSP.CARE	OTHER SERVICES
<input type="checkbox"/> Bathing/Showering <input type="checkbox"/> Drying/Dressing <input type="checkbox"/> Hairdressing <input type="checkbox"/> Makeup <input type="checkbox"/> Shaving <input type="checkbox"/> Nail Care <input type="checkbox"/> Toilet <input type="checkbox"/> Incontinence Care	<input type="checkbox"/> Vacuum <input type="checkbox"/> Damp Mop <input type="checkbox"/> Change Bedding <input type="checkbox"/> General Tidying <input type="checkbox"/> Dusting <input type="checkbox"/> Clean Kitchen <input type="checkbox"/> Clean Bathroom <input type="checkbox"/> Clean/Tidy Bedroom	<input type="checkbox"/> Wash <input type="checkbox"/> Dry <input type="checkbox"/> Iron <input type="checkbox"/> Fold <input type="checkbox"/> Put Away	<input type="checkbox"/> Meal Planning <input type="checkbox"/> Preparation <input type="checkbox"/> Cooking <input type="checkbox"/> Serving <input type="checkbox"/> Wash Dishes <input type="checkbox"/> Pre-cooked Meals <input type="checkbox"/> Assistance feeding	<input type="checkbox"/> Wash <input type="checkbox"/> Walk <input type="checkbox"/> Clean up after <input type="checkbox"/> Feed	<input type="checkbox"/> Shopping <input type="checkbox"/> Appointments <input type="checkbox"/> Outing Services <input type="checkbox"/> Visit Friends <input type="checkbox"/> Social Activities <input type="checkbox"/> Escort to Doctor <input type="checkbox"/> Escort to Hospital	<input type="checkbox"/> Wound care <input type="checkbox"/> Medication <input type="checkbox"/> Eye Drops <input type="checkbox"/> Injections <input type="checkbox"/> Other:	<input type="checkbox"/> Light exercises <input type="checkbox"/> Aid with reading <input type="checkbox"/> Companionship <input type="checkbox"/> Mental Stimulation <input type="checkbox"/> Medication reminder <input type="checkbox"/> Wound Care

I certify that the above hours shown here, accurately represent the hours I worked during this pay period

Employee Signature

____/____/____
Date

OFFICE USE ONLY: PAY PERIOD: ____/____/____ to ____/____/____ Paid Back Pay Other

Payroll Signature: _____ Date: ____/____/____