CANDIDATE FULL NAME: _____

NAME OF SCHOOL: _____

WEEK ENDING DATE: _____

	FULL DAY	HALF DAY (Please state AM or PM)
MONDAY		
TUESDAY		
WEDNESDAY		
THURSDAY		
FRIDAY		
TOTAL		

I confirm that the information provided on this timesheet is true and accurate. I understand that it is an offence to make any false declarations regarding the stated hours/days worked.

TEACHERS NAME: _____

SIGNATURE: _____

I certify that the above named person has completed the total hours/days stated. I accept your charges and agree to pay New Vision Education Limited in accordance with their Terms and Conditions of Business.

SCHOOL NAME: _____ **CONTACT NAME:** _____

DATE: _____ **SIGNATURE:** _____

Please return timesheets via fax 01443 307535 or scan and email to:

info@newvisioneducation.co.uk