

**Employer's and Medical Practitioner's Report
Maternity Benefit / Maternity Leave Benefit**

Applicant's Details

Identity Card Number: * _____

Name: * _____

Surname: * _____

To be filled by the Employer of Applicant

The person applying for the Maternity Benefit WILL AVAIL OF WILL NOT AVAIL OF maternity leave.

If Yes, the maternity leave started on (DD/MM/YYYY) __/__/____, ended on (DD/MM/YYYY) __/__/____, will return/returned to work on (DD/MM/YYYY) __/__/____.

Employer / Company's Details

Name: * _____

Address: * _____

Contact Number: * _____

Email: _____

Employer's Signature

Date

To be filled by a Self-Occupied Applicant

The maternity leave started on (DD/MM/YYYY) __/__/____, ended on (DD/MM/YYYY) __/__/____, will return/returned to work on (DD/MM/YYYY) __/__/____.

Employment Details

Business Name: * _____

Address: * _____

Contact Number: * _____

Email: _____

Signature

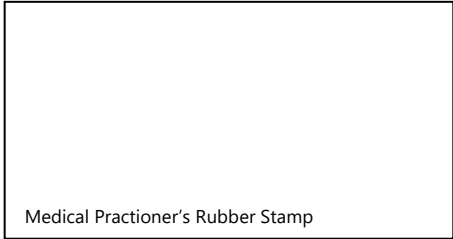
Date

Medical Practitioner's Certificate (To be filled in case the baby has not yet been born)

For the purpose of the Social Security Act, I certify that the person whose details appear above is pregnant and has entered the eighth (8) month of her pregnancy.

The applicant is expected to give birth approximately

on (DD/MM/YYYY) _ _ / _ _ / _ _ _ _ *



Medical Practitioner's Name and Surname

Medical Council Number

Medical Practitioner's Signature

Date