Employer's and Medical Practioner'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 Practioner'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.

Medical Practioner's Rubber Stamp

The applicant is expected to give birth approximately

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

_____ _____

Medical Practioner's Name and Surname Medical Council Number

_____ _____

Medical Practioner's Signature Date