Maternity / Adoption Benefit
Maternity / Adoption Leave Benefit
Employer and Medical Report

Applicant's Details

Identity Card Number: * _____

Name: * _____ Surname: * _____

Applicant's Employment Details (To be filled by the Employer)

The person who is applying for the Maternity Benefit is self-occupied? ☐ Yes ☐ No

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

If Yes, the maternity leave started on (DD/MM/YYYY) _ _ / _ _ / _ _ _ _ and ended on (DD/MM/YYY) _ _ / _ _ / _ _ _ _ ,

will return / returned to work on (DD/MM/YYYY) _ _ / _ _ / _ _ _ _ .

I declare that the above information is correct.

Employer / Company's Details

Name: * _____

Address: * _____

_____

Contact Number: * _____

Email: _____

Employer's Rubber Stamp

_____ _____

Employer's Signature Date

Doctor's Certificate (To be filled in case the child is 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 eight (8) month of her pregnancy.

The applicant is expected to give birth approximately

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

Doctor's Rubber Stamp

_____ _____

Doctor's Name and Surname Medical Council Number

_____ _____

Signature Date