NATIONAL INSURANCE AND SOCIAL SECURITY ACT CHAPTER 36:01

(In according with the national and Social Security (Medical Certification) Regulations No. 36 of 1969)

MEDICAL CERTIFICATE – POST CONFINEMENT

I, ……………………………………………………………………………………………………

A duly qualified registered medical practitioner, hereby certify that

* Miss/Mrs. ………………………………………………………………………………………..
(Name)

of ………………………………………………………………………………………………...
(Address)

was examined by me on ………………………………………………………………………

at ……………………………………….. for the *first/second …………………………………...

time and in my opinion she was at the time of examination suffering from ………………………

……………………………………………………………………… Which has resulted from her *pregnancy/confinement.

As a result she –

(a) will be fit to resume work *today/tomorrow/on …………………………………...
…………………………………. or

(b) Will remain incapable of work for a period of ……………………………… days.

Any other remarks by doctor: ……………………………………………………………...

……………………………………………………………………………………………………

……………………………………………………………………………………………………

……………………………………………………………………………………………………

……………………………………………. ……………………………………………….

Date Doctor's Signature

Address: ………………………………….

……………………………………………

* Delete where inapplicable

** The date indicated must not be more that seven days (Public Holidays, including Sundays included) after the date of examination.

* The period entered must not exceed 14 days (Public Holidays, including Sundays included) in the case of a first or second certificate or 28 days for a third or subsequent certificate.

CLAIM FOR EXTENDED MATERNITY ALLOWANCE

I, the undersigned hereby apply for extended maternity allowance under the National Insurance and Social Security (Amendment) Act, 1986, and furnish a medical certificate at back hereof and the following particulars: -

1. My full name is (in BLOCK LETTERS) ……………………………………………………...
2. My address is ……………………………………………………………………………..
3. My National Insurance Number is ………………………………………………………
4. My employer is ……………………………………………………………………………..
5. My occupation is/was ……………………………………………………………………
6. I last worked there on ……………………………………………………………………...
7. I was confined on ……………………………………………………………….……...

I declare that the information given above is true and correct to the best of my knowledge and belief.

Date: ……………………………………… ………………………………………………
Signature or Mark of Claimant

Note: Where the claimant cannot sign her name she should make her mark and have it witnessed by a responsible person (Doctor, Lawyer, Teacher, Justice of Peace etc.) who should complete the dotted lines below.

Signature of Witness or mark: ……………………………………………………..

Profession or occupation: ………………………………………………………

Address: …………………………………………………………………………

Date: …………………………………….