

MATERNITY LEAVE FORM

To Be Completed in Triplicate (one for applicant, Central Registry personnel file and the other for departmental file). Attach Discharge form from a recognised health facility).

SECTION ONE (To be filled by applicant)

Name of applicant:

Position held:

Department/Unit:

Date of assumption of duties on first appointment:.....

Date of return from last maternity leave:

Present Maternity leave entitlement:.....

Maternity leave currently required:.....days. From:..... To:.....

Address while on Leave:.....

Signature of applicant:..... Date

SECTION TWO (To be filled by the Head of Department)

Leave due from: To:

Leave odd days/leave taken off:.....days

I certify that the applicant is entitled to maternity leave applied for and recommend that leave be granted.

Signature: Date:

SECTION THREE (To be completed by the Director Human Resource)

Leave approved/ not approved as recommended above.

The leave is taken up to:.....

Signature:..... Date:.....