



# MONTERRAT Social Security Act, 1985 MEDICAL CERTIFICATE OF CONFINEMENT

**Note: To be completed by a Medical Practitioner or Registered Midwife.**

Social Security Reg. No. 

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CL No. 

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NIMS No. 

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To : Director  
Social Security

Mrs.....  
Miss *Full Name*

I certify that I attended the above named person at her confinement involving the  
birth of one child or

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children which took place at .....

*Place*

on 

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*dd mm yy*

*Please print* .....  
*Name of Medical Practitioner or Midwife*

*Signature* .....  
*Medical Practitioner or Midwife*

*Registered number of Midwife*.....

*Date certificate given*

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*dd mm yy*

*Doctor's stamp  
and  
Registration No.*

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**To: Please submit this certificate within four (4) weeks of date of confinement. Payment of Maternity Allowance will be discontinued after confinement if this certificate is not received at the Social Security Office by the prescribed time.**