Form MC_4

MONTSERRAT
Social Security Act, 1985
MEDICAL CERTIFICATE OF CONFINEMENT

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

Social Security Reg. No. [| | | | |]

CL No. [ ]

NIMS No. [ ]

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 [ ] children which took place at ....
Place

on [| | | | |]
dd mm yy

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

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

Registered number of Midwife...

Date certificate given [| | | | |]
dd mm yy

Doctor's stamp and Registration No. [ ]

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

Social Security Reg. No. [| | | | |]

CL No. [ ]

NIMS No. [ ]

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 [ ] children which took place at ....
Place

on [| | | | |]
dd mm yy

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

Signature ....
Medical Practitioner or Midwife

Registered number of Midwife...

Date certificate given [| | | | |]
dd mm yy

Doctor's stamp and Registration No. [ ]

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.