|  |  |
| --- | --- |
| **Please tick one:** | **(Clinical Staff / Non-clinical staff)** |
| **Name of Applicant** |  |
| **Father’s name** |  |
| **Designation** |  |
| **Employee status**  *(select one option)* | **Civil / Institutional / Contractual / Daily Wager** |
| **Date of Maternity Leave applied** |  |
| **In reference (first/second/or third) maternity** |  |
| **Duty cover by if any (his/her name & sign)** |  |
| **Department /section/unit** |  |
| **Signature of applicant** |  |
| **(MR No. /Biometric ID)** |  |

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| **DOCTOR / CONSULTANT**  (*Name , Designation, Signature & Stamp)*  ***Note:*** *Leave must be advised by Senior Registrar or Assistant Professor & Above*  **Attached Original OPD Slip & Ultra Sound Report** |  |
| **Yes\_\_\_\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

|  |  |
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| **Remarks of Controlling Officer** |  |
| **HOD Name & Designation** |  |
| **Signature & Stamp** |  |

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| **Hospital Director Remarks & Signature**  *(Sanctioning Authority)* |  |