

Medical Certificate for Maternity Benefit

D746365C

Social Welfare Services

MB 3

Data Classification R



If you are **self-employed** or **not currently employed**, your doctor must complete this form **after your 24th week of pregnancy**.

I certify that I have examined

PPSN of applicant:

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Name of applicant:

**and that in my opinion
she may expect to give
birth on:**

D	D	M	M	Y	Y	Y	Y		

Date of examination:

D	D	M	M	Y	Y	Y	Y		

Doctor's name:

DSP panel number:

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IMC number:

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Address:

County

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Postcode

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**Doctor's telephone
number:**

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Doctor's email address:

Doctor's Signature (not block letters)

Doctor's official stamp

If you make any alterations after you complete the form, you must initial and date them otherwise the information supplied cannot be accepted.

