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| **How to complete this form:*** Section A to be completed by all applicants
* Sections B/C/D – chose one section that applies to you
* Section E to be completed by your manager
* Forward this form and include your original MATB1 form/Adoption Certificate to the HR Support and Advice Unit to HRSAU, Level 2, West Glasgow ACH, Yorkhill Campus.
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| **Section A – Personal Details** |
| Forename |  |
| Surname |  |
| Pay Number |  |
| Current Post |  |
| Department/Location |  |
| Home Address |  |
| Email Address |  |
| Preferred method for confirmation of maternity leave | Email [ ]  Post [ ]   |
| Contracted Hours |  |
| Is your employment permanent, temporary, fixed term or for training purposes? |  |
| If Fixed Term/Training Contract, date of expiry |  |
| Date of commencement with NHS GG&C |  |
| Date of commencement with NHS (if different) |  |
| Have you been on maternity/adoption leave in the last 12 months? Y/N |  |
| Expected date of childbirth/adoption |  |
| First day of commencement of maternity leave/adoption leave (excluding annual leave) |  |

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| **Section B – complete if you intend to return to work after maternity/adoption leave** |
| *Please confirm how many weeks maternity/adoption leave you wish to take by ticking on of the boxes below* |
| 1. 39 weeks maternity/adoption leave OR
 |  |
| 1. 52 weeks maternity/adoption leave
 |  |
| Would you like your occupational maternity/adoption pay to be calculated in equal weekly payments? | Yes/No(Please circle) |
| *If you circled yes, please indicate the portion of your maternity/adoption leave you wish to receive equal payments for:*  |
| 26 weeks |  |
| 39 weeks |  |
| 52 weeks |  |

\*PLEASE NOTE during any period of unpaid maternity/adoption leave, you must maintain payment to your NHS pension scheme if applicable.

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| **Section C – complete if you are undecided whether you intend to return to work** (please tick to show agreement) |
| I am aware that my application for maternity/adoption leave will be considered in accordance with the maternity/adoption guidelines which I have read and understood. I elect to remain undecided regarding my return to work after my maternity/adoption leave. |  |
| If I should decide to return to work for an NHS Employing Authority, it will be for a minimum period of 3 months. I will advise my manager no less than 8 weeks before the date I would like to return. |  |
| I understand that if I subsequently do not abide by the agreed conditions, I am liable to repay the maternity/adoption pay as set out in conditions of service. |  |

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| **Section D – complete if you do not intend to return to work** |
| I wish to terminate my employment with NHS Greater Glasgow and Clyde (please tick to show agreement) |  |
| My last working day will be (please note in the box) |  |

**Please sign below to confirm that you have read and understood the guidelines relating to maternity or adoption leave and pay and that you understand that if you do not return to work for a period of at least three months you will be required to repay any occupational pay received.**

**Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **Section E – to be completed by the line manager** |
| *I am aware that the applicant detailed in this form (please tick the most relevant)* |
| 1.Does not intend to return to work following their maternity/adoption leave |  |
| 2a. Intends to return to work following their maternity/adoption leave no later than 52 weeks from the commencement of her period of maternity/adoption leave |  |
| 2b. Intends to return to work following their maternity/adoption leave no later than 39 weeks from the commencement of her period of maternity/adoption leave |  |
| 2c. Intends to return to work following their maternity/adoption no later than 26 weeks from the commencement of her period of maternity/adoption leave |  |
| 3. Is undecided about whether they intend to return to work |  |
| 4.Annual leave accrued before maternity/adoption leave commencement |  |
| **\*Please note for Medical Staff only \* All annual leave accrued prior to and during maternity/adoption leave must be taken in advance of the next rotation.** |

**I acknowledge receipt of this application form and confirm that the information contained in this form is accurate.**

**Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Designation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*If you are not responsible for completion of Notification of Change form (to inform Payroll) when employee returns from maternity/adoption leave, please give details of person to contact below:*

*Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Designation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Telephone No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

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| **Section F – to be completed by HR Department** |
| *To Payroll Department* |
| **Qualifying Week for SMP:** |  |
| **Occupational Entitlement** (*please tick*): |
| 1. The applicant intends to terminate employment on ………………………… (***enter date***) The applicant is/is not entitled to Statutory Maternity/Adoption Pay.
 |  |
| 1. The applicant intends to return to work following her childbirth and is entitled to maternity/adoption leave as detailed in the enclosed copy letter to her.
 |  |
| 1. The applicant intends to take up the Third Option and is entitled to maternity/adoption leave as detailed in the enclosed copy letter.
 |  |

Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Designation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Section G – to be completed by the Payroll Department where SMP earnings criteria not met** |
| **Name of Applicant:** |  |
| **Post:** |  |
| **Staff Pay Number:** |  |
| **Qualifying Week for SMP/SAP:** |  |
| *If average earnings for Statutory Maternity/Adoption Pay purposes are below the Lower Earnings Limit for National Insurance contributions the Payroll Department must return MATB1/Adoption Certificate and Form SMP/SAP1 to the employee, notifying the relevant HR Department of action taken by electronic mail.*  |

Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Designation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_