

MEDICAL CERTIFICATION FOR MATERNITY LEAVE (MULTIPLE BIRTH)

Date: [Date]

To: [Employer Name/Human Resources Department]

Company: [Company Name]

Address: [Company Address]

Patient Name: [Employee Full Name]

Date of Birth: [Employee Date of Birth]

To whom it may concern,

I am the attending healthcare provider for [Employee Name]. This letter serves to officially certify the patient's pregnancy and the requirement for maternity leave due to a multiple birth pregnancy.

Clinical Details:

- **Expected Date of Delivery:** [Date]
- **Number of Fetuses:** [Number, e.g., Twins/Triplets]
- **Pregnancy Status:** Multiple Gestation

Recommended Leave Period:

Due to the increased physical demands and medical considerations associated with a multiple pregnancy, I recommend the patient commence maternity leave on [Start Date].

The estimated duration of the postpartum recovery period is [Number] weeks, with an anticipated return to work date of [Return Date], subject to postnatal evaluation.

If you require any further medical documentation or clarification, please contact my office directly.

Sincerely,

Signature: _____

Provider Name: [Physician Name]

Medical License Number: [License #]

Clinic/Hospital Name: [Facility Name]

Phone Number: [Phone Number]