UNIVERSITY OF MEDICAL SCIENCES (UNIMED)
LAJE ROAD, ONDO CITY, ONDO STATE.

OFFICE OF THE REGISTRAR

RESUMPTION FROM MATERNITY LEAVE FORM

Leave Year ..... Staff Number .....

Full Name (Surname Last) .....

Designation .....

Department/Faculty .....

Number of leave days/weeks .....

Date embarked on Leave .....

Date of Resumption from Leave .....

Did you fully utilize your leave? Yes/No .....

If No, How many day(s) do you have left? .....

State reason(s) for not fully utilizing your leave .....

.....

Staff Signature ..... Date .....

Comments by the Head of Department/Unit .....

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Name of the Dean/HOD/Unit .....

Signature of Dean/HOD/Unit ..... Date .....

Comments by the Establishment & Human Resources Officer .....

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Signature..... Date .....