Guidelines for Internship

SRI LANKA MEDICAL COUNCIL

REVISED 2013

GUIDELINES FOR INTERNSHIP OF MEDICAL PRACTITIONERS

General

The pre-registration (Internship) appointment is a continuation of the medical education programme of a medical practitioner and a requirement for Registration in the Medical Council as a Medical Practitioner.

The Intern Medical Officer is a trainee and shall be under the administrative control of the Head of the Institution (Director/Medical Superintendent of the hospital) to which the intern, is appointed. The intern would be assigned to a Consultant and shall work under his/her guidance and supervision. Senior House Officers/Registrars/Senior Registrars are available in the unit, depending on the type of hospital. The intern should seek their guidance and assistance at all times.

Dress

The intern should be neatly dressed in keeping with the dignity of the medical profession, and wear a white overcoat while on duty. The recommended dress for a gentleman is trousers, shirt and tie with shoes and for a lady, saree, a long skirt and blouse, or a shalwar kameez with appropriate footwear. The Identity card issued by the Medical Council should be worn while on duty.

Quarters

The Intern Medical Officer would be provided with quarters free of rent. On being appointed to an institution the intern shall report to the Head of the Institution, who would assign accommodation. Inventories of the assigned quarters must be taken over by the intern.

All inventory items are government property and the intern is expected to look after them carefully and be responsible for them. Inventories need to be handed over to the Head of the Institution on completion of internship. The intern should consult the Head of the Institution for any clarification in respect of any problem that may arise regarding quarters or other facilities. On completion of internship, the quarters must be vacated even if they continue to work in the same station. All rules and regulations governing government quarters should be strictly adhered to.

Allocation of Appointment

The Head of the Institution would allocate both appointments to Intern Medical Officers on the first day. Generally there are two methods of allocation. One is by general consensus of all involved. The other is based on the merit or rank order and the choice is by the intern. Two appointments of six months each should be completed. The internship appointments could be in Medicine or Paediatrics, and either General Surgery, Obstetrics and Gynaecology or Paediatric Surgery. In exceptional instance, a combination of Surgery and Obstetrics and Gynaecology is accepted. The combinations that are not accepted are: Medicine and Paediatrics, Surgery and Paediatric Surgery, Paediatrics and Paediatrics Surgery. In case of doubt the Sri Lanka Medical Council should be consulted.

Duty Hours

The duty hours are 8.00 a.m. to 12 noon and 2.00 p.m. to 4.00 p.m. During these times the interns must be physically present at the workplace. Outside these times the intern should be 'on-call' to the unit. Arrangements for 'on-call' duties and working during weekends and public holidays should be made in consultation with the Head of the Institution/Unit, based on the requirements of the Sri Lanka Medical Council.

When an intern goes off duty for the day or weekend, he/she should intimate to the officer on duty the condition of the patients under his/her care. The weekend commences at 12 noon on Saturday and ends at 8.00 a.m. on Monday. The interns who have been 'off' for the night or weekend, should on their return familiarize themselves with the patients under their care before the Consultant commences the ward round.

Maintenance of the Diary

Every intern should maintain a diary provided by the Institution. The time of arrival in the ward, the time of departure, time of night rounds and any special activities carried out should be recorded daily in the diary. The Head of the Institution and the Consultant should peruse and initial the diary at least once a month.

Attitude

The intern should at all times be kind and courteous to patients. Any complaint of discourtesy or harassment would be viewed seriously and is liable for disciplinary action. The intern should keep the patient and the relations informed about the condition of the patient and answer any queries that may arise.

Work and Conduct

The work and conduct of Intern Medical Officers must be exemplary. They should maintain the dignity of the noble profession to which they belong. Heads of Institutions as well as Consultants will closely supervise the work and conduct of interns. **Violations of rules in respect of work and conduct, neglect of patient care, duties and responsibilities would be viewed seriously and would make the intern liable to repeat the internship for varying periods depending on the gravity of the offence. It should be**

noted that repetition of internship would be without pay and would delay registration by that period.

Private Practice

Interns are not allowed to engage in any form of private practice. They should strictly adhere to this rule. Interns found guilty of engaging in private practice would be severely dealt with including cancellation of their appointments. Head of Institutions should ensure that this rule is strictly enforced.

Work in the Units/Wards

The work in the wards is based on the Unit System. Interns should work only in the unit to which they are assigned. In exceptional circumstances, the intern may be requested to work outside his/her unit by the Head of the Institution with the concurrence of the Consultant, and the intern should comply.

Each Unit would be assigned at least three intern medical officers. There would be a fixed cadre of interns for each unit and the number would depend on the workload in the unit. The intern is advised to be in the ward by 7.30 a.m. or earlier. The intern should be well informed of the condition of the patients under his/her care. Interns must do a complete ward round in the morning before the Consultant's ward round, and enter the patients' clinical notes daily.

They should ensure that the investigations ordered are carried out or arranged. All acutely ill patients should be given priority and must also be examined in the afternoon and night, and more often as required. Proper records must be maintained on all patients examined.

The intern should promptly attend on a patient when summoned by the ward sister or nurse.

Under no circumstances should treatment be prescribed over the telephone. Every patient must be seen before prescribing treatment or advising on management.

During ward rounds, interns should switch off cellular phones in their possession.

Records of Patients' Clinical Notes (B.H.T.) – New Admission, Diagnosis etc.

The Intern Medical Officer should clerk all new admissions to the ward and write detailed clinical histories. The importance of eliciting and recording a relevant clinical history cannot be over emphasized. All patients admitted to the ward should be seen with minimum delay. Those admitted in the morning must be seen before 12.00 noon and those admitted in the afternoon before 4.00 p.m.

However, all admissions that are 'stamped' as urgent by the admitting officer must be seen immediately. It is important to record on the clinical notes (B.H.T.) the date and time a patient is first seen. After the initial clerking of a patient, a provisional or differential diagnosis should be made based on the symptoms and signs, and entered in the clinical notes.

The condition of seriously ill patients should be regularly monitored and the SHO/Registrar/Consultant kept informed. The intern should not hesitate to summon the SHO/Registrar/Consultant at any time of the day or night, if the necessity arises. When a call is sent to the SHO/Registrar/Consultant, the intern should enter on the clinical notes the time the call was sent. Daily record of the condition of the patient should be entered in detail. When a

patient is on a regimen of treatment, the response of the patient should be monitored and reviewed and brought to the notice of SHO/Registrar/ Consultant. All reports of investigations should be seen by the intern, relevant information entered in the clinical notes and attached to it in chronological order. Abbreviations used should only be the standard, commonly accepted ones.

Referring a patient in the unit to personnel outside the unit is not the duty of the intern, unless instructed to do so by the Consultant. In 'exceptional' circumstances, he/she may have to use his/her discretion in this regard.

All entries in the clinical notes should be neat, legible and written in ink. Every sheet of the clinical notes should bear the name, reference (B.H.T.) number and the number of the ward. All operations and intervention procedures, transfusions and instructions given by the Consultant should be recorded in the clinical notes.

When investigations are completed and the final diagnosis arrived at, or when the patient is discharged, the final diagnosis should be entered in the admission sheet in block capitals in the space provided. The diagnosis should be according to the International Classification of Diseases (ICD). The intern should ensure that clinical notes (B.H.T.) do not accumulate in the ward due to delay in entering the diagnosis.

Prescribing

Great care should be exercised in prescribing drugs. As far as possible drugs in the hospital formulary must be prescribed. Prescription should be by generic name. It is important to enter the dose, the number of times the drug needs to be administered during a 24 hour period and the route of administration. It is advisable for the intern inquire from the patient from time to time, as to whether the drugs prescribed have been administered.

A drug which is not available in the hospital but essential for the patient may have to be purchased locally. However, such local purchase of drugs should be kept to a minimum. When a drug needs to be purchased locally, the Consultant's authorization is necessary before the request is sent to the Head of the Institution.

The intern should be aware of the cost of the drugs and avoid excessive use of drugs. The treatment afforded to a patient must be reviewed regularly so as to ascertain the need for continuation of the drugs. Use of a combination of many drugs for a single complaint, ('polypharmacy') must be avoided.

Surgical Operations

Before any surgical procedure, written consent of the patient should be taken and duly recorded on the clinical notes (B.H.T.). In the case of minors or unconscious patients, the closest relative or the guardian may grant such consent. In very rare instances, as a life saving measure, the Head of the Institution could grant consent in the absence of a relative or guardian. In such instances, the relative or guardian should be informed by telegram of the date and time of the operation. All patients undergoing surgery should have their clinical status and the reports of investigations recorded in the notes. The list for operations to be performed should be prepared in triplicate, and copies sent to the Head of the Institution, the Anaesthetist and the Sister in Charge of the Operating Theatre. In the case of routine morning (a.m.) operations, the lists must reach the above mentioned persons by 12 noon the previous day, and for routine afternoon (p.m.) operations by 9.00 a.m. of the same day. All operations must be entered in detail in the clinical notes and in the register of minor/major operations maintained in the Operating Theatre. The responsibility of obtaining blood for routine operations rests with the Intern Medical Officer.

Investigations

(a) Laboratory Investigations

Requests for laboratory investigations should be on the prescribed forms. They should be requested on a rational basis. A short clinical history should be entered in the space provided in the form. The Investigation form must be completed in full. The name of the patient, BHT number and the ward should be legibly entered. The intern needs to ensure that the specimen with the requisite form is sent to the laboratory well in time. When an investigation is required urgently, this should be marked 'urgent' on the form and the time of the request also entered.

(b) Radiological Examinations

Requests for radiological examinations must be made on the prescribed request form. In every instance, a brief clinical history must be entered in the request form.

In respect of special examinations such as a Barium meal, Barium enema, IVU examination, dates would have to be obtained from the Radiology Department. When an appointment has been made for these examinations, any cancellation should be intimated to the Radiology Department well in advance.

(c) Ultra Sound and CT Scan examinations

Dates have to be obtained from the Radiology Department for the above examinations and cancellation would have to be informed well in advance.

(d) The interns should be able to take an Electrocardiogram (ECG) recording if the need arises.

Blood Transfusions

When a patient requires a blood transfusion, the relatives may be requested to donate blood. Before transfusing blood or blood products, it is the responsibility of the intern to check that the blood is of the correct group and that the compatibility test reports on the pack and the clinical notes tally.

Critically Ill Patients

Regular attention of the intern is necessary in respect of critically ill patients. In most institutions, Intensive/Critical Care Units exist and the intern should discuss with the Consultant/Registrar/SHO the need to transfer the patient to such a Unit. When a patient is admitted to the Intensive Care Unit, the intern must continue to follow up the patient. The relative must be kept informed of the condition of the patient. The procedure is for the intern to write to the hospital Office in the clinical notes and inform the relatives when the condition of the Patient deteriorates or is poor.

Follow-up Patients

If a patient who had been treated in a unit is subsequently admitted to another Unit of the same hospital, with a complaint which may or may not be related to the previous illness for which the patient was warded, the patient may be transferred to the unit where the patient was warded earlier. The history of the patient should be written by the intern of the unit to which the patient was admitted and treatment commenced before transferring the patient.

Discharge of Patients

When a patient is discharged from the ward, the patient's condition before discharge and the date and time of discharge should be entered in the clinical notes. On discharge, the patient must be given a Diagnosis Card with details of investigations, Operation performed (with the finding), the diagnosis and the treatment given. If a patient is required to attend the clinic for follow-up, this should be entered in the Diagnosis Card. All patients leaving the ward should have their clinical notes duly completed on the same day and signed by the intern.

Wherever possible adequate notice should be given to the patient regarding discharge, so that arrangements could be made for the patient to go home. If a patient had been transferred from another hospital, and requires further care at that hospital, the patient may be transferred. Adequate information should be given in the transfer form regarding the condition of the patient, diagnosis and further management. If a patient is transferred from a Mental or Prison hospital, the patient must be transferred back to that hospital. The final diagnosis should be seen by the Consultant.

Transfer of Patients

When transferring a patient from one institution to another, Form Health 946 should be completely filled stating the reason for transfer. In addition, a short clinical history, probable diagnosis, report of relevant investigations done and the treatment given should also be included. If an operation is likely to be performed, a letter of consent should be obtained prior to transfer. When transferring children or unconscious patients who need immediate surgical intervention, consent for operation should be obtained in writing

from the parent or guardian. All transfers must be recommended by the Consultant and authorized by the Head of the Institution.

Leave to Patients

Requests for leave by patients should be entered in the clinical notes and submitted to the Head of the Institution for approval if the patient is fit to avail of such leave. When leave is requested, the Intern Medical Officer should state the period, the date and time of commencement of the leave. Leave should be granted for few hours only and overnight stay not allowed. The time of departure and arrival of the patient should be recorded in the clinical notes.

Valuables of Patients

Patients should be informed at the time of admission that money and other valuables must be handed over to the Sister or Nurse in-charge of the ward, and that the hospital authorities would not be responsible for the loss of any such items not handed over. All articles handed over are entered in a Patient's Property Register. The valuables should be sent to the hospital office for safe custody. These would be returned to the patient at the time of discharge.

Members of the Clergy

Venerable monks and nuns, and priests of all religions should be afforded privacy and due respect in a general ward. Clergy of any religion should be allowed to enter the ward and perform religious rites without interfering with ward routine or inconveniencing other patients.

Dieting

The intern should be aware of the nutritional requirements of their patients. If there is no restriction required, a 'Normal Diet' may be prescribed. Special diets are required when there are restrictions on the types of food to be consumed. e.g. 'diabetic diet' for a patient with diabetes mellitus, 'low protein diets' for certain liver and renal diseases. The intern should inquire from the patient whether he or she gets food from sources other than that supplied by the hospital and give appropriate advice.

a. Recording of Diets

If a member of the nursing staff or the ward clerk enters the diet and 'extras', such entries must be initialed by the intern. Full diets, half diets and quarter diets as appropriate should be prescribed according to the following groups:-

(a) Patients 02 years and over but less than 06 years – quarter diets;

(b) Patients 06 years and over but less than 12 years – half diets;

(c) Patients 12 years and over – full diets.

When an adult patient is unable to take a full diet, he shall be placed on half diet and any extras necessary. If he cannot take half diet, he should be placed on no diet and any necessary extras. For children, it will be half the quantity referred to above.

Patients who bring food from home should be marked as 'no diets'. The parent or relative of a sick child under 07 years may be allowed to remain with the child and be given a diet.

b. Extras

Extras may be authorized for patients who do not receive a full diet. Care should be exercised when expensive items are ordered as extras. Extras should be ordered only if they are considered necessary as a food supplement. The cost of such a diet, as far as possible, should not exceed the cost of a full diet. When extras are ordered, the intern medical officer should inform the patient that extras have been ordered and inquire from the patient whether he received the extras ordered.

Registration of births

An Intern Medical Officer should be familiar with the relevant sections of the Births and Deaths Registration Act. When a birth occurs in a government hospital, a written declaration from the informant of the birth should be obtained and transmitted to the Registrar of the Division within 42 days of the date of birth together with a statutory declaration, which should be issued under section 16 read with section 63 of the Act mentioned above. The counterfoil of the statutory declaration should indicate the name, designation and the initials of the officer who perfected the Form. It is the responsibility of the informant and the registrar to satisfy themselves that the information furnished is accurate. The necessary forms would be supplied by the District Registrar under Section 20 of The Act. If there is any delay on the part of the hospital authorities in informing the birth, the value of the stamps required for the declaration has to be borne by the hospital authorities.

Reporting of Notifiable (Communicable) Diseases

In 1897, the Quarantine and Prevention of Diseases Ordinance was enacted to arrest the spread of communicable diseases in the country. The Ordinance though enacted over 100 years ago, still remains the most forceful instrument in disease control and prevention. Notification of communicable diseases is not only mandatory but "any person who contravenes this Ordinance (and its regulations) without lawful authority or excuse, shall be guilty of an offence under the Quarantine and Diseases Ordinance (Chapter 222) and such person shall be prosecuted in the magistrate's court under Section 4 of the Ordinance".

Notification of Communicable Diseases is the first step in the prevention and control of disease outbreaks. Though diagnosis and treatment of diseases have advanced tremendously, the value of notification in the prevention of disease still remains unchanged, and is important today as it was over 100 years ago. Unless a disease is notified, the public health authorities will be unaware of such a case. It is well to remember that all epidemics start with a single index case.

Gazette Notification No. 1131/24 of 10/05/2000 states that "every medical practitioner or person professing to treat diseases, who attends on any person suffering from any disease set out in the schedule of these regulations shall notify forthwith to the proper authority, **the name, sex, age and place of residence of the person on whom he attends and the nature of the disease**".

The notification should be done soon after seeing the patient and even on a provisional diagnosis, with subsequent communication following a positive diagnosis.

All medical officers, including Intern Medical Officers, must report all notifiable diseases occurring in the ward/unit. For your guidance, a list of current notifiable diseases is given below. Notification should be done on Form Health 544 (Notification of a Communicable Disease). These forms are available in the ward. Any special investigation done on the patient would also have to be entered in the notification form. Every ward maintains a Notification Register that documents all notification made from the ward. The notification form with the relevant entry in the ward notification register is sent to the office for dispatch to the Medical Officer of Health (MOH)/ Divisional Director of Health Services (DDHS), of the area in which the patient resides. It must be ensured that the patient's correct address is stated in full when making the notification to the MOH. Before a patient suffering from a communicable disease is discharged, the intern should advise the patient about any precautions that need to be taken. The fact that the case was notified should be entered in the first page of the clinical notes.

List of notifiable diseases in Sri Lanka

(Approved by the Advisory Committee on Communicable Diseases on 05th September 2008)

Column I	Column II	Column III
Disease	**Proper Authority**	**Mode of Notification**
Cholera Plague Yellow Fever	Director General of Health Services, Deputy Director General (Public Health Services), Epidemiologist, Regional Epidemiologist, Divisional Director of Health Services/Medical Officer of Health	By telephone, fax or telegram and in notification form I (H-544)
Acute Poliomyelitis/Acute Flaccid Paralysis Chicken pox Dengue Fever/ Dengue Hemorrhagic Fever Diphtheria Dysentery Encephalitis Enteric Fever Food Poisoning Human Rabies Leptospirosis Malaria Measles Meningitis Mumps Rubella/Congenital Rubella Syndrome Simple Continued Fever of 7 days or more Tetanus/Neonatal Tetanus Typhus Fever Viral Hepatitis Whooping Cough Leishmaniasis	Divisional Director of Health Services/Medical Officer of Health	By notification in form I (H-544)
Sever Acute Respiratory Syndrome (SARS)/ Suspected for SARS	Director General of Health Services, Deputy Director General (Public Health Services), Director/Quarantine, Air Port Health Officer, Port Health Officer, Epidemiologist, Regional Epidemiologist, Divisional Director of Health Services/Medical Officer of Health	By telephone, fax or telegram and in notification form I (H-544)
Tuberculosis	Director/National Programme for Tuberculosis Control and Chest Diseases	By notification in form II (H- 816)

Medico-Legal

All injuries noted on admission of a patient to any ward should be carefully recorded in the clinical notes by the Intern Medical Officer, whether they are accidental, self-inflicted or caused by another person. These include burns, near drowning, electrocution, poisoning etc. When there is evidence or a suspicion of an offence being committed, the police should be informed by recording in the clinical notes, e.g. abortion, rape, child abuse. The police after inquiry would issue a General Hospital Police Ticket (GHT), which has to be completed by the Judicial Medical Officer.

Inquests

Inquests are conducted by Inquirers into Sudden Deaths (ISD or "Coroner") or a Magistrate, on receiving information that a person has died due to an unnatural cause such as suicide, accident, violence, machinery, an animal attack, or while in the custody of the police, in a house of detention, an inmate of a mental hospital, or on the operating table while under anaesthesia, and due to poisoning, rabies or tetanus.

An inquest is also necessary when a patient dies unexpectedly and the medical team is unable to give the cause of death.

At the inquest, the police have to state the results of the inquiries made and the recorded evidence of the relatives. This may cause inconvenience to relatives and delays in making funeral arrangements. Where it is mandatory, an inquest should not be avoided as it is a judicial requirement. An inquest is not required when a patient dies of an undiagnosed illness after prolonged treatment. In such an instance, a Pathological Postmortem examination may be performed after obtaining approval of the Head of the Institution and the consent of the next of kin.

An inquest is not necessary when a patient dies of a natural cause even within 24 hours of admission to a ward if the cause of death can be ascertained. In case of doubt, the advice of the Consultant of the unit should be obtained. In every instance, efforts should be made to minimize inconvenience to relatives of the patients, but the intern should not be coerced into avoiding a postmortem examination when indicated.

Death Certification

Certification of death is a responsibility of the Intern Medical Officer. The Ward Sister/Nurse may summon the Intern Medical Officer to certify death of patient. Extreme care should be taken before pronouncing death, and the body must be seen and examined. When a death occurs, the relatives of the patient have to be informed by telegram/telephone through the hospital office. When the Intern Medical Officer declares the cause of death, Form Registration B 31 has to be filled, carefully entering all the particulars requested. The cause of death should not be written when an inquest is requested.

Requests for Documents

Clinical notes (Bed Head Tickets) are confidential documents meant for departmental use only. Requests for copies of clinical notes by members of the public should not be entertained. However, original or certified copies may be furnished, when required by a Court of Law or the Registrar/ Sri Lanka Medical Council. If the Head of the Government Department calls for a copy of the clinical notes (BHT) for an administrative purpose, there is no legal objection for granting such a request, if the circumstances are reasonable. A Corporation is not a Government Department. Similar documents may sometimes be required by the police in the course of investigations. The permission of the Head of the Institution should be obtained before any document is handed over.

Medical Certificates

Officers of the Public Service who are bound by the Establishment Code and whose emoluments are paid out of the Consolidated Fund are entitled to the issue of Medical Certificates (MC) free of charge. Form Health 170 should be used in respect of the category of major staff and Form Health 231 in respect of minor staff. For others, Private Medical Certificates on form Health 307 may be issued on the payment of the prescribed fee.

The patient has to pay the fee to the hospital office and produce the receipt for the medical officer to write the MC. All cages in the MC must be completed in full. Intern Medical Officers are authorized to issue a MC with the approval of the Consultant, only to patients in their units/wards and to those attending their follow up clinics.

MCs should be issued only to those who are unfit to attend to official duties on account of an illness, and not for trivial ailments.

Leave is recommended for a maximum period of three months, one month at a time for the first two months, and two periods of two weeks each thereafter. Only the minimum period of leave has to be recommended. A medical certificate from a medical officer should not cover more than five days past absence except in the case of an indoor/ward patient, to cover a period of stay in hospital. When a state officer/employee is likely to be on leave for three months or more, a recommendation to the Head of the relevant Department should be made, to arrange for a Medical Board.

For further details, intern medical officers are advised to read the "Guidelines on issuing of Medical and Death Certificates" provided to them by the Sri Lanka Medical Council at the time of Provisional Registration.

Academic Activities

Academic activities form an important component of continuing medical education of an intern medical officer. The SHO/ Registrars should take the initiative and organize clinical meetings, clinico-pathological conferences etc. with the guidance of the Consultants and the Head of Institutions and the interns should actively participate.

Appraisal

There would be an objective appraisal of internship during and at the end of each period, for which a record book will be provided. Interns should familiarize themselves with the areas of appraisal given in the book titled "Evaluation Certificate for internship".

Leave to Intern Medical Officers

Leave is allowed to an intern medical officer up to a total of 14 days during the period of internship, of which not more than two days should be taken at a time, except in the case of an illness. In such an instance, a medical certificate acceptable to the Sri Lanka Medical Council has to be submitted. If leave for more than 14 days is availed of, internship has to be repeated for that period. If internship is extended for any period, the intern is not entitled to any emoluments during that period.

Maternity Leave

Interns are granted maternity leave during internship as in the case of other Government employees. The minimum period of maternity leave that should be taken in the case of a live birth is twenty eight (28) days. Hence no intern should report for duty within 28 days of delivery of a live baby.

Eighty four (84) days of maternity leave is allowed for interns without loss of 'seniority' or 'merit position'. In calculating this, week-ends and public holidays are not included. However, the intern should work in each unit for a total of six months (minus 14 days if no other leave is taken).

For further information please refer annex 1 and 2.

Annexure 01

Salient points from the Public Administrative Circular 4/2005 of 3 February 2005

(Amendment to section 18 Chapter XII of the Establishment Code)

1. Government has decided to grant female public officers 84 days maternity leave with full pay, 84 days maternity leave on half pay, 84 days maternity leave on no pay in respect of every child birth.
2. All female public officers whether permanent, temporary, casual or trainee are entitled to maternity leave under this section.
3. Maternity leave with full pay
    - Female officer is entitled to 84 working days full pay leave in respect of every live child birth and they will not be allowed to resume duties before the expiry of 4 weeks after the birth of the child.
    - In calculating maternity leave public holidays, Saturdays and Sundays falling within such period should not be included.
    - In the case of a still birth or the death of a child before the expiry of 6 weeks from the child birth, 6 weeks leave from the date of child birth should be granted as special full pay leave.
4. Maternity leave on half pay
    - After the exhaustion of leave mentioned in the previous paragraph the officer is entitled to 84 days leave on half pay for her to look after the child.
5. Maternity leave on no pay
    - After the end of leave approved under the previous two paragraphs, it is possible to grant 84 days no pay leave only if

such leave is required for the purpose of looking after the child. However, the approval of the leave would be by the Head of the relevant Department.

6. In the case of a miscarriage the officer can avail herself of the vacation leave she is entitled to on the production of the medical certificate.
7. After the expiration of the maternity leave obtained as described earlier the officer should be allowed to leave office one hour before the normal time of departure in order to breast feed the child provided no maternity leave on half pay has been availed of.
8. Further, when the officer reaches the fifth month of pregnancy she should be allowed to attend office half an hour later than the normal time of attendance and leave office half an hour before the normal time of departure.

Annexure 02

Public Administration Circular Letters: 3/2013 of 27 August 2013.

Granting of Maternity leave in Terms of Public Administration Circular No. 04/2005 to new appointees to Public Service who receive their permanent appointments after child birth.

1. A large number of inquiries are received in respect of procedure that should be followed in granting maternity leave in terms of Public Administration Circular No. 04 /2005 to female public officers who have delivered a baby prior to receiving their permanent appointments. At such occasions action should be taken in the following manner.
2. As per the provisions of the above circular, female public officers are granted maternity leave to ensure nutrition and protection to the

child. Accordingly the remaining number of days after deducting the number of days between the date of the child birth and the date of assumption of duties of the newly appointee, from the maternity leave of 84 days can be granted as full pay leave as per provision of Public Administration Circular No. 04/2005.

3. In case where the officer is entitled to obtain either leave with half pay or no-pay after the above calculation, the officer shall also be granted such leave on her request.

4. Further, it is informed that leave granted to the officers deviating from the above instructions, who have received appointments in public service after child birth and who are still within the period entitled to obtain leave with full pay, half pay and no-pay as per Public Administration Circular No. 04/2005, shall be revised making necessary adjustments.