

# Infectious Disease Prevention & Control Unit Health Promotion and Disease Prevention Directorate

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## Form A5 - Application form for Health Screening for Work Permit

### **Applicable for first time applicants working as Food Handlers**

*Those engaged in the preparation, manufacturing, and treatment of a food business and who handle or prepare food intended for human consumption, in terms of the Food Safety Act and Subsidiary Legislation 449.27*

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## **CONFIDENTIAL**

### **Please read the following instructions carefully**

As a potential employee, applicants have a duty to provide the relevant information to the Infectious Disease Prevention and Control Unit (IDCU) within the Health Promotion and Disease Prevention Directorate. All medical and sensitive personal information applicants provide, will be held in complete confidence by the Directorate.

### **Documentation**

All employees should plan any required vaccinations sufficiently in advance so that these, together with any blood tests needed to show immunity, are completed prior to submitting their application.

The employee will need to go to a private Medical Doctor for this form to be duly filled and to carry out the required medical examination and tests as requested according to the job applying for.

All documentation should be in **English**.

The Directorate will only accept blood tests and investigations from radiology clinics or laboratories in Malta licensed by the Superintendence of Public Health.

Any abnormal results kindly forward a copy to IDCU on [workpermit.idcu@gov.mt](mailto:workpermit.idcu@gov.mt) for the necessary action.

## Section A: PERSONAL INFORMATION

1. Job applying for: \_\_\_\_\_

1<sup>st</sup> time application

Change of job

2. What year did you start working in Malta? \_\_\_\_\_

3. Details of Employee:

Surname *(as it appears on passport)*:

Name *(as it appears on passport)*:

Gender:

Date of Birth:

**Day:**

**Month:**

**Year:**

Place of Birth:

Nationality:

ID/Passport Number:

Address in Malta:

Mobile:

Email:

List all the countries you have lived in for a period of **6 months or more**:

Detailed job description:  
(Please see list in website)

**Food Handling Course (tick where applicable)**  
**Certificate must be attached**

**Category A:** \_\_\_\_\_ (MM/YY) - **Valid for 2 years**

*For people who work indirectly with food like waiters, food & beverage servers, and bar staff*

**Category B:** \_\_\_\_\_ (MM/YY) - **Valid for 5 years**

*For people who are directly involved in preparing food like chefs*

**4. Details of Employer:**

Name of Employer:

Name of company (if applicable):

Email:

Mobile/Telephone:

Address:

**I hereby declare that the information given in this application is true to the best of my knowledge.**

\_\_\_\_\_  
**Employee's Signature** (applicant)

\_\_\_\_\_  
**Employer's Signature**

**Date:** \_\_\_\_\_

**ID number:** \_\_\_\_\_

## Section B: HEALTH SCREENING

### **To be completed by the private Medical Doctor**

It is important that employees are screened for relevant infectious diseases prior to their initiation of employment.

**Please note that it is MANDATORY that this section of the form is completed by ONE (1) doctor only and the doctor's contact telephone number and email address are clearly written down.**

**Failure to comply with this will result in the application form NOT being processed.**

### 1. Chest X-Ray

#### **To be done locally in the PRIVATE SECTOR by some employees\***

- Employees who were born or who have lived for 6 months or more in a country reported as High/Very High Risk for TB need to take a Chest X-Ray.
- Chest X-Rays need to be taken within the last 6 weeks from the date of the application form.
- Employees who are **changing jobs**, can present their previous Chest X-Ray if this was taken within the past year. If the Chest X-Ray was taken more than 1 year ago, a repeat of Chest X-Ray is required.
- Important to fill in the date when Chest X-Ray was taken.
- If results show any **abnormalities**, please send a copy of the report with the application form.
- **A copy of the Chest X-Ray report must be attached with the application form.**

Requirement	Results submitted (Tick as Applicable)	Date taken
<b>CHEST X-RAY</b>  * For applicants who are born or have spent 6 months or more in a country reported as High/Very High Risk for TB by the World Health Organisation	<input type="checkbox"/> CXR Normal  <input type="checkbox"/> CXR Abnormal	

## 2. Vaccines and Blood Investigations

- **Only vaccines administered in Malta are accepted for processing.**
- Important to duly complete the form, including **dates and batch numbers** for vaccinations taken.
- Should one of the vaccines be out of stock, kindly document it on the application form and send it for processing. We will guide you accordingly.

Health Screening	Results submitted (Tick as applicable)	Date taken
<b>HEPATITIS A</b>		
<b>1. TWINRIX VACCINE</b> (Hepatitis A & B)  <p style="text-align: center;"><b><u>OR</u></b></p> <b>HAVRIX / AVAXIM</b> (Hepatitis A)	<u>Dosing schedule</u> <input type="checkbox"/> 0 months <input type="checkbox"/> 1 month <input type="checkbox"/> 6 months	<u>DATES &amp; BATCH No.</u>
	<input type="checkbox"/> 0 months <input type="checkbox"/> 6 months	
<b><u>OR</u></b>		
<b>2. Hepatitis antibody - (anti-HAs)*</b>	<b>A</b> <input type="checkbox"/> anti-HAs greater than 10mIU/ml <input type="checkbox"/> anti-HAs less than 10mIU/ml*	<u>Date</u>

\*Test to be taken **only** if

- Hepatitis A vaccination record is unavailable, **or**
- Hepatitis A vaccines were given more than 10 years from the date of application.

**If anti-HAs is less than 10mIU/ml, applicant needs to start Hepatitis A vaccination schedule**

<b>TYPHOID</b>		
<b>TYPHIM VI</b> (Valid for 3 years)	<input type="checkbox"/> Vaccination record	<u>DATE:</u>
<b>POLIO / DIPHTHERIA</b> Full immunity is required		
1. <b>1 dose administered in MALTA</b>	<input type="checkbox"/> IPV Boostrix <input type="checkbox"/> Repevax (Sanofi) <input type="checkbox"/> Imovax <input type="checkbox"/> Dultavax <input type="checkbox"/> Revaxis	<u>DATE:</u>
		<u>BATCH/LOT NUMBER</u>
<b>OR</b>		
2. <b>Poliovirus and Diphtheria immunity test</b>	<input type="checkbox"/> Immune <input type="checkbox"/> Non-immune	<u>DATE:</u>
Should blood level show <b>no immunity</b> , applicant must receive one dose of vaccine.		
<b>MEASLES</b>		
<b>Documented vaccinations</b>	<input type="checkbox"/> Records available <input type="checkbox"/> Records unavailable*	<u>DATES &amp; BATCH NO.</u>
* If vaccination records <b>unavailable</b> or vaccine never taken, it is recommended that the applicant takes 1 dose of MMR vaccine.		

## Covid-19

<b>COVID-19 VACCINES</b>		
<b>If COVID-19 vaccine was received, kindly tick accordingly</b>		
<b>1. Vaccines</b>	<input type="checkbox"/> Comirnaty (Pfizer) <input type="checkbox"/> Spikevax (Moderna) <input type="checkbox"/> Vaxzevria (AstraZeneca) <input type="checkbox"/> Janssen (Johnson & Johnson <sup>*1 dose*</sup> )	<u>DATE OF 2<sup>ND</sup> DOSE OF VACCINE</u>
<b>2. Booster vaccine</b>	<input type="checkbox"/> Received <input type="checkbox"/> Not received	<u>DATE OF BOOSTER VACCINE</u>

## Section C: INFORMATION FOR MEDICAL DOCTORS

All employees need to be examined to exclude symptoms of scabies, food and water borne illnesses (gastroenteritis) and vaccine preventable diseases such as chickenpox and measles.

I declare that the employee is not suffering from the above-mentioned infectious diseases.

I declare that the employee is showing no symptoms suggestive of active tuberculosis (prolonged cough for more than 2 weeks; Haemoptysis; Fever; Weakness; Weight loss; Night sweats; Chest pain).

I declare that I have vetted all the necessary investigations requested to apply for a work permit and found

**NO ABNORMALITIES.**

**ABNORMALITIES**, that include; \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Kindly inform applicant/employer to send application to [workpermit.idcu@gov.mt](mailto:workpermit.idcu@gov.mt) together with a copy of the abnormal results to be followed up as necessary**

**Comments:**

Doctor's Name & Surname (in block letters): \_\_\_\_\_

Medical Council Registration No: \_\_\_\_\_

Mobile No: \_\_\_\_\_

Email address: \_\_\_\_\_

Signature: \_\_\_\_\_

Stamp

**Kindly ensure that the details provided are all legible. Otherwise, the application will not be processed. Only rubber stamps with legible information requested above will be accepted.**



## Section D: EMPLOYEE'S DECLARATION

**Employee:**

I declare that to the best of my knowledge the information provided is correct. I understand that approval for work permit is subject to successful completion of a medical test and that any test as for which I have provided results may need to be repeated.

**Signature of employee:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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The personal data requested is being processed according to Article 27 (a) (i) of the Public Health Act, the General Data Protection Regulation (EU) 2016/679 and the Data Protection Act 2018.