



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

Form A6 - Application form for Health Screening for Work Permit

Applicable for first time applicants working as

**Beauty Therapists, Beauticians, Spa Therapists and
Massage Therapists**

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 for the necessary action.

Section A: PERSONAL INFORMATION

1. Job applying for: _____

1st 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:

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 application form.
- Employees who are **changing job**, 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.
- **A copy of the Chest X-Ray report must be attached with the application form.**

Requirement	Results submitted (Tick as Applicable)	Date taken
CHEST X-RAY * 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

- **Hepatitis B antigen test (HBsAg)** needs to be taken immediately prior to initiating Hepatitis B vaccination schedule.
- **IMP:** Vaccinations taken abroad are no longer accepted for processing.

Health Screening	Results (Tick as applicable)	Date Taken
HEPATITIS B		
1. Hepatitis B Surface Antigen (HBsAg)	<input type="checkbox"/> HBsAg Negative <input type="checkbox"/> HBsAg Positive	
2. Hepatitis B antibody* (anti-HBs)	<input type="checkbox"/> Anti-HBs greater than 10mIU/ml <input type="checkbox"/> Anti-HBs less than 10mIU/ml	
<p>*Test to be taken only if</p> <ul style="list-style-type: none"> • Hepatitis B vaccines <u>were not</u> taken in Malta • Hepatitis B vaccines were taken more than <u>10 years</u> from the date of application. <p>If anti-HBs is less than 10mIU/ml, applicant is to be given a booster dose.</p>		
3. Hepatitis B Vaccines A. <u>Twinrix Vaccine</u> (Hepatitis A & B)	<u>Dosing Schedule</u> <input type="checkbox"/> 0 months <input type="checkbox"/> 1 month <input type="checkbox"/> 6 months	<u>Date and Batch No.</u>
B. <u>Engerix</u> (Hepatitis B)	<u>Dosing Schedule</u> <input type="checkbox"/> 0 months <input type="checkbox"/> 1 month <input type="checkbox"/> 6 months	<u>Date and Batch No.</u>

HEPATITIS C		
Hepatitis C antibody result (HCV)	<input type="checkbox"/> Negative test	DATE:
	<input type="checkbox"/> Positive test*	

*If anti-HCV result is positive – this needs to be confirmed through confirmatory antibody test (immunoblot) or through Hepatitis C virus nucleic acid test (HCV RNA).

POLIO / DIPHTHERIA Full immunity is required		
1. 1 dose administered in MALTA	<input type="checkbox"/> IPV Boostrix <input type="checkbox"/> Repevax (Sanofi) <input type="checkbox"/> Imovax <input type="checkbox"/> Dultavax <input type="checkbox"/> Revaxis	DATE: BATCH/LOT NUMBER
OR		DATE:
2. Poliovirus and Diphtheria immunity test	<input type="checkbox"/> Immune <input type="checkbox"/> Non-immune	

Should blood level show **no immunity**, applicant must receive one dose of vaccine.

MEASLES		
<p>If Measles vaccines were not taken in Malta, applicant is to provide proof of vaccination. If vaccine records are provided and IgG measles test is not taken, applicant is to take 1 booster dose of Measles vaccine. If IgG measles is taken and result is positive, no booster dose is required. If result is negative, 2 doses of Measles vaccine are to be taken</p>		
Measles Antibody titre result (IgG measles)	<input type="checkbox"/> Immune (Positive) <input type="checkbox"/> Not immune (Negative)	DATES & BATCH NO.

Measles booster dose taken	<input type="checkbox"/> Yes <input type="checkbox"/> No	<u>DATE & BATCH No.</u>
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If applicant never received the vaccine, records are not provided or IgG result is **negative**, two (2) doses of Measles vaccine need to be administered

Vaccination (2 doses)	<input type="checkbox"/> 0 weeks <input type="checkbox"/> 8 weeks	<u>DATES & BATCH No.</u>
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If 2 doses of the Measles vaccine are required, the second dose has to be taken as scheduled. If not taken prior to renewal, the renewal application will not be approved.

Covid-19

COVID-19 VACCINES If COVID-19 vaccine was received, kindly tick accordingly		
1. Vaccines	<input type="checkbox"/> Comirnaty (Pfizer) <input type="checkbox"/> Spikevax (Moderna) <input type="checkbox"/> Vaxzevria (AstraZeneca) <input type="checkbox"/> Janssen (Johnson & Johnson*) <small>*1 dose</small>	<u>DATE OF 2ND DOSE OF VACCINE</u>
2. Booster vaccine	<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 employee/employer to send application to 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:** _____

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.