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

Form B - Application form for Health Screening for Work Permit

Applicable for first time applicants coming from countries with High Tuberculosis incidence doing Other Jobs;

(E.g. administrative, construction/manual workers, cleaners/housekeepers, footballers, hairdressers/makeup artists, working in transport, delivery persons, security guards, laboratory technicians working in a non-medical field (e.g. construction, chemicals, pharmaceuticals, etc))

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

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 investigations from radiology clinics 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 actions.

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: *(Please see list in website)*

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.

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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**
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	☐ CXR Normal ☐ CXR Abnormal	

2. Vaccines and Blood Investigations

. Important to duly complete the form, including dates for health screening investigations and batch numbers for vaccinations.

POLIO / DIPHTHERIA **Full immunity is required**		
1. **1 dose administered in MALTA**	☐ IPV Boostrix ☐ Repevax (Sanofi) ☐ Imovax ☐ Dultavax ☐ Revaxis	DATE: BATCH/LOT NUMBER
OR 2. **Poliovirus and Diphtheria immunity test**	☐ Immune ☐ Non-immune	DATE:
Should blood level show **no immunity**, applicant must receive one dose of vaccine.		
MEASLES		
Documented vaccinations	☐ Records available ☐ Records unavailable*	DATES & BATCH NO.
***** If vaccination records **unavailable** or vaccine never taken, it is recommended that the applicant takes 1 dose of MMR vaccine.		

Covid-19

COVID-19 VACCINES If COVID-19 vaccine was received, kindly tick accordingly		
1. Vaccines	☐ Comirnaty (Pfizer) ☐ Spikevax (Moderna) ☐ Vaxzevria (AstraZeneca) ☐ Janssen (Johnson & Johnson* *1 dose*)	DATE OF 2ND DOSE OF VACCINE
2. Booster vaccine	☐ Received ☐ Not received	DATE OF BOOSTER VACCINE

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: _____

Stamp

Signature: _____

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.