

# Infectious Disease Prevention & Control Unit

## Health Promotion and Disease Prevention Directorate

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### Form R1 – Application form for Health Screening for renewal of Work Permit

*\*All investigations are to be carried out at a **LOCAL PRIVATE CLINIC**\**

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#### Who should fill this Health Screening for renewal of Work Permits Application Form?

- 1. Foreigners who were born or have lived for 6 months or more in a country reported as very high-risk for tuberculosis**

All foreigners who were born or have lived for 6 months or more in a country reported as very high-risk for tuberculosis need to complete 1 Health Screening for Renewal of Work Permits. The application form R1 needs to be completed **one year after the first application was made (a total of 2 years applying for health screening and working in Malta)** regardless of the job they have applied for. Applications need to be sent by the **employer** to the Infectious Disease Prevention and Control Unit (IDCU) on [workpermit.idcu@gov.mt](mailto:workpermit.idcu@gov.mt)

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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

Application form should be duly filled by all parties and the requested health screening investigations carried out and documented on the application. Any abnormal chest x-ray reports or any health screening investigations that merit attention, need to be submitted with the application form to IDCU on [workpermit.idcu@gov.mt](mailto:workpermit.idcu@gov.mt).

Kindly write 'Renewal Form' in the subject of the email.

You will receive approval via email.

## Section A: PERSONAL INFORMATION

### 1. Details of Employee:

Name & Surname:

*(As it appears on passport)*

Nationality/ Citizenship:

Email:

Mobile:

Year when started working in Malta:

### 2. Details of Employer:

Name of Employer:

Name of company *(if applicable)*:

Email:

Mobile/Telephone:

Job Reapplying for: \_\_\_\_\_

Detailed job description: \_\_\_\_\_

Renewal year with present employer:      1<sup>st</sup> renewal (2<sup>nd</sup> year working in Malta)

2<sup>nd</sup> renewal (3<sup>rd</sup> year working in Malta)

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

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Signature of Employer

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

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

## Section B: HEALTH SCREENING

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. Physical Examination

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 above-mentioned individual is not suffering from the above-mentioned infectious diseases.
- I declare that the above-mentioned individual is showing no symptoms suggestive of active tuberculosis (prolonged cough for more than 2 weeks; Haemoptysis; Fever; Weakness; Weight loss; Night sweats; Chest pain).

**Important to state the dates when the CXR, vaccinations and health screening were taken. Otherwise, the form will not be accepted**

### 2. Chest X-Ray

#### **To be done locally in the PRIVATE SECTOR**

The Chest X-Ray needs to be taken within the **last 6 weeks** of submission of the renewal 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>	<input type="checkbox"/> CXR Normal <input type="checkbox"/> CXR Abnormal	

### 3. Hepatitis B Vaccination

- Full immunity against Hepatitis B is required amongst the following applicants prior to renewal of work permit namely; **Doctors, Dentists, Midwives, Nurses, Professions Complementary to Medicine, Carers/Childcarers, Nannies, Beauty Therapists, Beauticians, Spa Therapists & Massage Therapists and Tattooists.**
- **Hepatitis B antigen test (HBsAg)** needs to be taken immediately prior to initiating Hepatitis B vaccination schedule.

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

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

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

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

#### 4. Food Handlers

*Applicants 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)*

**\*Employees working as food handlers need to have taken the full course of Hepatitis A and Typhoid vaccination prior to renewal\***

Health Screening	Results submitted (Tick as applicable)	Date
<b>HEPATITIS A</b>		
<b>TWINRIX VACCINE</b> (Hepatitis A & B)  <p style="text-align: center;"><b><u>OR</u></b></p>          <b>HAVRIX</b> (Hepatitis A)	<u>Dosing schedule</u> <input type="checkbox"/> 0 months  <input type="checkbox"/> 1 month  <input type="checkbox"/> 6 months  <hr/> <input type="checkbox"/> 0 months  <input type="checkbox"/> 6 months	<u>DATES &amp; BATCH No.</u>
<b><u>OR</u></b>		
<b>3. Hepatitis antibody - A</b> <b>(anti-HAs)*</b>	<input type="checkbox"/> anti-HAs <b>greater than 10mIU/ml</b>  <input type="checkbox"/> anti-HAs <b>less than 10mIU/ml*</b>	<u>Date</u>

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

- a. Hepatitis A vaccination record is unavailable, **or**
- b. 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**

## TYPHOID

### TYPHIM VI

(Valid for 3 years)

Vaccination record

DATE & BATCH No.

Important to state the dates when the vaccinations were taken. Otherwise, the form will not be accepted.

## MEASLES

If on first time application applicant never received the vaccine, records were not provided or IgG result was **negative**, two (2) doses of Measles vaccine needed to be administered

**If 2 doses of the Measles vaccine were required, the second dose had to be taken as scheduled. If not taken prior to renewal, the renewal application will not be approved.**

Please indicate dates when vaccines were given and batch numbers below:

Vaccination (2 doses)

2 doses required

- Yes  
 No

DATE & BATCH No.

### Comments:

## Section C: MEDICAL DOCTOR'S DETAILS

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

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

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

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

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

Stamp
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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.