Infectious Disease Prevention & Control Unit

Health Promotion and Disease Prevention Directorate

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

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

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

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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.

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: 1st renewal (2nd 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
CHEST X-RAY	☐ CXR Normal ☐ 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.

<table>
<tr><th>Health Screening</th><th>Results
(Tick as applicable)</th><th>Date taken</th></tr>
<tr><td colspan="3">HEPATITIS B</td></tr>
<tr><td rowspan="2">1. Hepatitis B vaccination:

A. TWINRIX VACCINE
(Hepatitis A & B)

<u>OR</u>

B. ENGERIX
(Hepatitis B)</td><td><u>Dosing schedule</u>
☐ 0 months
☐ 1 month
☐ 6 months</td><td><u>Date & Batch No.</u></td></tr>
<tr><td><u>Dosing schedule</u>
☐ 0 months
☐ 1 month
☐ 6 months</td><td><u>Date & Batch No.</u></td></tr>
<tr><td colspan="3"><u>OR</u></td></tr>
<tr><td>2. Hepatitis B antibody - (anti-HBs)*</td><td>☐ anti-HBs greater than 10mIU/ml

☐ anti-HBs less than 10mIU/ml*</td><td><u>Date</u></td></tr>
</table>

*Test to be taken **only** if
a. Hepatitis B vaccination record is unavailable, **or**
b. 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**
HEPATITIS A		
TWINRIX VACCINE (Hepatitis A & B) **OR** **HAVRIX** (Hepatitis A)	**Dosing schedule** ☐ 0 months ☐ 1 month ☐ 6 months ☐ 0 months ☐ 6 months	DATES & BATCH NO.
OR		
3. Hepatitis A antibody - (anti-HAs)*	☐ anti-HAs **greater than 10mIU/ml** ☐ anti-HAs **less than 10mIU/ml***	Date

*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

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.