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

Form A4 - Application form for Health Screening for Work Permit

Applicable for first time applicants working as

Nannies & Child carers

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. If there are any abnormal results copies of these should be forwarded to IDCU on workpermit.idcu@gov.mt for any necessary action, together with this application form.

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Section A: PERSONAL INFORMATION

1. **Job being applied 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:

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

Detailed job description: *(To include the number of children in your care and their ages)*

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**: _____

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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 commencing 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.

It is also the doctor's responsibility to ensure that they see all CXR reports/vaccination records that they are reporting on below. Where vaccination records are not provided a booster dose will be required, as indicated below.

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.**

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Requirement	Results submitted (Tick as Applicable)	Date taken
CHEST X-RAY *For applicants who were 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

- **IMP:** Vaccinations taken abroad are no longer accepted for processing.
- **Vaccination records MUST BE SEEN by the doctor. Where records are not provided a booster dose of the vaccine is required, as indicated below.**

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.

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MEASLES

Full immunity is required

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

Measles Antibody titre result **(IgG measles)**	☐ Immune (Positive) ☐ Not immune (Negative)	DATE
Measles booster dose taken	☐ Yes ☐ No	DATE & BATCH NO.

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

	☐ 4 weeks	

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.

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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 and seen all the necessary investigations/documents 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 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.

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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 further investigations may be required if there is an indication that one may be suffering from an infectious disease (Public Health Act, Article 29 (1) (c).

Signature of employee: _____ **Date:** _____

Please send a scanned copy of this form together with:

1. **Proof of certification (where required)**
2. **Chest X-Ray report (where required)**
3. **Scan of vaccination card/record (in English)**
4. **Scan of any blood tests (where required)**

Failure to send any of the required documentation will delay processing of this application form.

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.

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