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. 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:

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 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.

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 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-Rray 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.**

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Requirement		Results submitted (Tick as Applicable)	Date
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

- **Hepatitis B antigen test (HBsAg)** needs to be taken immediately prior to initiating Hepatitis B vaccination schedule.
- **Vaccination records MUST BE SEEN by the doctor. Where records are not provided a booster dose of the vaccine is required, as indicated below.**
- **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)	☐ HBsAg Negative ☐ HBsAg Positive	
2. Hepatitis B antibody* (anti-HBs)	☐ Anti-HBs greater than 10mlU/ml ☐ Anti-HBs less than 10mlU/ml	

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

- Hepatitis B vaccines were not taken in Malta
- Hepatitis B vaccines were taken more than 10 years from the date of application.

If anti-HBs is less than 10mlU/ml, applicant is to be given a booster dose.

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3. Hepatitis B Vaccines A. Twinrix Vaccine (Hepatitis A & B)	Dosing Schedule ☐ 0 months ☐ 1 month ☐ 6 months	Date and Batch No.
B. Engerix (Hepatitis B)	Dosing Schedule ☐ 0 months ☐ 1 month ☐ 6 months	Date and Batch No.

HEPATITIS C		
Hepatitis C antibody result (HCV)	☐ Negative test ☐ Positive test*	DATE:

*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).

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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 a booster dose of MMR vaccine.

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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 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.

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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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