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

Application form for Health Screening for Students (aged 18 years and over) studying for a Healthcare Profession*

(to be completed by individuals who are studying ONLY. Students who are working as well as studying need to complete a different form)

*Healthcare Profession includes dentists, doctors, midwives, nurses, professions complementary to medicine, carers - for patients, the elderly, vulnerable groups, amongst others

CONFIDENTIAL

Please read the following instructions carefully

All students studying for a Healthcare Profession have a duty to provide the following information. All medical and sensitive personal information applicants provide will be held in complete confidence by the Directorate.

Documentation

All applicants 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. Forms are to be sent 3 months prior to onset of the course to ensure that they are processed in good time.

The applicant will need to go to a **private Medical Doctor** for this form to be duly filled.

All documentation should be in **English.**

Once completed the form should be forwarded to workpermit.idcu@gov.mt. This includes any abnormal results. Copies of everything should kindly be forwarded to IDCU on workpermit.idcu@gov.mt for further investigations together with this application form.

Section A: PERSONAL INFORMATION

1. **Course being followed:** _____

2. **Educational facility (***tick or complete as relevant)***:**

   - ☐ University of Malta
   - ☐ MCAST
   - ☐ Other government educational entity: name _____
   - ☐ Private entity: name _____

3. **Personal Details:**

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 phone no: Email address:
List all the countries you have lived in for a period of **6 months or more**:

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

_____ _____

Applicant's Signature **Date**

Section B: HEALTH SCREENING

To be completed by the private Medical Doctor

It is important that applicants are screened for relevant infectious diseases within a month of starting their studies.

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 applicants*

- Applicants 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.
- 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 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

. **Vaccination records <u>MUST BE SEEN</u> by the doctor. Where records are not provided a booster dose of the vaccine is required, as indicated below.**

POLIO / DIPHTHERIA **<u>Full immunity is required</u>**		
1. **Documented vaccination**	☐ Records available ☐ Records unavailable	<u>DATE:</u>
OR 2. **Poliovirus and Diphtheria immunity test**	☐ Immune (Positive) ☐ Not immune (Negative)	<u>DATE:</u>
Should vaccination records not be available, or blood level show **no immunity**, it is highly recommended that the applicant must receive at least one dose of vaccine – if required complete point 3 below:		
3. **1 dose administered in MALTA**	☐ Yes ☐ No	<u>DATE:</u> <u>BATCH/LOT NUMBER</u>

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

Vaccination (2 doses)	☐ 0 weeks ☐ 4 weeks	DATES & BATCH NO.

If 2 doses of the Measles vaccine are required, the second dose has to be taken as scheduled.

HEPATITIS B

Full immunity is required

1. **Documented vaccination**	☐ Records available ☐ Records unavailable	DATE:
OR 2. **Hepatitis B immunity test**	☐ Immune (Positive) ☐ Not immune (Negative)	DATE:

Should vaccination records not be available, or blood level show **no immunity**, the applicant must be given a Hepatitis B vaccine course – if required complete point 3 below:

3. **Vaccine course administered in MALTA**	☐ Yes ☐ No	DATE: BATCH/LOT NUMBER

A. **Twinrix Vaccine:** (Hepatitis A & B) **OR** B. **Engerix Vaccine:** (Hepatitis B)	Dosing Schedule: ☐ 0 months ☐ 1 month ☐ 6 months Dosing Schedule: ☐ 0 months ☐ 1 month ☐ 6 months	DATE: BATCH/LOT NUMBER DATE: BATCH/LOT NUMBER

Section C: Information for Medical Doctors

I declare that all the above documentation is authentic and that all information provided is correct.

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.

Section D: APPLICANT'S DECLARATION

Applicant:

I declare that to the best of my knowledge, the information provided is correct. I understand 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 applicant: _____ **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.