GOVERNMENT OF MALTA
MINISTRY FOR HEALTH AND ACTIVE AGEING

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

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

CONFIDENTIAL

Please read the following instructions carefully

All students who are NOT studying for a Healthcare Profession are required to provide the following medical information. All medical and sensitive personal information applicants provide will be held in complete confidence.

Documentation

All applicants should plan any required vaccinations sufficiently in advance so that these, together with proof of vaccination (vaccination card from your own country or Malta), are completed prior to submitting their application, **kindly ensure that all medical documents are in the English language**. 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. **Duration of the Course**

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

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

4. **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.

5. Details of School:

Name of School:

Name and Duration of course. Healthcare Profession course: YES NO

Email:

Mobile/Telephone:

Address:

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

Signature and Stamp of School

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 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 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 MUST BE SEEN by the doctor. Where records are not provided a booster dose of the vaccine is required, as indicated below.

A copy of the Vaccination Card Must be attached with the application form.

DIPHTHERIA, TETANUS AND POLIO (DTP) **Full immunity is required.** **PREVENTION OF DISEASE ORDINANCE DTP CAP 36**		
1.Documented vaccination	☐ Records available ☐ Records unavailable	
Should vaccination records not be available or less then 4, applicant must receive a Booster dose of DTP vaccine – if required complete point 2 below:		
2.Booster dose given in Malta.	☐ Yes ☐ No	DATE: BATCH NO:
MEASLES, MUMPS AND RUBELLA (MMR VACCINE)		
1.Documented vaccination	☐ Records available ☐ Records unavailable	
Should vaccination records not be available, it is highly recommended that the applicant must receive a Booster dose of MMR – if required complete point 2 below:		
2.Booster dose of MMR in Malta	☐ Yes ☐ No	DATE: BATCH NO:

Section C: Information for Medical Doctors

All students 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 _____

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.

Please send a scanned copy of this form together with:

1. **Chest X-Ray report (where required).**
2. **Scan of vaccination card/record (in English) if available**
3. **DTP Vaccine – minimum of 4 doses taken.**
4. **MMR Vaccine minimum of 1 dose is highly recommended**

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