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**

**Important Instructions for ALL Students Applicants**

All students applying a course must submit specific medical documentation. Please read and follow these steps carefully:

**1. Vaccination Requirements**

* Ensure all required vaccinations are completed **before submitting your application**.
* Provide **proof of vaccination** (vaccination card from your home country or Malta).
* All medical documentation must be in **English**.

**2. Medical Form**

* Visit a **private Medical Doctor** to have the required **application form completed**.
* Submit all **medical forms and test results**, including any **abnormal findings**.

**3. Submission Timeline**

* Submit all forms and documents **at least 1 month before your course starts** to allow time for processing.

**4. Document Submission**

* Send the completed form and any related documents to:
 **workpermit.idcu@gov.mt**
**Email Subject Line:** “Student form”
* Also include **copies of all documentation** with the form submission for further investigation by the IDCU.

# **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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
1. **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 **6 months or more**:

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

**Section B: Details of School:**

Name of School:

Name of the course:

Duration of the course:

Start Date of Course: End Date 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 Date**

**Section C:** **Medical Screening Section – To Be Completed by a Private Medical Doctor in Malta**

This section **must be completed by one (1) licensed Medical Doctor only**.

**Important Notes:**

* **Screening for relevant infectious diseases must be conducted within one month** of the start of the applicant’s studies.
* The **doctor must provide their full contact details**, including:
	+ **Telephone number**
	+ **Email address**

**Doctor’s Responsibilities:**

* The doctor must **personally review** all:
	+ **Chest X-ray (CXR) reports**
	+ **Vaccination records**
* If **vaccination records are not provided**, the applicant is required to receive a **booster dose**, as outlined in the form.

🔴 **Failure to meet these requirements will result in the application form not being processed.**

Chest X-Ray **(CXR) Requirements for TB Screening**

**Who needs to do this?**
Applicants who were **born in** or have **lived for 6 months or more** in a country classified as **High or Very High Risk for Tuberculosis (TB)** must undergo a Chest X-ray.

**Chest X-Ray Guidelines:**

* Must be done **locally in the private sector**.
* The **CXR must be taken within the last 6 weeks** before submitting the application form.
* The **exact date** the Chest X-ray was taken must be **written on the form**.
* **Attach a copy of the CXR report** to the application form.

**If Abnormalities Are Found:**

* A **copy of the report** highlighting any findings must be **included** with the application.

🔴 **Failure to submit a recent and valid Chest X-ray report will result in delays or non-processing of your application**

|  |  |  |
| --- | --- | --- |
| **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 |  |

**Vaccines – Important Information**

* **Vaccination records must be reviewed by the Medical Doctor** completing this form.
* If **vaccination records are not available**, the applicant is **required to receive a booster dose** of the relevant vaccine, as indicated.
* All vaccination documentation must be in **English**.
* A **copy of the Vaccination Card must be attached** to this application form.

|  |
| --- |
| **DIPHTHERIA, TETANUS, and POLIO (DTP)****Full immunity is required.**  **PREVENTION OF DISEASE ORDINANCE DTP CAP 36** |
|  **1. Documented vaccination****2. Booster dose given in Malta.**  |  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: Yes No | Date:Batch No: |
| **Measles, Mumps, and Rubella (MMR VACCINE)** |

|  |  |  |
| --- | --- | --- |
|  **1. Documented vaccination** **2. Booster dose of MMR in Malta** |  Records available Records unavailableShould 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:. |  |
|  Yes No |  Date: Batch No: |

**Section D**: **Medical Doctor's Declaration**

I, the undersigned Medical Doctor, certify that

* I have **examined the student** to exclude symptoms of the following:
	+ Scabies
	+ Food and waterborne illnesses (e.g., gastroenteritis)
	+ Vaccine-preventable diseases such as chickenpox and measles
* I declare that the student is **not suffering** from the above-mentioned infectious diseases.
* I declare that the student shows **no symptoms suggestive of active tuberculosis**, including:
	+ Prolonged cough (lasting more than 2 weeks)
	+ Haemoptysis (coughing up blood)
	+ Fever
	+ Weakness
	+ Weight loss
	+ Night sweats
	+ Chest pain
* I declare that I have **personally reviewed all required investigations and documents** submitted by the applicant in support of this application.
* [   ] **Tick if applicable or cut if not applicable:** **The applicant is suffering from a blood-borne infection (e.g., HIV, Hepatitis B, or Hepatitis C)**

(If ticked, please attach relevant documentation and note that Public Health authorities may follow up.)

**Comments:**

Doctor’s Name & Surname (in block letters): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Council Registration No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stamp

Mobile No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 E: APPLICANT’s Declaration**

I, the undersigned, declare that to the best of my knowledge:

* The information I have provided in this form is **true and correct**.
* I **do not suffer** from any **blood-borne infections**, including **HIV, Hepatitis B, or Hepatitis C**.
* I understand that **further investigations may be required** if there is any indication that I may be suffering from an infectious disease, under the **Public Health Act, Article 29(1)(c)**.

**Name of Applicant:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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.

**Final Submission Checklist – Required Documents**

Please **scan and submit** the **completed form** together with **all the following documents**:

1. **Chest X-Ray report** (only if required – see TB screening guidelines).
2. **Vaccination card/record** (must be in English).
3. **DTP Vaccine** – Proof of a **minimum of 4 doses**.
4. **MMR Vaccine** – At least **1 dose is highly recommended**.

**Important Notice**

**Failure to submit any of the above documentation will delay processing of your application form.**