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

Important Instructions for ALL Student Applicants

All students applying to 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 _____

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 **6 months or more**:

I hereby declare that the information given in this application is accurate 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 accurate 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) **Complete 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:

PREGNANT	**YES**	**NO**	**WEEKS**

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: 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: _____

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 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 **one dose is highly recommended**.

Important Notice

Approval will not be granted if all required documentation is not submitted or if the individual does not successfully pass the health screening.