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 Family Reunification All Adults (over 18, low-risk Countries)

CONFIDENTIAL

Please read the following instructions carefully.

Key Points for All Third-Country Nationals (TCN) Applicants:

1. **Vaccinations**
   - Must be completed *before* applying.
   - Proof of vaccination required (vaccination card from home country or Malta).
   - Ensure vaccinations are done well in advance.
2. **Medical Documentation**
   - All medical forms must be in **English**.
   - Visit a **private Medical Doctor** to complete the required form.
   - Submit medical forms **at least three months before the course start date**.
3. **Submission**
   - Completed form + supporting documents should be sent to: **hsu.hpdp@gov.mt**.
   - Even **abnormal results** must be included.
   - Copies of all documents + application form should also be sent to: **hsu.hpdp@gov.mt**

Section A: PERSONAL INFORMATION

1. **Date when you first arrived in Malta.**

2. **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 accurate to the best of my knowledge.

Applicant's Signature **Date**

Section B: HEALTH SCREENING

Doctor's Responsibility

- Only **one doctor** can complete this section.
- The doctor must clearly provide:
  - **Contact telephone number**
  - **Email address**
- The doctor must personally review **all vaccination records** before reporting.
- If vaccination records are missing → **booster doses are required**.
- If instructions are not followed, → **application will NOT be processed**.

Vaccines Requirements

1. **Doctor's Obligation**
   - The doctor must **personally review** all vaccination records.
   - If **records are missing**, the applicant must receive the **booster dose(s)** indicated.
2. **Applicant's Obligation**
   - Provide a **copy of the Vaccination Card**.
   - Attach the copy to the **application form**.

DIPHTHERIA, TETANUS, AND POLIO (DTP) **Complete immunity is required.** PREVENTION OF DISEASE ORDINANCE 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

1. **Infectious Disease Screening**
   - Applicant must be examined to **exclude symptoms of**:
     - Scabies
     - Food- and water-borne illnesses (e.g., gastroenteritis)
     - Vaccine-preventable diseases (including **chickenpox** and **measles**)
2. **Tuberculosis Screening**
   - Applicant must be examined for **symptoms suggestive of active TB**, such as:
     - Prolonged cough (> 2 weeks)
     - Haemoptysis (coughing up blood)
     - Fever
     - Weakness
     - Weight loss
     - Night sweats
     - Chest pain
3. **Review of Medical Records**
   - Doctor confirms they have:
     - Vetted and reviewed all **necessary investigations/documents** required for **Family Reunification**.
4. **Final Clinical Assessment**
   - Option A: **NO ABNORMALITIES**
   - Option B: **ABNORMALITIES**, specify:

Comments:

Doctor's Name & Surname (in block letters): _____

Medical Council Registration No: _____

Mobile No: _____

Email address: _____

Signature: _____

Stamp

Please ensure that all provided details are legible. Otherwise, the application will not be processed. Only rubber stamps with legible information requested above will be accepted.

Section D: APPLICANT'S DECLARATION

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 I may be suffering from an infectious disease, in accordance with the **Public Health Act, Article 29 (1)(c)**.

Signature of Applicant: _____

Date: _____

Data Protection Notice

The personal data requested is being processed in line with:

- **Public Health Act, Article 27 (a)(i)**
- **General Data Protection Regulation (EU) 2016/679 (GDPR)**
- **Data Protection Act 2018**

Please send a scanned copy of this form together with the following documents to hasu.hpdp@gov.mt

1. **Scan of vaccination card/record (in English).**
2. **Complete DTP Vaccination.**
3. **MMR Vaccine, a minimum of 1 dose, is highly recommended.**

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