



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

Application form for Health Screening for Family Reunification All Adults (over 18- High 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. Chest X-ray Applicants **born in or who have lived **6 months or more** in a **High/Very High TB risk country**- in Malta**

3. 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**.

4. Submission

- Completed form + supporting documents should be sent to:
hsu.hdpd@gov.mt.
- Even **abnormal results** must be included.
- Copies of all documents + application form should also be sent to:
hsu.hdpd@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.**

Chest X-Ray Requirement

- **Who needs it?**
 - Applicants **born in** or who have lived **6 months or more** in a **High/Very High TB risk country.**
 - To be done **locally in the private sector.**
- **Validity & Timing**
 - Chest X-Ray must be taken **within the last 6 weeks** before applying- done in Malta
 - The doctor must fill in the exact date of the Chest X-ray.
- **Reporting**
 - If abnormalities are detected:
 - Attach a **copy of the Chest X-Ray report.**
 - Send results along with the application form.
 - Even if normal:
 - A **copy of the Chest X-ray report** must still be attached.



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 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) <u>Complete immunity is required.</u> PREVENTION OF DISEASE ORDINANCE CAP 36		
1. Documented vaccination	☐ Records available ☐ Records unavailable	
Should vaccination records not be available or less than 4, applicant must receive a Booster dose of DTP vaccine – if required complete point 2 below:		
2. Booster dose given in Malta.	☐ Yes ☐ No	<u>DATE:</u> <u>BATCH NO:</u>



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**
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Please bring this form and the following documents with you for the appointment at the Health Screening Unit HSU

- 1. Chest X-Ray report(in Malta).**
- 2. Scan of all vaccination card/record (in English).**
- 3. Complete DTP Vaccination.**
- 4. MMR Vaccine, a minimum of 1 dose, is highly recommended.**

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