



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

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## Application form for Health Screening for Family Reunification All Adults (over 18, low-risk Countries)

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### **CONFIDENTIAL**

**Please read the following instructions carefully.**

#### **Key Points for All Third-Country Nationals (TCN Low-risk Countries) 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.**



<b>DIPHTHERIA, TETANUS, AND POLIO (DTP)</b> <u>Complete immunity is required.</u> PREVENTION OF DISEASE ORDINANCE CAP 36		
<b>1. Documented vaccination</b>	<input type="checkbox"/> Records available <input type="checkbox"/> 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:		
<b>2. Booster dose given in Malta.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<u>DATE:</u>  <u>BATCH NO:</u>
<b>MEASLES, MUMPS, AND RUBELLA (MMR VACCINE)</b> N50 of 1989 Prevention of Diseases Ordinance (Cap. 36)		
<b>1. Documented vaccination</b>	<input type="checkbox"/> Records available <input type="checkbox"/> Records unavailable	
Should vaccination records not be available- Mandatory for ALL Female applicants with 2 Doses If vaccination records are not available, vaccination is highly recommended for males.		
<b>2. Booster dose of MMR in Malta</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<u>DATE:</u>  <u>BATCH NO:</u>
<b>3. Vaccination course administered in Malta (2 doses)</b>	<input type="checkbox"/> 0 weeks  <input type="checkbox"/> 4 weeks	<u>DATE:</u> <u>BATCH NO:</u>  <u>DATE:</u> <u>BATCH NO:</u>



## 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)**.

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**Signature of Applicant:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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### 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 send a scanned copy of this form together with the following documents to [hasu.hpdp@gov.mt](mailto:hasu.hpdp@gov.mt)**

- 1. Scan of vaccination card/record (in English).**
- 2. Complete DTP Vaccination– Proof of a minimum of 4 doses**
- 3. MMR Vaccine- Mandatory for ALL Female applicants (2 Doses), and highly recommended for male applicants.**

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