



# Infectious Disease Prevention & Control Unit

## Health Promotion and Disease Prevention Directorate

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### Application form for Health Screening for Students (aged 18 years and over) studying for a Healthcare Profession\*

\*Healthcare professionals include student dentists, doctors, midwives, nurses, professionals complementary to medicine, and carers within healthcare

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## CONFIDENTIAL

### Essential Instructions for Healthcare Professional Applicants

All students applying for a Healthcare Profession 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 B: Details of School:

Name of School:

Name of the course:

Duration of 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.
<p><b>CHEST X-RAY</b></p> <p>* 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 Organization</p>	<input type="checkbox"/> CXR Normal  <input type="checkbox"/> CXR Abnormal	

## Hepatitis B, Hepatitis C, and HIV Testing & Vaccination Requirements

### 1. Hepatitis B Antigen Test (HBsAg)

- Must be conducted **immediately before** starting the **Hepatitis B vaccination schedule**.
- A **copy of the blood test results** must be **attached** to the application form.

### 2. Hepatitis C antibody result (HCV).

### 3. HIV Blood result for Nurses and Doctors Course ONLY

### 3. Vaccination Records

- The **doctor must personally verify** all vaccination records.
- If **no vaccination records are available**, a **booster dose** of the Hepatitis B vaccine is **required**.

### 4. Documentation to Attach:

- **All blood test results** (including HIV, HBsAg, and Hepatitis C antibody)
- **All Blood tests must be done in Malta**
- **Copy of the vaccination card**

● **Incomplete or missing documentation may delay or prevent processing of your application.**

HEPATITIS C		
Hepatitis C antibody result (HCV) in Malta	<input type="checkbox"/> Negative test	DATE:
	<input checked="" type="checkbox"/> Positive test*	
<p><b>If the anti-HCV result is positive, it must be confirmed through a confirmatory antibody test (immunoblot) or a Hepatitis C virus nucleic acid test (HCV RNA).</b></p>		



HEPATITIS B		
<b>1. Hepatitis B Surface Antigen (HBsAg) in Malta</b>	<input type="checkbox"/> HBsAg Negative <input type="checkbox"/> HBsAg Positive	<u>DATE:</u>
<b>2. Documented vaccination* (Fully vaccinated with three doses)</b>	<input type="checkbox"/> Records available <input type="checkbox"/> Records unavailable	
<p>*Hepatitis B vaccine- Fully vaccinated with 3 doses-If NO proof of fully vaccinated with 3 doses-Booster is required</p> <p>*Hepatitis B vaccines were taken more than <u>10 years</u> from the date of application. Booster vaccination is required</p> <p>*If NO Records of vaccination available- Full immunisation with 3 doses is required</p>		
<b>3. Booster dose</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<u>DATE:</u> <u>BATCH/LOT NUMBER</u>
<b>4. Vaccine course administered in Malta.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>A. <u>Twinrix Vaccine</u> (Hepatitis A &amp; B)</b>	<u>Dosing Schedule</u> <input type="checkbox"/> 0 months <input type="checkbox"/> 1 month <input type="checkbox"/> 6 months	<u>Date and Batch No.</u>
<b>B. <u>Engerix</u> (Hepatitis B)</b>	<u>Dosing Schedule</u> <input type="checkbox"/> 0 months <input type="checkbox"/> 1 month <input type="checkbox"/> 6 months	<u>Date and Batch No.</u>



<b>DIPHTHERIA, TETANUS, AND POLIO (DTP)</b> <b>Complete immunity is required.</b> <b>PREVENTION OF DISEASE ORDINANCE CAP 36</b>			
<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 doses, the 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>			
<b>1. Documented vaccination* (Fully vaccinated with two doses)</b>	<input type="checkbox"/> Records available <input type="checkbox"/> Records unavailable		
<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>
<b>PREGNANT</b>	<b>YES</b>	<b>NO</b>	<b>WEEKS</b>

<b>HUMAN IMMUNODEFICIENCY VIRUS (HIV)</b> <b>For Doctors and Nurses Course ONLY</b>		
<b>HIV ANTIBODY (HIV) result</b>	<b>Negative test</b>	<b>DATE</b>
	<b>Positive test</b>	



## 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.
- **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

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

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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, stamp and signature of the doctor visible).
3. **DTP Vaccine** – Proof of a **minimum of 4 doses**.
4. **MMR Vaccine** – **Mandatory for ALL Healthcare professionals (2 doses)**.
5. **Hepatitis B Vaccine** – Proof of **3 doses**.
6. **All blood investigation results**, including HIV, Hepatitis B antigen (HBsAg), and Hepatitis C antibody test.
7. **HIV Blood test -Mandatory ONLY for Doctors and Nurses Courses**

### 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.**