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

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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 Organization	☐ 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)

LN50 of 1989 Prevention of Diseases Ordinance (Cap. 36)

1. Documented vaccination **(Fully vaccinated with two doses for all female applicants)**	☐ Records available ☐ 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.		
2. Booster dose of MMR in Malta	☐ Yes ☐ No	DATE: BATCH NO:
3. Vaccination course administered in Malta (2 doses)	☐ 0 weeks ☐ 4 weeks	DATE: BATCH 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.
- [ ] **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, stamp and signature of the doctor visible).
3. **DTP Vaccine** – Proof of a **minimum of 4 doses**.
4. **MMR Vaccine** – **Mandatory for ALL Female applicants (2 Doses),** and highly recommended for male applicants.

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.