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

Health Screening for Work Permit

Applicable for first time applicants working as

Doctors, Dentists, Midwives, Nurses

CONFIDENTIAL

Please read the following instructions carefully

As a potential employee, applicants have a duty to provide the relevant information to the Infectious Disease Prevention and Control Unit (IDCU) within the Health Promotion and Disease Prevention Directorate. All medical and sensitive personal information applicants provide, will be held in complete confidence by the Directorate.

Documentation

All employees should plan any required vaccinations sufficiently in advance so that these, together with any blood tests needed to show immunity, are completed prior to submitting their application.

The employee will need to go to a private Medical Doctor for this form to be duly filled and to carry out the required medical examination and tests as requested according to the job applying for.

All documentation should be in **English.**

The Directorate will only accept blood tests and investigations from radiology clinics or laboratories in Malta licensed by the Superintendence of Public Health.

Any abnormal results kindly forward a copy to IDCU on workpermit.idcu@gov.mt for further investigations.

Section A: PERSONAL INFORMATION

1. **Job applying for:** _____

☐ 1st time application ☐ Change of job

2. **What year did you start working in Malta?**_____

3. **Details of Employee:**

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:
Email:
List all the countries you have lived in for a period of **6 months or more**:

Job applying for:

Maltese Registration Number with relevant Council: ***(To attach proof of Maltese Registration Certificate with relevant Council)***

4. Details of Employer:

Name of Employer:

Name of company (*if applicable*):

Email:

Mobile/Telephone:

Address:

I hereby declare that the information given in this application is true to the best of my knowledge.

_____ _____

Employee's Signature *(applicant)* **Employer's Signature**

Date: _____ **ID number:** _____

Section B: HEALTH SCREENING

To be completed by the private Medical Doctor

It is important that employees are screened for relevant infectious diseases prior to their initiation of employment.

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1. Chest X-Ray

To be done locally in the PRIVATE SECTOR by some employees*

- Employees who were born or who have lived for 6 months or more in a country reported as High Risk for TB need to take a chest x-ray.
- Chest x-rays need to be taken within the **last 6 weeks** from the date of the application form.
- Employees who are **changing jobs**, can present their previous chest x-ray if this was taken within the past year. If the chest x-ray was taken more than 1 year ago, a repeat of chest x-ray is required.
- Important to fill in the date when chest x-ray was taken.
- If results show any **abnormalities**, please send a copy of the report with the application form.

Requirement	Results submitted (Tick as Applicable)	Date taken
CHEST X-RAY *For applicants who are born or have spent 6 months or more in a country reported as High Risk for TB* by the World Health Organisation (Annex A)	☐ CXR Normal ☐ CXR Abnormal	

2. Vaccines and Blood Investigations

- **Hepatitis B antigen test (HBsAg)** needs to be taken immediately prior to initiating Hepatitis B vaccination schedule.
- **IMP:** Vaccinations taken abroad are no longer accepted for processing.

Health Screening	Results (Tick as applicable)	Date Taken	
TUBERCULOSIS			
Interferon-Gamma TB test	☐ Negative ☐ Positive		
HEPATITIS B			
1. Hepatitis B Surface Antigen (HBsAg)	☐ HBsAg Negative ☐ HBsAg Positive		
2. Hepatitis B antibody* (anti-HBs)	☐ Anti-HBs greater than 10mlU/ml ☐ Anti-HBs less than 10mlU/ml		
3. Hepatitis B Vaccines A. Twinrix Vaccine (Hepatitis A & B)	Dosing Schedule ☐ 0 months ☐ 1 month ☐ 6 months	Accelerated Schedule ☐ 0 days ☐ 7 days ☐ 21 days ☐ 1 year	Date and Batch No.
B. Engerix (Hepatitis B)	Dosing Schedule ☐ 0 months ☐ 1 month ☐ 6 months	Accelerated Schedule ☐ 0 days ☐ 7 days ☐ 21 days ☐ 1 year	Date and Batch No.

***Test to be taken **only** if**

- Hepatitis B vaccines were not completed in Malta
- Hepatitis B vaccines were taken more than 10 years from the date of application.

If anti-HBs is less than 10mlU/ml, applicant is to start Hepatitis B vaccination schedule. For previously vaccinated applicants, a booster dose is to be administered.

HEPATITIS C		
Hepatitis C antibody result (HCV)	☐ Negative test ☐ Positive test	DATE:
HUMAN IMMUNODEFICIENCY VIRUS (HIV)		
HIV antibody (HIV) result	☐ Negative test ☐ Positive test	DATE:
MEASLES **All employees are required to take 2 doses of Measles vaccination**		
If Measles vaccines were not taken in Malta, applicant is to check for **IgG Measles.** If **negative**, to give booster dose of Measles vaccine.		
Measles Antibody titre result **(IgG measles)**	☐ Positive test ☐ Negative test	DATE
Measles booster dose	☐ Received ☐ Not received	DATE & BATCH NO.
If applicant never received the vaccine, two (2) doses of Measles vaccines need to be administered		
Vaccination (2 doses)	☐ 0 weeks ☐ 8 weeks	DATES & BATCH NO.
POLIO **All employees are required to take 1 dose of Polio vaccination in Malta**		
Vaccination administered	☐ IPV Boostrix ☐ Repevax (Sanofi) ☐ Imovax ☐ Dultavax ☐ Revaxis	DATE: BATCH/LOT NO.

Covid-19

COVID-19 VACCINES & VACCINATION CERTIFICATE *(TO BE ATTACHED)* 2 doses are strongly recommended		
1. Locally approved vaccines	☐ Comirnaty (Pfizer) ☐ Spikevax (Moderna) ☐ Vaxzevria (AstraZeneca) ☐ Janssen (Johnson & Johnson*) *1 dose	DATE OF 2ND DOSE OF VACCINE
2. Booster vaccine	☐ Received ☐ Not received	DATE OF BOOSTER VACCINE

Section C: EMPLOYEE'S DECLARATION

Employee:

I declare that to the best of my knowledge, the information provided is correct. I understand that approval for work permit is subject to successful completion of a medical test and that any test as for which I have provided results may need to be repeated.

Signature of employee:_____ **Date:** _____

Section D: INFORMATION FOR MEDICAL DOCTORS

All employees need to be examined to exclude symptoms of scabies, food and water borne illnesses (gastroenteritis) and vaccine preventable diseases such as chickenpox and measles.

☐ I declare that the employee is not suffering from the above-mentioned infectious diseases.

☐ I declare that the employee is showing no symptoms suggestive of active tuberculosis (prolonged cough for more than 2 weeks; Haemoptysis; Fever; Weakness; Weight loss; Night sweats; Chest pain).

☐ I declare that I have vetted all the necessary investigations requested to apply for a work permit and found

- ☐ **NO ABNORMALITIES.**
- ☐ **ABNORMALITIES,** that include; _____

_____

_____

Kindly inform employee/employer to send application to workpermit.idcu@gov.mt together with a copy of the abnormal results to be followed up as necessary

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

Medical Council Registration No: _____

Mobile No: _____

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.

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.