INFECTIOUS DISEASE PREVENTION & CONTROL UNIT

HEALTH PROMOTION AND DISEASE PREVENTION DIRECTORATE

HEALTH SCREENING FOR WORK PERMIT

Applicable for first time applicants working as

Beauty Therapists, Beauticians, Spa Therapists and

Massage Therapists

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 the necessary action.

Applicant's Name and Surname: _____

Section A: PERSONAL INFORMATION

1. **Job applying for:** _____

☐ 1st time application ☐ Change of job ☐ Change of employer

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**:

Applicant's Name and Surname: _____

Detailed job description:

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.

_____ _____

Applicant's Signature **Employer's Signature**

Date: _____ **ID number:** _____

Applicant's Name and Surname: _____

Section B: HEALTH SCREENING

To be completed by the private Medical Doctor

It is important that applicants 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 applicants*

- Applicants 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.
- Applicants who are **changing job or employer**, 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	

Applicant's Name and Surname: _____

2. Vaccines and Blood Investigations

- Important to duly complete the form, including dates for health screening investigations and batch numbers for all vaccinations.
- **Hepatitis B antigen test (HBsAg)** needs to be taken immediately prior to initiating Hepatitis B vaccination schedule.
- Only follow the below-listed **vaccination schedule.**

<table>
<tr><th>Health Screening</th><th>Results
(Tick as applicable)</th><th colspan="2">Date taken</th></tr>
<tr><td colspan="4">HEPATITIS B</td></tr>
<tr><td>1. Hepatitis B Surface Antigen (HBsAg)</td><td>☐ HBsAg negative
☐ HBsAg positive</td><td colspan="2">DATE</td></tr>
<tr><td rowspan="2">2. Hepatitis B vaccination:

A. TWINRIX VACCINE
(Hepatitis A & B)

OR

B. ENGERIX
(Hepatitis B)</td><td>Dosing schedule
☐ 0 months
☐ 1 month
☐ 6 months</td><td>Accelerated schedule
☐ 0 days
☐ 7 days
☐ 21 days
☐ 1 year</td><td>Date & Batch No.</td></tr>
<tr><td>Dosing schedule
☐ 0 months
☐ 1 month
☐ 6 months</td><td>Accelerated schedule
☐ 0 days
☐ 7 days
☐ 21 days
☐ 1 year</td><td>Date & Batch No.</td></tr>
<tr><td>3. Hepatitis B antibody - (anti-HBs)

(Test to be taken only if Hepatitis B vaccination record is unavailable)</td><td colspan="2">☐ anti-HBs greater than 10mIU/ml
☐ anti-HBs less than 10mIU/ml*</td><td>Date</td></tr>
</table>

*If anti-HBs is **less than 10mIU/ml**, applicant needs to start Hepatitis B vaccination schedule

Applicant's Name and Surname: _____

HEPATITIS C		
Hepatitis C antibody result (HCV)	☐ Negative test ☐ Positive test	DATE:
MEASLES		
Documented vaccination (2 doses) **OR** Measles Antibody titre result **(IgG measles)***	☐ 0 weeks ☐ 8 weeks ☐ Positive test ☐ Negative test	DATES & BATCH NO.
***If IgG measles result is NEGATIVE to give measles vaccine - Priorix**		
POLIO		
1. Documented vaccination	☐Records available ☐Records unavailable**	DATES:
****If records are unavailable, to give 1 (one) dose of Polio vaccine**		
2. Vaccination administered **IMPORTANT:** **Only 1 (one) dose of the mentioned vaccines is to be administered and will be approved for processing.**	☐ IPV Boostrix ☐Repevax (Sanofi) ☐Imovax ☐Dultavax ☐Revaxis	AFFIX STICKER HERE DATE

Important to state the dates when the vaccinations were taken. Otherwise, the form will not be accepted.

Applicant's Name and Surname: _____

3. Covid-19

Rapid Antigen Tests (RATs) are not accepted for processing

- All applicants need to attach a copy of their Covid19 Vaccination certificate, whether with EMA approved vaccines or not.
- Applicants not in possession of a Covid19 Vaccination certificate, need to send a copy of their SARS-CoV-2 test (RT-PCR) * result. Test needs to be carried out in Malta at a local private clinic, within the last 72 hours from the date of the application.
- Applicants coming directly from the list of **Dark Red Countries**, need to send a copy of their SARS-CoV-2 test (RT-PCR) * at day 11/12 of the quarantine period in Malta.
- For a full list of recognised vaccine certificates, updated country list and for further information, kindly access www.traveltomalta.gov.mt

SARS-CoV-2 TEST (RT-PCR) FOR 'DARK RED COUNTRY' APPLICANTS AND THOSE WITHOUT A COVID19 VACCINATION CERTIFICATE		
SARS-CoV-2 testing (RT-PCR) (To be carried out in Malta, at a local private clinic)	☐ Negative test ☐ Positive test ☐ Copy of result attached	DATE:
COVID-19 VACCINES & VACCINATION CERTIFICATE		
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
3. Covid19 Vaccination Certificate	☐ Certificate with EMA approved vaccines ☐ Certificate with other Covid19 vaccines	☐ Attached ☐ Attached

Applicant's Name and Surname: _____

Section C: INFORMATION FOR MEDICAL DOCTORS

All applicants 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 applicant is not suffering from the above-mentioned infectious diseases.

☐ I declare that the applicant 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.**

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

Please list **ABNORMALITIES** here _____

_____

_____

Kindly inform applicant/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.

Applicant's Name and Surname: _____

Section D: APPLICANT'S DECLARATION

Applicant:

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 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.