



**INFECTIOUS DISEASE PREVENTION & CONTROL UNIT**  
**HEALTH PROMOTION AND DISEASE PREVENTION DIRECTORATE**

**HEALTH SCREENING FOR WORK PERMIT**

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**Applicable for first time applicants working as**  
**Nannies**

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**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](mailto:workpermit.idcu@gov.mt) for the necessary action.

Applicant's Name and Surname: \_\_\_\_\_

## Section A: PERSONAL INFORMATION

**1. Job applying for:** \_\_\_\_\_

1<sup>st</sup> 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:  
(To include the number of children in your care and their ages)

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

## 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 commencing 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
<b>CHEST X-RAY</b>  * For applicants who are born or have spent 6 months or more in a country reported as <u>High Risk for TB</u> * by the World Health Organisation (Annex A)	<input type="checkbox"/> CXR Normal  <input type="checkbox"/> 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 number for 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**.

Health Screening	Results (Tick as applicable)	Date taken	
<b>TUBERCULOSIS</b>			
<b>Interferon-Gamma TB test</b>	<input type="checkbox"/> Negative test <input type="checkbox"/> Positive test	<u>DATE</u>	
<b>HEPATITIS B</b>			
<b>1. Hepatitis B Surface Antigen (HBsAg)</b>	<input type="checkbox"/> HBsAg negative <input type="checkbox"/> HBsAg positive	<u>DATE</u>	
<b>2. Hepatitis B vaccination:</b>  A. <u>TWINRIX VACCINE</u> (Hepatitis A & B)  <p style="text-align: center;"><b>OR</b></p> B. <u>ENGERIX</u> (Hepatitis B)	<u>Dosing schedule</u> <input type="checkbox"/> 0 months <input type="checkbox"/> 1 month <input type="checkbox"/> 6 months	<u>Accelerated schedule</u> <input type="checkbox"/> 0 days <input type="checkbox"/> 7 days <input type="checkbox"/> 21 days <input type="checkbox"/> 1 year	<u>DATES &amp; BATCH No.</u>
	<u>Dosing schedule</u> <input type="checkbox"/> 0 months <input type="checkbox"/> 1 month <input type="checkbox"/> 6 months	<u>Accelerated schedule</u> <input type="checkbox"/> 0 days <input type="checkbox"/> 7 days <input type="checkbox"/> 21 days <input type="checkbox"/> 1 year	<u>DATES &amp; BATCH No.</u>
<b>3. Hepatitis B antibody - (anti-HBs)</b>  (Test to be taken <u>only</u> if Hepatitis B vaccination record is unavailable)	<input type="checkbox"/> anti-HBs <b>greater than 10mIU/ml</b>  <input type="checkbox"/> anti-HBs <b>less than 10mIU/ml*</b>	<u>DATE</u>	
<p>*If anti-HBs is <b>less than 10mIU/ml</b>, applicant needs to start Hepatitis B vaccination schedule</p>			

Applicant's Name and Surname: \_\_\_\_\_

HEPATITIS C		
Hepatitis C antibody result (HCV)	<input type="checkbox"/> Negative test <input type="checkbox"/> Positive test	DATE:
MEASLES		
Documented vaccination (2 doses)  <u>OR</u>  Measles Antibody titre result (IgG measles) *	<input type="checkbox"/> 0 weeks <input type="checkbox"/> 8 weeks  <input type="checkbox"/> Positive test <input type="checkbox"/> Negative test	<u>DATES &amp; BATCH NO.</u>
<b>*If IgG measles result is NEGATIVE to give measles vaccine - Priorix</b>		
POLIO		
1. Documented vaccination	<input type="checkbox"/> Records available <input type="checkbox"/> Records unavailable**	DATES:
<b>**If records are unavailable, to give 1 (one) dose of Polio vaccine</b>		
2. Vaccination administered  <p style="text-align: center;"><b><u>IMPORTANT:</u></b></p> <p><b>Only 1 (one) dose of the mentioned vaccines is to be administered and will be approved for processing.</b></p>	<input type="checkbox"/> IPV Boostrix <input type="checkbox"/> Repevax (Sanofi) <input type="checkbox"/> Imovax <input type="checkbox"/> Dultavax <input type="checkbox"/> Revaxis	<u>AFFIX STICKER HERE</u>   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](http://www.traveltomalta.gov.mt)

<b>SARS-CoV-2 TEST (RT-PCR)</b>		
FOR ' <u>DARK RED COUNTRY</u> ' APPLICANTS AND THOSE WITHOUT A COVID19 VACCINATION CERTIFICATE		
<b>SARS-CoV-2 testing (RT-PCR)</b> <small>(To be carried out in Malta, at a local private clinic)</small>	<input type="checkbox"/> Negative test <input type="checkbox"/> Positive test <input type="checkbox"/> Copy of result attached	<u>DATE:</u>
<b>COVID-19 VACCINES &amp; VACCINATION CERTIFICATE</b>		
<b>1. Locally approved vaccines</b>	<input type="checkbox"/> Comirnaty (Pfizer) <input type="checkbox"/> Spikevax (Moderna) <input type="checkbox"/> Vaxzevria (AstraZeneca) <input type="checkbox"/> Janssen (Johnson & Johnson*) <small>*1 dose*</small>	<u>DATE OF 2<sup>ND</sup> DOSE OF VACCINE</u>
<b>2. Booster vaccine</b>	<input type="checkbox"/> Received <input type="checkbox"/> Not received	<u>DATE OF BOOSTER VACCINE</u>
<b>3. Covid19 Vaccination Certificate</b>	<input type="checkbox"/> Certificate with EMA approved vaccines <input type="checkbox"/> Certificate with other Covid19 vaccines	<input type="checkbox"/> Attached  <input type="checkbox"/> 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](mailto: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:** \_\_\_\_\_

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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.