INFECTIONIOUS DISEASE PREVENTION & CONTROL UNIT

HEALTH PROMOTION AND DISEASE PREVENTION DIRECTORATE

HEALTH SCREENING FOR WORK PERMIT

Applicable for first time applicants coming from countries with High Tuberculosis incidence doing Other Jobs:

(E.g. administrative, construction/manual workers, cleaners/housekeepers, footballers, hairdressers/makeup artists, working in transport)

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

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 investigations from radiology clinics 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: To be filled in by the employer in TYPED or BLOCK LETTERS

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:

Name & Surname: ____________________________________________________________

Current Nationality: ________________________________

Nationality at Birth: ________________________________

Date of Birth: ________________________________

Gender: ________________________________

ID/Passport Number: ________________________________

Address in Malta: ________________________________

Mobile: ________________________________

Email: ________________________________

List all the countries you have lived in for a time period of 6 months or more:
Job applying for:
(Please see list in website)

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  Signature of Employer

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 their initiation of employment.

1. Chest X-Ray

To be done locally in the PRIVATE SECTOR by 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 within the last 6 weeks if a new applicant and in the last year if changing job within the past year of applying.

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Documentation Required</th>
<th>Results submitted (Tick as Applicable)</th>
<th>Date taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHEST X-RAY</td>
<td>For applicants who are born or have spent ≥ 6 months in a country reported as High Risk for TB* by the World Health Organisation (Annex A)</td>
<td>CXR Normal</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CXR Abnormal</td>
<td></td>
</tr>
</tbody>
</table>

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.

Doctor’s Name & Surname (in block letters): ____________________________________________

Medical Council Registration No: ____________________________

Signature: ________________________________________________

Stamp
2. **Health Screening**

   Important to duly complete the form, including dates for health screening investigations and batch numbers for vaccinations.

<table>
<thead>
<tr>
<th><strong>MEASLES</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Documented vaccination</td>
</tr>
</tbody>
</table>

*If records for MEASLES are UNAVAILABLE, to give 1 (one) dose of vaccine*

<table>
<thead>
<tr>
<th><strong>POLIO</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Documented vaccination</td>
</tr>
</tbody>
</table>

** If records for POLIO are UNAVAILABLE, to give 1 (one) dose of vaccine

<table>
<thead>
<tr>
<th><strong>COVID-19 TESTING - ONLY FOR 1ST TIME APPLICANTS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>SARS-CoV-2 test***</td>
</tr>
</tbody>
</table>

***To send copy of the result received by SMS/TEXT or EMAIL with application***
**Information for Medical Doctors**

**Applicant’s Name and Surname:**

---

**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:**

---

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 C

Applicant’s Declaration

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.