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: 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:
Applicant’s Name and Surname: _____________________________________________________

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 _______________
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.

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</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 <strong>High Risk for TB</strong> 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 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**.

<table>
<thead>
<tr>
<th>Health Screening</th>
<th>Results (Tick as applicable)</th>
<th>Date taken</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TUBERCULOSIS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interferon-Gamma TB test</td>
<td>□ Negative test □ Positive test</td>
<td></td>
</tr>
<tr>
<td><strong>HEPATITIS B</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Hepatitis B Surface Antigen (HBsAg)</td>
<td>□ HBsAg negative □ HBsAg positive</td>
<td></td>
</tr>
<tr>
<td>2. Hepatitis B vaccination:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. <strong>TWINRIX VACCINE</strong> (Hepatitis A &amp; B)</td>
<td>Dosing schedule □ 0 months □ 1 month □ 6 months Accelerated schedule □ 0 days □ 7 days □ 21 days □ 1 year</td>
<td></td>
</tr>
<tr>
<td>OR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. <strong>ENGERIX</strong> (Hepatitis B)</td>
<td>Dosing schedule □ 0 months □ 1 month □ 6 months Accelerated schedule □ 0 days □ 7 days □ 21 days □ 1 year</td>
<td></td>
</tr>
<tr>
<td>3. Hepatitis B antibody - (anti-HBs)</td>
<td>□ anti-HBs <strong>greater than 10mIU/ml</strong> □ anti-HBs <strong>less than 10mIU/ml</strong></td>
<td></td>
</tr>
</tbody>
</table>

*If anti-HBs is **less than 10mIU/ml**, applicant needs to start Hepatitis B vaccination schedule*
Applicant’s Name and Surname: ____________________________________________

<table>
<thead>
<tr>
<th>Health Screening</th>
<th>Results (Tick as applicable)</th>
<th>Date taken</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MEASLES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documented vaccination (2 doses)</td>
<td>□ 0 weeks □ 8 weeks</td>
<td></td>
</tr>
<tr>
<td><strong>OR</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles Antibody titre result* (IgG measles)</td>
<td>□ Positive test □ Negative test</td>
<td></td>
</tr>
<tr>
<td>*If IgG measles result is NEGATIVE to give measles vaccine</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **POLIO**        |                               |            |
| 1. Documented vaccination | □ Records available □ Records unavailable |            |
| **If records for POLIO are UNAVAILABLE, to give 1 (ONE) dose of vaccine |
| 2. Vaccination** | □ 1 dose given                 |            |

| **COVID-19 TESTING – ONLY FOR 1ST TIME APPLICANTS** | | |
| SARS-CoV-2 testing*** | □ Negative test □ Positive test | |
| ***To send copy of the result received by SMS/TEXT or EMAIL with application form | | |
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 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: ___________________________