INFECTIOUS DISEASE PREVENTION & CONTROL UNIT

HEALTH PROMOTION AND DISEASE PREVENTION DIRECTORATE

HEALTH SCREENING FOR WORK PERMIT

Applicable for first time applicants working as Food Handlers

Those engaged in the preparation, manufacturing and treatment of a food business and who handle or prepare food intended for human consumption, in terms of the Food Safety Act and Subsidiary Legislation 449.27

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.

Applicant's Name and Surname: _____

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.

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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

Requirement	**Documentation Required**	**Results submitted** (Tick as Applicable)	**Date taken**
CHEST X-RAY	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)	☐ CXR Normal ☐ CXR Abnormal	

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. To be filled in for applicants working as FOOD HANDLERS:

(Those engaged in the preparation, manufacturing and treatment of a food business and who handle or prepare food intended for human consumption, in terms of the Food Safety Act and Subsidiary Legislation 449.27)

- Important to duly complete the form, including **dates and batch numbers** for vaccinations taken.
- Only follow the below-listed **vaccination schedule**.
- ALL applicants require full course of **Hepatitis A and Typhoid vaccination.**

<table>
<tr><th>Health Screening</th><th colspan="2">Results submitted
(Tick as applicable)</th><th>Date taken</th></tr>
<tr><td colspan="4">HEPATITIS A</td></tr>
<tr><td rowspan="2">TWINRIX VACCINE
(Hepatitis A & B)

<u>OR</u>

HAVRIX / AVAXIM
(Hepatitis A)</td><td><u>Dosing schedule</u>
☐ 0 months
☐ 1 month
☐ 6 months</td><td><u>Accelerated schedule</u>
☐ 0 days
☐ 7 days
☐ 21 days
☐ 1 year</td><td rowspan="2"><u>DATES & BATCH NO.</u></td></tr>
<tr><td colspan="2">☐ 0 months
☐ 6 months</td></tr>
<tr><td colspan="4">TYPHOID</td></tr>
<tr><td>TYPHIM VI
(Valid for 3 years)</td><td colspan="2">☐ Vaccination record</td><td><u>DATE:</u></td></tr>
<tr><td colspan="4">MEASLES</td></tr>
<tr><td>1. Documented vaccination</td><td colspan="2">☐ Available
☐ Not available</td><td><u>DATE</u></td></tr>
<tr><td colspan="4">*If records for MEASLES are UNAVAILABLE, to give 1 (one) dose of vaccine</td></tr>
<tr><td>2. Vaccination*</td><td colspan="2">☐ 1 dose given</td><td><u>DATE & BATCH NO.</u></td></tr>
</table>

Applicant's Name and Surname: _____

POLIO		
1. Documented vaccination	☐ Records available ☐ Records unavailable	DATES:
***If records for POLIO are UNAVAILABLE, to give 1 (one) dose of vaccine**		
2. Vaccination*	☐ 1 dose given	DATES & BATCH NO.
COVID-19 TESTING - ONLY FOR 1ST TIME APPLICANTS		
SARS-CoV-2 test**	☐ Negative test ☐ Positive test	DATE:
****To send copy of the result received by SMS/TEXT or EMAIL with application**		

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

Applicant's Name and Surname: _____

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: _____

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 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.