L-Università ta' Malta
Faculty of Health Sciences

OHP submitted	
Annex 1 submitted	
Occupational health assessment	
Support recommended	

OCCUPATIONAL HEALTH PROTOCOL (OHP)

Applicable to Visiting Students

CONFIDENTIAL

Please read these instructions carefully

1. As potential future health care professionals, students have a duty to provide the relevant information to the Faculty of Health Sciences. Failure to disclose information about a physical or mental health problem (that could affect safety: of the student him/herself and of others; including: patients, clients, other students or staff members) would be in breach of the University Suitability to Practice Regulations. All medical and sensitive personal information provided by students will be held in complete confidence by the Faculty of Health Sciences and the Occupational Health (Medical) Unit (OHU). The Faculty of Health Sciences will be informed by the OHU of the impact of a health problem or impairment, if relevant to the student's educational needs and/or student, or safety and if there are any recommendations on support or adjustments, that could be of assistance to students.

Documentation

2. The Occupational Health Protocol (OHP) and the Health Questionnaire in Annex 1 should be submitted **within three months prior to the commencement of the exchange**. Students are required to submit their documentation to the Occupational Health Unit by email. This is to be addressed to the Occupational Health Unit on ohu.phc@gov.mt

3. All documentation should be in English.

4. The University of Malta will accept blood results either from ISO – 15189- accredited – laboratories as evidenced by the accreditation symbol on the report, or any laboratory in Malta licensed by the Department of Health.

Certification and Liability

5. Once students satisfy the following requirements, the Occupational Health Unit shall issue an Occupational Health Certificate for all students:
   a) Occupational Health Protocol; and
   b) Annex I submitted.

   These Certificates are subsequently forwarded to the Faculty of Health Sciences.

6. All students who have a low antibody titre even after taking the 3 Hepatitis B vaccinations (doses) and a booster dose are required to fill in the Consent Form in Annex 2 in order to obtain authorisation for placements.

Section 1: Personal Details

Name: _____

Date of Birth: _____

Male/Female: _____

Title: (Mr, Ms, Mrs, etc): _____

ID/Passport No.: _____

Address: _____

Home Contact No: _____

Mobile Phone No: _____

Email Address: _____

Your GP's name: _____

GP's Mobile Phone No: _____

GP's Address: _____

GP's Email Address: _____

Section 2: Health and Function Capabilities

2.1 Do you have problems with any of the following?	**Yes**	**No**
a) **Learning** – such as dyslexia, dyspraxia, dyscalculia		
b) **Vision** – such as visual impairment, colour blindness, tunnel vision		
c) **Communication** – such as speech, hearing, social interaction		
d) **Mobility** – such as walking, using stairs, balance		
e) **Agility** – such as bending, reaching up, kneeling down		
f) **Dexterity** – getting dressed, writing, using tools		
g) **Physical exertion** – such as lifting, carrying, running		

2.2 Do you have any of the following?	**Yes**	**No**
a) **Allergies** (such as to latex, medicines, foods)		
b) **Chronic Skin conditions** (such as eczema, psoriasis)		
c) **Endocrine disease** (such as diabetes)		
d) **Respiratory conditions** (such as asthma)		
e) **Heart conditions**		
f) **An eating disorder** (such as bulimia, anorexia nervosa, compulsive eating)		
g) **Chronic fatigue syndrome** (or similar condition)		
h) **Neurological disorder** (such as epilepsy, multiple sclerosis)		
i) **Sudden loss of consciousness** (such as fits or seizures)		
j) **Mental health problems requiring psychiatric intervention** (ex: anxiety, depression, phobias, OCD, nervous breakdown, personality disorders, over-dose or self-harm, drug or alcohol dependency)		
k) **Have you ever received treatment from a psychiatrist, psychotherapist or counsellor?**		
l) **Are you currently taking any medication or treatment?**		

2.3 Did you make use of special arrangements to address an impairment or health problem?
If you answer yes, please give details (continue on separate sheet if necessary)

Please give details of the condition causing the impairment (which necessitates special arrangements) and list certification provided.

2.4 Do you have any impairment or health condition, not already mentioned above, towards which you think you may require support during your education or training?

2.5 If the answer to 2.3 is yes please indicate what medical reports are being provided.

2.6 List all countries in which you have lived for more than 6 months, including dates:

Section 3: Doctor's Certificate

The University requires that a student's medical doctor verifies the health information provided by the student on the basis of their knowledge of the patient.

	Yes	No
1. Are you the student's family doctor?		
2. Are you a relative of the applicant?		
3. Do you hold the applicant's medical record?		
4. Can you confirm whether the disclosed information is correct?		
5. Do you wish to provide any further information relating to conditions previously disclosed? (please provide details on a separate sheet)		
6. Are you aware of any additional medical information, not previously disclosed?		
7. (If yes, provide details on a separate sheet)		

Costs related to the completion of this form are the responsibility of the student.

Medical Doctor's Signature _____

Medical Council registration number _____

Date _____

Stamp

Section 4: Student's Declaration

DECLARATION

Student:

I declare that to the best of my knowledge the information provided is correct.

I am aware that if I fail to submit the Occupational Health Protocol and Annex 1 or fail to disclose information about a physical or mental health problem that could affect safety, the University of Malta has every right not to approve my clinical placement.

Student's Signature: _____

Date: _____

FOR OFFICE USE ONLY

□ Documentation complete and satisfactory = No objection

□ Documentation incomplete - still requires _____

□ Other:

Signature: _____

Date: _____

Occupational Health Unit Officer in Charge

L-Università ta' Malta
Faculty of Health Sciences

ANNEX 1

HEALTH QUESTIONNAIRE

to be completed by the medical doctor who fills in Section 3

Name and Surname: _____

It is important that students are properly protected from relevant infectious diseases prior to their clinical placements. The questionnaire below will help assess the student's fitness for the duties related to their proposed studies.

PLEASE NOTE: It is your responsibility to take and follow specialist advice if you are, or you believe that you may be, infected with any blood-borne virus.

Requirement:	**Documentation Required**	**Result submitted** (Tick as applicable)	**Date**
HEPATITIS B			
Evidence of immunity or absence of markers of infectivity	Hepatitis B antibody (anti-HBs) result **If anti HBs is less than 10 mIU/ml** Hepatitis B Surface Antigen (HBsAg) result (Tested within the previous 3 months)	☐ anti-HBs > 10 mIU/ml ☐ HBsAg negative	
HEPATITIS C (HCV)			
Hepatitis C screen	Hepatitis C antibody result (Tested within the previous 3 months)	☐ Hepatitis C antibody result	
HUMAN IMMUNDEFICIENCY VIRUS (HIV)			
HIV Screen	HIV antibody Result (Tested within the previous 3 months)	☐ HIV antibody result	
RUBELLA			
Immunity to Rubella	Documented vaccination (2 doses) **OR** Result of Antibody titre to Rubella	☐ Vaccination records ☐ Rubella titre	
MEASLES			
Immunity to Measles	Documented vaccination (2 doses) **OR** Result of Antibody titre to Measles	☐ Vaccination records ☐ Measles titre	

VARICELLA			
Immunity to Varicella	Declaration of past infection from a medical practitioner **OR** Documented vaccination (2 doses) **OR** Result of Antibody titre to Varicella	☐ Declaration ☐ Vaccination records ☐ Varicella titre	
TUBERCULOSIS (TB)			
Free from active infection	All students are required to present the result of the Mantoux test and if the result is negative are advised to take the BCG vaccine. Students who have spent ≥ 6 months in a country reported as high risk for TB by the World Health are required to present: Chest X-Ray Report (CXR) Annex 3 includes a list of countries deemed as high risk by the World Health Organisation.	☐ Mantoux <6mm ☐ CXR negative	
Any Other Serious Medical Conditions			

Costs related to the completion of this form are to be covered by the student.

Doctor's Signature _____

Medical Council registration number_____

Date _____

Stamp

FOR OFFICE USE ONLY

- □ Documentation complete and satisfactory = No objection
- □ Documentation incomplete - still requires _____
- □ Other:

Signature: _____
Date: _____

Occupational Health (Medical) Unit / Officer in Charge

L-Università ta' Malta
Faculty of Health Sciences

Date: _____

ANNEX 2

LOW ANTI HBs ANTIBODY TITRE
CONSENT FORM

I, the undersigned, understand and agree that since, following three doses of a Hepatitis B vaccine my titre is not yet greater than 10mIU/ml, I will abide by all the policies and regulations which are in force by the Infection Control Unit of any teaching hospital in particular NOT to:

- perform any interventions that involve the use of sharps on patients;
- participate as an assistant in any operation

I bind myself to report any exposure to blood or body fluids (including needle stick injuries) to the Occupational Health or Infection Control Departments where I will be attached.

I also understand and agree that Infection Control may be carrying out further tests in this regard and that a final strategy shall be communicated in due course.

_____
Signature

_____
Name (IN BLOCK LETTERS)

_____
Identification Number

_____
Mobile Phone Number

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ANNEX 3

List of Countries deemed by the World Health Organisation as High risk for Tuberculosis

Please refer to the list available on the link below:

https://cdn.who.int/media/docs/default-source/hq-tuberculosis/who_globalhbcliststb_2021-2025_backgrounddocument.pdf?sfvrsn=f6b854c2_9