OHP submitted	
Annex 1 submitted	
Occupational health assessment	
Support recommended	

OCCUPATIONAL HEALTH PROTOCOL (OHP)

Applicable to applicants for the:
Master of Dental Surgery Course
Bachelor of Science (Honours) in Dental Hygiene Course
Bachelor of Science (Honours) in Dental Technology Course
Master of Science in Dental Sciences Course
Master of Science in Gerodontology
Master of Science in Digital Dentistry
Preparatory Course for Diploma in Dental Surgery Assistance
Diploma in Dental Surgery Assistance Course
Commencing in October 2024 or later

CONFIDENTIAL

Please read these instructions carefully

1. As a potential future **dental health professional**, students have a duty to provide relevant information to the **Faculty of Dental Surgery**. Failure to disclose information about a physical or mental health problem (that could affect patient safety) would breach the University Suitability to Practice Regulations. All medical and sensitive personal information students provide will be held in complete confidence by the Faculty of Dental Surgery and the Occupational Health Unit. The Faculty of Dental Surgery will be informed of the impact of a health problem or impairment, if relevant to the student's educational needs or patient safety, and of 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 as soon as possible but not later than 12th December 2024. Students must submit their documentation to the Faculty of Dental Surgery Faculty Office, Room 103, Level 0, Dar Ġużeppi Zahra, University of Malta. All documentation should be in English.

3. Students should plan any required vaccinations sufficiently in advance so that these, together with any blood tests needed to show immunity, are completed well in advance of the 12th December 2024 deadline.

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

5. All forms must be endorsed by a doctor and accompanied by documentary evidence supporting all vaccination / past history claims

6. The Faculty will send the complete original documentation to the Occupational Health Unit – OHU – following which an Occupational Health Assessment is scheduled. The Occupational Health Unit cannot clear students without full documentation.

7. Any costs for the completion of this form or tests required will be borne solely by the student.

8. All sections must be filled in, no part of this document is optional

Certification and Liability

9. Once students satisfy both of the following requirements:

a) Occupational Health Protocol and Annex I submitted;
b) The Occupational Health Assessment attended

The Occupational Health Unit shall then issue an Occupational Health Certificate for all students

These Certificates will be subsequently forwarded to the Faculty of Dental Surgery.

10. All students who fail to satisfy the requirements above or who fail to disclose information about a physical or mental health problem that could affect patient safety may be barred from progressing with their studies as per University Regulations.

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

Section 1: Personal Details (to be completed by the student)

Name and Surname: ____ Date of Birth: ____________________________

Male/Female:____________________ Title: (Mr, Ms, Mrs, etc)_____________ ID/Passport No.: ____________________

Address: ____

____

Phone: _________________________ Mobile: ________________________Email: ___________________________

Your GP's name: ______________________________GP Mobile Phone:_______________________________________

GP's Address:____

____

GP Phone _________________________________ Email address of GP ____

Section 2: Medical Review (To be completed by examining doctor)

Health and Function Capabilities

2.1 Does the student have problems with any of the following?	**YES**	**NO**
Learning – such as dyslexia, dyspraxia, dyscalculia		
Vision – such as visual impairment, colour blindness, tunnel vision		
Communication – such as speech, hearing		
Mobility – such as walking, using stairs, balance		
Agility – such as bending, reaching up, kneeling down		
Dexterity – getting dressed, writing, using tools		
Difficulties in physical exertion – such as lifting, carrying, running		

2.2 Does the student have any of the following?	**YES**	**NO**
Allergies (such as to latex, medicines, foods)		
Chronic Skin conditions (such as eczema, psoriasis)		
Endocrine disease (such as diabetes)		
An eating disorder (such as bulimia, anorexia nervosa, compulsive eating)		
Chronic fatigue syndrome (or similar condition)		
Neurological disorder (such as epilepsy, multiple sclerosis)		
Sudden loss of consciousness (such as fits or seizures)		
Mental health problems requiring psychiatric intervention (e.g. anxiety, depression, phobias, OCD, nervous breakdown, personality disorders, over-dose or self-harm, drug or alcohol dependency)		
Did the student receive any treatment from a Psychiatrist, Psychotherapist or Counsellor?		
Is the student currently taking any medication or treatment?		

2.3 Does the student make use of special arrangements to accommodate an impairment or health problem? If in the affirmative, please give details (continue on a separate sheet if necessary). Please give details of the condition and list certification provided.

2.4 Does the student have any impairment or health condition not already mentioned above for which you think the student may require support during your education or training?

2.5 If the answer to 2.4 is yes, please indicate what medical reports are being provided.

2.6 List all countries in which the student has lived for more than six months, including dates:

Section 3: Doctor's Declaration

The University requires students' doctors to complete Section 2 on the basis of their knowledge of the student.

	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. Do you wish to provide any further information relating to conditions previously disclosed? (Please provide details on a separate sheet)		
5. Are you aware of any additional medical information not previously disclosed? 6. (If yes, provide details on a separate sheet)		

Doctor's Signature ____

Medical Council registration number _________________________________

Date ____

Stamp

Section 4: Student's Declaration

DECLARATION

Student Name: ___________________________________

I declare that to the best of my knowledge, the information provided is correct. I understand that progression in the course is subject to successful completion of a medical test and that any tests for which I have provided results may need to be repeated.

I am aware that I am bound to inform the Faculty of Dental Surgery of any impairment/health condition which develops during the course of studies.

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 patient safety may be barred from progressing with my studies as per Course Regulations.

Signature of Student: _______________ **Date: ___________________**

FOR OFFICE USE ONLY

- **Documentation complete and satisfactory -- no objection**
- **Documentation incomplete -- still requires ____**
- **Other:**

Signature: __________________________ **Date: __________________________**

Occupational Health Unit Officer in Charge

ANNEX 1
Faculty of Dental Surgery

HEALTH QUESTIONNAIRE
To be completed by the medical doctor who fills in Sections 2 and 3

Name and Surname: ________________________________

It is important that students be 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 the proposed studies. **Proof of Vaccinations/Results MUST BE ATTACHED to this document.**

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. If antibody titres are required for Rubella and Measles, these will be carried out by the student at your own expense.

Requirement:	Documentation Required	Result submitted (Tick as applicable)	Date of Result or Vaccination
	HEPATITIS B*[1]		
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 IMMUNODEFICIENCY VIRUS (HIV)		
HIV Screen	- HIV antibody Result (Tested within the previous 3 months)	❑HIV antibody (HIV) result	

[1] If the titre for Hepatitis B is <10 mIU/ml , the student is required to follow this procedure:
i. Take a booster;
ii. After 8 weeks take a titre and send the result to the Faculty on sue.bonnici-ciantar@um.edu.mt to send to the Occupational Health Unit;
iii. The Occupational Health Unit will send the clearance that the titre is fine, through the Faculty.

RUBELLA*[2]			
Immunity to Rubella	- Documented vaccination (2 doses)	❑ Vaccination records	
MEASLES			
Immunity to Measles	- Documented vaccination (2 doses)	❑ Vaccination records	

VARICELLA			
Immunity to Varicella	- Declaration of past infection from a medical practitioner **OR** - Documented vaccination **OR** - Result of Antibody titre to Varicella	❑ Declaration ❑ Vaccination records ❑ Varicella titre result attached	

DIPHTHERIA AND POLIO			
Immunity to Diphtheria Immunity to Polio	- Documented vaccination (at least 4 doses) - Documented vaccination (at least 4 doses)	❑ Vaccination records attached ❑ Vaccination records attached	

TUBERCULOSIS (TB)			
Free from active infection	- Students who have spent ≥ 6 months in a country reported as high risk for TB by the World Health are required to present A Quantiferon Annex 3 includes a list of countries deemed as high risk by the World Health Organisation. During the Occupational Health Assessment, all students will be assessed by the Occupational Health Physician to determine whether there are any students who require further TB screening.	❑Quantiferon	
Any Other Serious Medical Conditions			

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

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[2] Students who have no vaccination records for measles and rubella and do not wish to take the vaccine may forward immunity tests for rubella and measles. These will be carried out by the student at his/her own expense.

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 Unit Officer in Charge

L-Università ta' Malta
Faculty of Dental Surgery

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 facility in particular I will NOT:

- 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 Number

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