



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 a potential health care professional, students have a duty to provide the relevant information to the Faculty of Medicine and Surgery. Failure to disclose information about a physical or mental health problem (that could affect patient safety) would be in breach of the University Suitability to Practice Regulations. All medical and sensitive personal information students provide will be held in complete confidence by the Faculty of Medicine & Surgery and the Occupational Health Unit. The Faculty of Medicine and 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 - within three months prior to commencement of elective. Students are required to submit their documentation to the Occupational Health Unit by email to the Occupational Medical Officer in charge on [ohu.phc@gov.mt](mailto: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.

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

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

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

### **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 Medicine and Surgery.

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 (to be filled in 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 filled in by the examining doctor)**

**Health and Function Capabilities**

**2.1 Does the student have problems with any of the following? (If yes, please comment in the line below)**

a) **Learning** – such as dyslexia, dyspraxia, dyscalculia. (YES/NO)

---

b) **Vision** – such as visual impairment, colour blindness, tunnel vision. (YES/NO)

---

c) **Communication** – such as speech, hearing. (YES/NO)

---

d) **Mobility** – such as walking, using stairs, balance. (YES/NO)

---

e) **Agility** – such as bending, reaching up, kneeling down. (YES/NO)

---

f) **Dexterity** – getting dressed, writing, using tools. (YES/NO)

---

g) **Physical exertion** – such as lifting, carrying, running. (YES/NO)

---

## 2.2 Does the student have any of the following?

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

**2.3 Does the student use any special arrangements to accommodate an impairment or health problem? If in the affirmative, please give details (continue on 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 2.3 is yes please indicate what medical reports are being provided.**

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

### Section 3: Doctor's Declaration

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

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

Doctor's Signature \_\_\_\_\_

Medical Council registration number \_\_\_\_\_

Date \_\_\_\_\_

<p><b>Stamp</b></p>
---------------------

## Section 4: Student's Declaration

### DECLARATION

**Student:**

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 Medicine and 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 attending the clinical placement in Malta.

**Signature of Student:** \_\_\_\_\_

**Date:** \_\_\_\_\_

As approved by Faculty Board at its meeting held on 23 May 2017 and revised by the Occupational Health Committee on 3 April 2019. Approved by Faculty Board at its meeting on 16 April 2019. Revised by the Occupational Health Committee on 17 September 2019. Approved by the Faculty Board on 15 October 2019. Approved by the Faculty Board on 9 April 2020. Approved by the Faculty Board on 13 April 2021. Approved by the Faculty Board on 22 February 2022. As recommended by the Occupational Health Committee on 9 April 2024 and as approved by Faculty Board at its meeting held on 30 April 2024.

### 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**

**HEALTH QUESTIONNAIRE**  
to be completed by the medical doctor who fills in Sections 2 and 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 your 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 anti-body titres are required for Rubella and Measles, these will be carried out by the student at his/her own expense.

<b>Requirement:</b>	<b>Documentation Required</b>	<b>Result submitted</b> (Tick as applicable)	<b>Date of result or vaccination</b>
<b>HEPATITIS B</b>			
Evidence of immunity or absence of markers of infectivity.	Hepatitis B antibody (anti-HBs) result  <b>If anti HBs is less than 10mIU/ml</b> Hepatitis B Surface Antigen (HBsAg) result (Tested within the previous 3 months)	<input type="checkbox"/> anti-HBs > 10 mIU/ml  <input type="checkbox"/> HBsAg negative	
<b>HEPATITIS C (HCV)</b>			
Hepatitis C screen	Hepatitis C antibody result (Tested within the previous 3 months)	<input type="checkbox"/> Hepatitis C antibody result	
<b>HUMAN IMMUNDEFICIENCY VIRUS (HIV)</b>			
HIV Screen	HIV antibody Result (Tested within the previous 3 months)	<input type="checkbox"/> HIV antibody result	



<b>RUBELLA *</b>			
Immunity to Rubella	- Documented vaccination (2 doses)	<input type="checkbox"/> Vaccination records attached	

<b>MEASLES *</b>			
Immunity to Measles	- Documented vaccination (2 doses)	<input type="checkbox"/> Vaccination records attached	

<b>VARICELLA</b>			
Immunity to Varicella	-Declaration of past infection from a medical practitioner OR  -Documented vaccination OR -Result of Antibody titre to Varicella	<input type="checkbox"/> Declaration/Vaccination records/titre result attached	

<b>DIPHTERIA and POLIO</b>			
Immunity to Diphtheria	-Documented vaccination (at least 4 doses)	<input type="checkbox"/> Vaccination records attached	
Immunity to Polio	-Documented vaccination (at least 4 doses)	<input type="checkbox"/> Vaccination records attached	

<b>TUBERCULOSIS (TB)</b>		
Free from active infection	-Students who have spent $\geq 6$ months in a country reported as high risk for TB by the World Health Organisation are required to present a Quantiferon  -Annex 3 includes a list of countries deemed as high risk by the World Health Organisation.	<input type="checkbox"/> Quantiferon result attached (if applicable)
<b>Any Other Serious Medical Conditions</b>		

Doctor's Signature \_\_\_\_\_

Medical Council registration number \_\_\_\_\_

Date \_\_\_\_\_

<b>Stamp</b>
--------------

**FOR OFFICE USE ONLY**

- Documentation complete and satisfactory -- no objection
- Documentation incomplete -- still requires \_\_\_\_\_
- Other: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Occupational Health Unit Officer in Charge

\* a. 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 [facultyoffice.ms@um.edu.mt](mailto:facultyoffice.ms@um.edu.mt) to send it to the Occupational Health Unit;
- iii. The Occupational Health Unit will send the clearance that the titre is fine, through the Faculty.

b. 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.



**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 the teaching hospital. I will be attending. 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 and Surname (IN BLOCK LETTERS)

\_\_\_\_\_

Identification Number

\_\_\_\_\_

Mobile Number

Date: \_\_\_\_\_



**L-Università ta' Malta**  
Faculty of Medicine & Surgery

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