Faculty of Dental Surgery

OCCUPATIONAL HEALTH PROTOCOL

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 Restorative Dentistry Course
Preparatory Course for Diploma in Dental Surgery Assistance
Diploma in Dental Surgery Assistance Course

Applicability for Courses commencing in October 2017 and later
1. The occupational health assessment is requested by the Board of the Faculty of Dental Surgery once applicants receive their official letter of acceptance from the University, in terms of the course bye-laws, or the course regulations, as applicable. The Senior Executive of the Medical School shall forward a list of all first year students to the Occupational Health Medical Unit (OHU), Ministry for Energy and Health.

International Students
2. International Students are required to send their duly filled in Health Form (as per ANNEX 1) completed by a private medical doctor or an occupational physician together with the results of all the tests to the OHU, prior to the commencement of the 2nd semester of the respective course.

Local Students
3. The OHU shall inform local students about the date when their occupational health assessment shall take place.

4. A standard physical examination, with particular attention to the upper limbs, is conducted by officials from the OHU. This shall also include a verification of the immunisation record and any medical information submitted. The Health Form (as per ANNEX 2) is duly filled in and any pending tests shall be electronically booked and taken at the OHU.

5. A signed consent is obtained prior to any blood tests for infectious diseases. (as per ANNEX 3).

Certification and Liability
6. The OHU shall issue a clearance certificate for all local and international students. These Certificates are subsequently forwarded to the Senior Executive of the Medical School.

7. All students who fail to undergo the assessment or are not deemed eligible for this certificate, as issued by the OHU, students who do not fulfil this requirement shall be barred from attending the clinical placements.
8. Local Students who have any missing vaccinations need to follow this procedure:

8.1 Students should contact the National Immunisation Services (NIS), Floriana Health Centre on 21243314 for an appointment from Monday to Friday from 0800 to 1330hrs.

8.2 Those students who have not yet reached their majority age of 18 need to produce a letter of consent for vaccination signed by a parent or guardian. The full name of the parent or guardian must be printed below the signature on the letter of consent.

8.3 Students should take with them the following documents to the National Immunisation Services (NIS) Floriana Health Centre:
   a. The National Identity Card;
   b. The Immunization Record;
   c. The Letter of Acceptance sent by the Registrar’s Office of the University of Malta; and
   d. The Form in Annex 4 duly filled in.

8.4 The Immunisation Staff will evaluate the immunization status and advice will be given on pending vaccines. Hepatitis B vaccine will be administered to those who require it.

8.5 Post-vaccination seroconversion titre should be done 6-8 weeks after the last dose of the Hepatitis B vaccination course. For the post-vaccination seroconversion titre students need to go to the Health Centre of the student’s locality and take with them:
   a. The National Identity Card;
   b. The Immunization Record;
   c. The Letter of Acceptance sent by the Registrar’s Office of the University of Malta; and
   d. The Form in Annex 5 duly filled in.

8.6 Prescription for the Varicella vaccine can be obtained from the private General Practitioner or the Health Centre of the student’s locality. Varicella vaccine is not available from the National Immunisation Services, Floriana.

8.7 Students should submit the documentation to the Occupational Health Unit as soon as possible in order to get clearance from the Occupational Health Unit prior to the commencement of the 2nd semester of the respective course.

9. 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 6 in order to get authorisation for clinical placements at any teaching hospital.
Facility of Dental Surgery

Health Form for International Students

Name: ____________________________________ Date of Birth: __________________________

ID/PassportNo.: __________________________

Current Academic Institution: __________________________________________________________

Dates of Proposed Attachment: _________________________________________________________

Proposed Specialty/Area of Study: ______________________________________________________

It is important that you are properly protected from relevant infectious diseases prior to your clinical placement. The questionnaire below will help assess your fitness for your required duties.

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.

MEDICAL HISTORY

Please tick the relevant response

<table>
<thead>
<tr>
<th>Have you suffered from:</th>
<th>NO</th>
<th>YES</th>
<th>REMARKS</th>
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<td>1. Faints, fits or diseases of balance or nervous system</td>
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<td>8. Any other injury or illness</td>
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</tr>
</tbody>
</table>

List all countries in which you have lived for more than 6 months:

____________________________________________________________________________________

DECLARATION

Student:
I declare that the above answers are true and complete to the best of my knowledge and belief. I understand that acceptance for the clinical placement is subject to successful completion of a medical test and that any tests for which I have provided results may need to be repeated.

Signature of Student: __________________ Date: __________________

FOR OFFICE USE ONLY

□ Documentation complete and satisfactory -- no objection
□ Documentation incomplete -- still requires ________________________________________________
□ Other: ______________________________________________________________________________

Signature: ___________________________ Date: __________________
HEALTH QUESTIONNAIRE
(to be completed by your medical doctor or an occupational physician)

Please ask your medical doctor, or occupational physician, to complete the following details about your health and sign the statement at the bottom of the form. ALL details in the form should be duly filled in. No alternatives are offered to the following certifications required.

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<td>Hepatitis B antibody (anti-HBs) result OR Hepatitis B Surface Antigen (HBsAg) -- if positive, include Hep B 'e' antigen test Please attach copies of results dated within the previous 3 months (in English)</td>
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<td>□ anti-HBs &gt; 10 IU/ml □ HBsAg negative □ HB 'e' antigen if indicated</td>
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<td><strong>TUBERCULOSIS</strong></td>
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<td>Free from active infection</td>
<td>Chest X-Ray Report (CXR) OR Interferon-Gamma TB test OR Mantoux/Heaf Test Please attach results dated within the previous 3 months (in English)</td>
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<tr>
<td>Evidence of immunity</td>
<td>Documented vaccination (2 doses) OR Result of Antibody titre to rubella Please attach results / certification dated within the previous 3 months (in English)</td>
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<tr>
<td></td>
<td></td>
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<td>Free from infection</td>
<td>□ Hepatitis C antibody (HCV) result Please attach results / certification dated within the previous 3 months (in English)</td>
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**Medical Doctor:**
I certify that the information included about the above student is correct.

Signed: ____________________________
Name(Capitals): ____________________________
Position: ____________________________
Date: ____________________________

**Official Stamp**

**PLEASENOTE:**
- The Health Form should be signed. The form, as well as all the results, should then be scanned and sent to the Medical Officer in charge of Occupational Health via e-mail to:
  
  robert.a.galea@gov.mt

- Copies of ALL test results and documentation should be in ENGLISH. They should also be scanned and attached to the same email.
- The email should be sent before the commencement of the course.
- Insufficient information will require further enquiries.
- All information provided will be kept strictly confidential.
Faculty of Dental Surgery

Health Form for Local Students

Name: ___________________________ Date of Birth: ___________________________

ID/PassportNo.: ___________________________

Current Academic Institution: ___________________________

Dates of Proposed Attachment: ___________________________

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Medical Doctor: 
I certify that the information included about the above student is correct. 

Signed: ___________________________
Name(Capitals): ___________________
Position: _______________________
Date: ___________________________

Official Stamp

PLEASE NOTE:

- Details in the Occupational Health Protocol.
- All information provided will be kept strictly confidential.
CONSENT FORM

Occupational Health (Medical) Unit
Ground Floor
St. Luke’s Hospital
G’Mangia

Tel:  21224425

Consent for Blood Tests for Infectious Diseases
(including Rubella, Varicella, Hepatitis and HIV)

I, the undersigned, hereby give my consent to have bloods taken to be tested for any infectious diseases as may be required.

Signature:_______________________  Signature of witness:_______________________
Name:__________________________  Name of witness:__________________________
I.D. Card No:____________________  I.D. Card No. of witness:___________________
Passport No:____________________  Date:__________________________________
ANNEX 4

UNIVERSITY OF MALTA

Faculty of Dental Surgery

Applicants who have not taken any Hepatitis B Immunisations are required to fill in the form below and present it to the National Immunisation Services (NIS), Floriana Health Centre from Monday to Friday from 08:00 hrs to 13:30 hrs.

It is important that you take with you your immunization record, your national identity card and the University Library identity card

Surname: ________________________

Name: ________________________

I.D.Number: ________________________

Address: ____________________________________________

Town: ________________________ Post Code: ________________

Mobile Number: ________________________ Tel. Number: ________________

Date of Birth: ________________________

Signature: ________________________ Date: ________________
Hepatitis B Antibodies

Applicants who have taken the three doses of Hepatitis B Immunisations are required to fill in the form below and present it to the respective Health Centre of their locality from Monday to Friday from 0800 hrs to 1700 hrs or Saturday from 0800 to 1300hrs.

It is important that you take with you your immunization record, your national identity card and the University Library identity card.

Surname: ______________________
Name: ______________________
I.D.Number: ______________________
Address: ________________________________________________
Town: ______________________ Post Code: _____________
Mobile Number: ______________________ Tel. Number: _____________
Date of Birth: ______________________

Signature: ______________________ Date: _____________
ANNEX 6

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, I will abide by all the policies and regulations which are in force by the Infection Control Unit of any teaching hospital in particular:
   - perform any interventions that involve the use of sharps on patients;
   - go to the operating theatre and 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