Faculty of Dental Surgery

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
Preparatory Course for Diploma in Dental Surgery Assistance
Diploma in Dental Surgery Assistance Course
commencing in October 2018 and later

CONFIDENTIAL

Please read these instructions carefully

1. As a potential future dental health professional, students have a duty to provide the 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 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 Occupational Health Unit. The Faculty of Dental Surgery will only 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) should be submitted as soon as possible but not later than 30th November 2018. Students may submit their documentation to the Occupational Health Unit by email to the Medical Officer in charge Dr Robert Galea on robert.a.galea@gov.mt.

3. The Health Questionnaire found in Annex 1 should be submitted as soon as possible and prior to the commencement of the second semester of the respective course.

4. Original copies signed by the student’s family doctor must be verified by the Occupational Health Unit during the occupational health assessment appointment. The Occupational Health Unit cannot clear students without full original documentation.
5. All documentation should be in English.

6. 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
7. The Occupational Health Unit shall issue an Occupational Health Certificate for all students. These Certificates are subsequently forwarded to the Faculty of Dental Surgery.

8. All students who fail to submit the Occupational Health Protocol and Annex 1 or who fail to disclose information about a physical or mental health problem that could affect patient safety may be barred from attending the clinical placements as per course regulations.

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 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: __________________________________________

Phone: ___________ Mobile: ___________ Email: __________________________

Your GP’s name: __________________________________________ GP Mobile Phone: __________________________

GP’s Address: __________________________________________

GP Phone ___________ Email address of GP __________________________________________

Section 2: Health and Function Capabilities

2.1 Do you have problems with any of the following?

<table>
<thead>
<tr>
<th>a) Learning – such as dyslexia, dyspraxia, dyscalculia</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>b) Vision – such as visual impairment, colour blindness, tunnel vision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Communication – such as speech, hearing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) Mobility – such as walking, using stairs, balance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e) Agility – such as bending, reaching up, kneeling down</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f) Dexterity – getting dressed, writing, using tools</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g) Physical exertion – such as lifting, carrying, running</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2.2 Do you have any of the following?

a) **Allergies** (such as to latex, medicines, foods)

b) **Chronic Skin conditions** (such as eczema, psoriasis)

c) **Endocrine disease** (such as diabetes)

d) **An eating disorder** (such as bulimia, anorexia nervosa, compulsive eating)

e) **Chronic fatigue syndrome** (or similar condition)

f) **Neurological disorder** (such as epilepsy, multiple sclerosis)

g) **Sudden loss of consciousness** (such as fits or seizures)

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)

i) **Have you ever received treatment from a psychiatrist, psychotherapist or counsellor?**

j) **Are you currently taking any medication or treatment?**
2.3 Did you make use of special arrangements to accommodate an impairment or health problem? If you answer yes, please give details (continue on separate sheet if necessary)

Please give details of the condition and list certification provided.

2.4 Do you have any impairment or health condition, not already mentioned above, for 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 students’ doctors to verify the health information provided by students on the basis of their knowledge of the patient.

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. Can you confirm whether the disclosed information is correct?  
   YES NO

5. Do you wish to provide any further information relating to conditions previously disclosed? (please provide details on a separate sheet)  
   YES NO

6. Are you aware of any additional medical information, not previously disclosed?  
   YES NO

7. (If yes, provide details on a separate sheet)

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

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 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 attending the clinical placements 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: ___________________________

Dr. Robert Galea
Occupational Health Unit Officer in Charge
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 your 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.

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Documentation Required</th>
<th>Result submitted (Tick as applicable)</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HEPATITIS B</strong></td>
<td>Evidence of immunity or absence of markers of infectivity.</td>
<td>☐ Hepatitis B antibody (anti-HBs) result OR Hepatitis B Surface Antigen (HBsAg) to be provided if anti HBs titre is less than 10 IU/ml</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hepatitis B antibody (anti-HBs) result OR Hepatitis B Surface Antigen (HBsAg) to be provided if anti HBs titre is less than 10 IU/ml</td>
<td>☐ anti-HBs &gt; 10 IU/ml ☐ HBsAg negative</td>
<td></td>
</tr>
<tr>
<td><strong>HEPATITIS C (HCV)</strong></td>
<td>Hepatitis C screen</td>
<td>☐ Hepatitis C antibody (HCV) result (Tested within the previous 3 months)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HIV Screen</td>
<td>☐ HIV antibody (HIV) Result (Tested within the previous 3 months)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HIV Screen</td>
<td>☐ HIV antibody (HIV) result</td>
<td></td>
</tr>
<tr>
<td><strong>HUMAN IMMUNDEFICIENCY VIRUS (HIV)</strong></td>
<td>HIV Screen</td>
<td>HIV antibody (HIV) Result (Tested within the previous 3 months)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HIV Screen</td>
<td>HIV antibody (HIV) result</td>
<td></td>
</tr>
<tr>
<td><strong>RUBELLA</strong></td>
<td>Immunity to Rubella Documented vaccination (2 doses) OR Result of Antibody titre to Rubella</td>
<td>☐ Vaccination records ☐ Rubella titre</td>
<td></td>
</tr>
<tr>
<td><strong>MEASLES</strong></td>
<td>Immunity to Measles Documented vaccination (2 doses) OR Result of Antibody titre to Measles</td>
<td>☐ Vaccination records ☐ Measles titre</td>
<td></td>
</tr>
</tbody>
</table>
## VARICELLA

| Immunity to Varicella | Documented recollection of past infection | ☐ Declaration  
|-----------------------|------------------------------------------|-----------------|  
|                       | OR Documented vaccination (2 doses)      | ☐ Vaccination records  
|                       | OR Result of Antibody titre to Varicella | ☐ Varicella titre  

## TUBERCULOSIS

| Free from active infection | Chest X-Ray Report (CXR)  
and Interferon-Gamma TB test | ☐ CXR negative  
|---------------------------|----------------------------|-----------------|  
|                           |                            | ☐ Interferon-Gamma TB test negative  

Any Other Serious Medical Conditions

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

Doctor’s Signature ________________________________  
Medical Council registration number ____________  
Date ________________________________

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### FOR OFFICE USE ONLY

☐ Documentation complete and satisfactory -- no objection  
☐ Documentation incomplete -- still requires ________________________________  
☐ Other: ________________________________  

Signature: ________________________________  
Dr. Robert Galea  
Occupational Health Unit Officer in Charge  
Date: ________________________________
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 10IU/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 Number