



OHP submitted	
Annex 1 submitted	
Occupational health assessment	
Support recommended	

OCCUPATIONAL HEALTH PROTOCOL (OHP)

applicable to applicants for
courses offered by the Faculty of Health Sciences
commencing in October 2023 and later*

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 Occupational Health (Medical) Unit provides a medical service** to the Faculty by screening all its students prior to the commencement of clinical placements/practicals. 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 **as soon as possible but not later than 30 November 2023**. Students are required to submit their documentation in a sealed envelope (including their name, ID Card No and course) to the Faculty of Health Sciences at the Reception Desk, Faculty of Health Sciences.
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 30 November deadline.
4. The Faculty will send the complete original documentation to the Occupational Health Unit – OHU – following which an Occupational Health Assessment is scheduled.
5. Original copies signed by the student's family doctor/ GP must be verified by the Occupational Health Unit during the occupational health assessment appointment. The Occupational Health Unit cannot report on the student's fitness/medical condition without full original documentation.
6. All documentation should be in English.

7. 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

8. Once students satisfy the following requirements, the Occupational Health Unit shall issue an Occupational Health Certificate:
 - a) Occupational Health Protocol and Annex I submitted; and
 - b) the Occupational Health Assessment attended.

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

9. **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 safety may be barred from progressing with their studies as per course Bye-Laws.**
10. 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/practicals.

** This protocol is applicable to all students following the Certificate for Graduates of Non-EU/EEA Nursing Programmes, the Preparatory Course for the Bachelor of Science (Honours) in Nursing, the Bachelor of Science (Honours) programme (direct entry), the Bachelor of Science (Honours) in Physics, Medical Physics and Radiation Protection, the Master of Science in Diabetes Care, the Master of Science in Mental Health Studies, the Master of Science in Orthotics and Prosthetics and the Postgraduate Diploma in Dietetics. Students following particular areas of study within the Master of Science (both mainly taught and mainly research streams) **may** be directed by the Board to complete this protocol.*

Section 1: Personal Details

Name and Surname:

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
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- 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

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2.2 Do you have any of the following?

Yes	No
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- 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?**

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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?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you a relative of the applicant?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you hold the applicant’s medical record?	<input type="checkbox"/>	<input type="checkbox"/>
4. Can you confirm whether the disclosed information is correct?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you wish to provide any further information relating to conditions previously disclosed? (please provide details on a separate sheet)	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you aware of any additional medical information, not previously disclosed?	<input type="checkbox"/>	<input type="checkbox"/>
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 _____	<div>Stamp</div>
Medical Council registration number _____	
Date _____	

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 Health Sciences 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 safety, I may be barred from progressing with my studies as per the course Bye-Laws.

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



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.

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 10mIU/ml (only) Hepatitis B Surface Antigen (HBsAg) result (Tested within the previous 3 months)	<input type="checkbox"/> anti-HBs > 10mIU/ml <input type="checkbox"/> HBsAg negative	
HEPATITIS C (HCV)			
Hepatitis C screen	Hepatitis C antibody (HCV) result (Tested within the previous 3 months)	<input type="checkbox"/> Hepatitis C antibody (HCV) result	
HUMAN IMMUNODEFICIENCY VIRUS (HIV)			
HIV Screen	HIV antibody (HIV) Result (Tested within the previous 3 months)	<input type="checkbox"/> HIV antibody (HIV) result	
RUBELLA			
Immunity to Rubella	Documented vaccination (2 doses) OR Result of Antibody titre to Rubella	<input type="checkbox"/> Vaccination records <input type="checkbox"/> Rubella titre	
MEASLES			
Immunity to Measles	Documented vaccination (2 doses) OR Result of Antibody titre to Measles	<input type="checkbox"/> Vaccination records <input type="checkbox"/> 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	<input type="checkbox"/> Declaration <input type="checkbox"/> Vaccination records <input type="checkbox"/> Varicella titre	
TUBERCULOSIS (TB)			
Free from active infection	<p>All students are required to attend the appointment set by the Faculty to undertake the Mantoux test.</p> <p>Students exhibiting a negative Mantoux test will be offered BCG vaccination.</p> <p>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)</p> <p>Annex 3 includes a list of countries deemed as high risk by the World Health Organisation.</p> <p>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.</p>	<input type="checkbox"/> Mantoux <6mm <input type="checkbox"/> 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 Unit Officer in Charge

Date: _____



L-Università ta' Malta
Faculty of Health Sciences

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