

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 their respective faculty. 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 their Faculty and the Occupational Health Office. The Faculty 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 date. Students are required to submit their documentation to the Occupational Health Office by email to the Occupational Medical Officer in charge on ohps@um.edu.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

8. Once students satisfy the following requirements, the Occupational Health Office shall issue an Occupational Health Clearance for all students:
- a) Occupational Health Protocol and
 - b) Annex I submitted

These Clearances are subsequently forwarded to the Faculty.

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 (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 _____

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 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:** _____

FOR OFFICE USE ONLY

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

Signature: _____ **Date:** _____

Full Name of Occupational Health Officer: _____

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.

Requirement:	Documentation Required	Result submitted (Tick as applicable)	Date of result or vaccination
HEPATITIS B			
Evidence of immunity or absence of markers of infectivity.	Hepatitis B antibody (anti-HBs) result 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 result	

RUBELLA *			
Immunity to Rubella	Documented vaccination (2 doses)	☐ Vaccination records attached	
MEASLES *			
Immunity to Measles	Documented vaccination (2 doses)	☐ Vaccination records attached	
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/titre result attached	
DIPHTERIA and POLIO			
Immunity to Diphteria 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 Organisation are required to present a Quantiferon Annex 3 includes a list of countries deemed as high risk by the World Health Organisation.	☐ Quantiferon result attached (if applicable)	
Any Other Serious Medical Conditions			

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: _____

Full Name of Occupational Health Officer: _____

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 on ohps@um.edu.mt;

iii. The responsible Occupational Health Officer will confirm that the clearance is complete.

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: _____

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