L-Università ta' Malta
Faculty of Medicine & Surgery

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.

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.

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

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?

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 Do you 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) **Have you ever received treatment from a psychiatrist, psychotherapist or counsellor?** (YES/NO)

j) **Are you currently taking any medication or treatment?** (YES/NO)

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 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 progressing with my studies as per Regulation 4 paragraph (7) of the M.D. Regulations.

Signature of Student: ____________________________ **Date: _____________________**

FOR OFFICE USE ONLY

- ◻ Documentation complete and satisfactory -- no objection
- ◻ Documentation incomplete -- still requires __________________________
- ◻ Other:

Signature: _____________________________ Date: _______________

Occupational Health Unit Officer in Charge

L-Università ta' Malta
Faculty of Medicine & Surgery

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** 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 IMMUNDEFICIENCY VIRUS (HIV)		
HIV Screen	- HIV antibody Result (Tested within the previous 3 months)	❑ HIV antibody result	

RUBELLA			
Immunity to Rubella	- Documented vaccination (2 doses) **OR** - Result of Antibody titre to Rubella	❑ Vaccination records ❑ Rubella titre	
MEASLES			
Immunity to Measles	- Documented vaccination (2 doses) **OR** - Result of Antibody titre to Measles	❑ Vaccination records ❑ Measles titre	
VARICELLA			
Immunity to Varicella	-Declaration of past infection from a medical practitioner OR -Documented vaccination OR -Result of Antibody titre to Varicella		

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: - Chest X-Ray Report (CXR) -Annex 3 includes a list of countries deemed as high risk by the World Health Organisation.	
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 ____

Stamp

FOR OFFICE USE ONLY

- ☐ Documentation complete and satisfactory -- no objection
- ☐ Documentation incomplete -- still requires___________________________
- ☐ Other:______________________

Signature: ____________________ Date: ___________________________

Occupational Health Unit Officer in Charge

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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 and Surname (IN BLOCK LETTERS)

____
Identification Number

____
Mobile Number

Date: ________________________

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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

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. Approved by Faculty Board on 07 March 2023.