

To whom it may concern,

In line with applicable legislation, the Directorate for Educational Services is committed to safeguard the Health and Safety of potentially pregnant educators who work in close proximity with children.

In view of this, educators who are not immune and would like to receive vaccination against the chickenpox virus are kindly requested to submit the attached form duly counter-signed by their Medical Doctor and sent by **registered mail under confidential cover** addressed to:

**Ms Marthese Fenech,  
Ministry for Education and Employment,  
Room 339, Great Siege Road,  
Floriana.  
VLT 2000**

This form shall be used for the necessary administrative procedures required for the completion of this exercise and shall thereafter be retained in your personal file.

You are kindly asked to fill in page 1, of the attached forms, even if you are not going to avail yourself of the immunisation and send it to [maria.theresa.fenech@ilearn.edu.mt](mailto:maria.theresa.fenech@ilearn.edu.mt).

I, the undersigned, currently posted at \_\_\_\_\_ am formally informing you that:

I would like to be vaccinated as per medical note signed by \_\_\_\_\_

I would **not** like to be vaccinated against chickenpox. In so doing, I acknowledge that notwithstanding refusal, my employer has fulfilled his obligations under the applicable legislation.

Name and Surname: \_\_\_\_\_

ID card No: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Form to be filled by Medical Doctor**  
**Vaccination Against Chickenpox Virus**

**1. Details of Patient**

Name and Surname: \_\_\_\_\_

ID card: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**2. Has patient ever contracted the chickenpox virus?**

Yes                       No                       Not sure

**3. Has the patient been vaccinated against chickenpox?**

Yes                       No                       Not sure

**4. Does the patient require vaccination?**

Yes

Yes – one booster dose

Yes – two doses

Medical Doctor's Signature and stamp: \_\_\_\_\_

Registration Number: \_\_\_\_\_

Date: \_\_\_\_\_