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.

(**Females Only**)

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: _________________

Email (important):____

Signature: _____________________ Date: _____________________

Form to be filled by Medical Doctor

Vaccination Against Chickenpox Virus (Females Only)

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**

☐ **No**

Medical Doctor's Signature and stamp: _________________________________

Registration Number: ______________________ Date: __________________