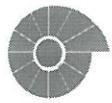




Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

Petroleum Development Oman
MEDICAL DEPARTMENTPLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALSPlace of examination **NML AL HAIL** Date **09/03/2023**

If a dependant enter employee's name here:

Surname: **AKHTAR**Surname **AKHTAR**Forenames **TANVEER**

Address

Home telephone number

99080164Birth date: **08/09/1971**Nationality: **PAKISTANI**

Country of birth:

Religion:

 Male Female Married Single Separated /Divorced

Relationship to employee

 Wife Son DaughterNumber of
children: **4**

Reason for examination

Pre-Employment

Job:

Pre-Overseas

Area:

Name and address of family doctor

List your last 3 jobs

(1)

(2)

Are you a Registered Disabled Person? (UK only)

Do you belong to any Medical Insurance Scheme?

DO YOU HAVE OR HAVE YOU HAD:- (Tick "Yes" or "No" column or put a (?) if uncertain exclude minor ailments.)

Y**N****Y****N****Y****N**

1. Sinus trouble

21. Cancer

HAVE YOU EVER BEEN:-

2. Neck swelling/glands

22. Heart Disease

40. Rejected for employment or
insurance for medical reasons

3. Difficulty in vision

23. Rheumatic fever

41. Awarded benefits for industrial
injury/illness

4. Any ear discharge

24. Abnormal heartbeat

42. Treated for a mental condition,
e.g. depression

5. Asthma/bronchitis

25. High blood pressure

43. Treated for problem drinking or
drug abuse

6. Hayfever /other significant allergy

26. Stroke

44. Exposed to toxic
substance or noise

7. Any skin trouble

27. Serious chest pain

FOR WOMEN ONLY

8. Tuberculosis

28. Any blood disease

45. Have you ever had:-

9. Shortness of breath

29. Kidney disease

46. An abnormal smear

10. Coughed/vomited blood

30. Blood in urine

47. Any gynaecological treatment

11. Severe abdominal pain

31. Diabetes

48. Are you pregnant?

12. Stomach ulcer

32. Headaches/migraine

49. HAVE YOU HAD AN ILLNESS
NOT MENTIONED ABOVE

13. Recurrent indigestion

33. Dizziness/fainting

50. NOT MENTIONED ABOVE

14. Jaundice or hepatitis

34. Epilepsy

51. Have you ever had:-

15. Gall Bladder disease

35. Joints/spinal trouble

52. An abnormal smear

16. Marked change in bowel habite

36. Surgical oporation

53. Any gynaecological treatment

17. Blood in stools (motions)

37. Serious accident/fracture

54. Are you pregnant?

18. Marked change in weight

38. Tropical disease

55. HAVE YOU HAD AN ILLNESS
NOT MENTIONED ABOVE

19. Varicose veins

39. Fear of heights

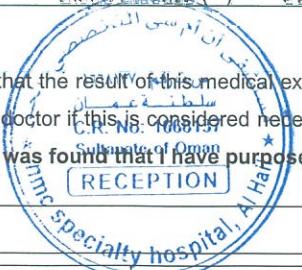
56. NOT MENTIONED ABOVE

20. Lump in breast/armpit

How much tobacco each day? **No**Average daily alcohol consumption **No**Have you ever taken elicited drugs? **(X)** PDO test all new/potential employees for elicited/recreational drugsFAMILY HISTORY: Diabetes **(X)**Tuberculosis **(X)**Epilepsy **(X)**Asthma **(X)**Eczema **(X)**Heart disease **(X)**High blood pressure **(X)**Stroke **(X)**Blood Disease **(X)**Cancer **(X)**

PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT:-

I declared these statements to be true to the best of my knowledge and belief and I agree that the result of this medical examination in general terms may be revealed to the Company if required, and the details sent to my own doctor if this is considered necessary by the examining medical officer. I am also aware that PDO reserve the right to dismiss me if it was found that I have purposely withheld important medical information.

Date: **9/3/23**

Signature of Applicant:



FOR COMPLETION BY EXAMINING DOCTOR OR NURSE
Further details of medical history and recreational activities

| N = Normal A = Abnormal (please describe) | | PHYSICAL EXAMINATION | | | | | | | | | |
|---|---|--|-------------|-------------------|--------------------|-------------------|------------------------------------|---------------------------|----------------------------------|------------------------|----------------|
| N | A | | | | | | | | | | |
| ✓ | | 1. Eyes & Pupils | | | | | | | | | |
| ✓ | | 2. E.N.T. | | | | | | | | | |
| ✓ | | 3. Teeth & Mouth | | | | | | | | | |
| ✓ | | 4. Lungs & Chest | | | | | | | | | |
| ✓ | | 5. Cardiovascular System | | | | | | | | | |
| ✓ | | 6. Abdo, Viscera | | | | | | | | | |
| ✓ | | 7. Hernial Orifices | | | | | | | | | |
| ✓ | | 8. Anus & Rectum | | | | | | | | | |
| ✓ | | 9. Genito-urinary | | | | | | | | | |
| ✓ | | 10. Extremities | | | | | | | | | |
| ✓ | | 11. Musculo-skeletal | | | | | | | | | |
| ✓ | | 12. Skin & Varicose Vns. | | | | | | | | | |
| ✓ | | 13. C.N.S. | | | | | | | | | |
| HEIGHT cm 176 | | WEIGHT kg 82 | BMI 26.4 | B.P. 138 84 | PULSE 90 /mins. | HEARING L R | VISION Uncorrected Corrected | DISTANT R 6/9 L 6/9 | NEAR R N L N | Colour Vision N. | Blood Group |
| N | A | LABORATORY AND OTHER SPECIAL INVESTIGATIONS | | | | | N | A | | | |
| ✓ | ✓ | 1. Urinalysis | | | | | ✓ | | 7. Audiogram | | |
| ✓ | | 2. Hb, Bloodcount, ESR | | | | | ✓ | | 8. Lung Function | | |
| ✓ | ✓ | 3. LFT, RFT, RBS | | | | | ✓ | | 9. Chest X Ray | | |
| ✓ | | 4. Drug Screen | | | | | ✓ | | 10. ECG | | |
| ✓ | | 5. Lipids (40 years +) | | | | | ✓ | | 11. CVS risk for 40 yrs. & above | | |
| ✓ | | 6. Sickle Cell test | | | | | ✓ | | 12. HIV, Hepatitis screening | | |

OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)

| ASSESSMENT: | | | | | | | | | | | |
|--|---------------|--|--------------------------|----------------------|--|--------------------------|-----------------|--|--------------------------|-------|--|
| <input type="checkbox"/> | FIT ALL AREAS | | <input type="checkbox"/> | FIT WITH RESTRICTION | | <input type="checkbox"/> | TEMPORARY UNFIT | | <input type="checkbox"/> | UNFIT | |
| <div style="display: flex; align-items: center;"> <div style="flex: 1;"> </div> <div style="flex: 1;"> <p>DR. NISANTH KALLINKEE Specialist - Internal Medicine MOH Lic. No. 16847</p> </div> <div style="flex: 1; text-align: right;"> </div> </div> | | | | | | | | | | | |
| <p>Date: 09/03/2023 Name (Block Capitals): Dr. / Nurse Signature:</p> | | | | | | | | | | | |

| REVIEW/CONSULTATION | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|
| <p>Internal Medicine Consultation for diabetes Control.</p> | | | | | | | | | | | |
| <div style="display: flex; align-items: center;"> <div style="flex: 1;"> <p>Date: Name (Block Capitals): Dr. / Nurse</p> </div> <div style="flex: 1;"> <p>DR. ASWATHY RAVI General Practitioner MOH Lic. No: 20556 nmc speciality hospital, Al Hail</p> </div> <div style="flex: 1; text-align: right;"> </div> </div> | | | | | | | | | | | |
| <p>Signature RECEPTION</p> | | | | | | | | | | | |

09.03.2023. -Reviewed the patient - He is asymptomatic
- OTG changed. Suggested diet modification
- Fit to continue work

DR.
09/03/2023

LINKEEL
Medicine
16847
Hospital, Al Hail