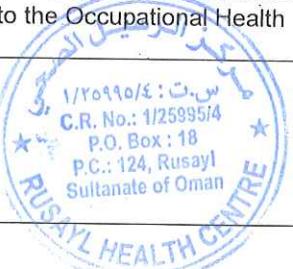


ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE
ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Mobile No. 79122743		Home/Leave Address:		Surname/Forenames MOHAMMAD ELIAS NUR MIAN																																																																																					
				Nationality BANGLADESH																																																																																					
				Company Number: 1635	Reference Indicator:																																																																																				
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<p>STATEMENT: I have read the above questions and the above answers are correct and no information concerning my present or past state of health has been withheld. I understand and agree that this form will be held as a confidential record by PDO Medical Department, and may be copied (by paper or secure electronic transmission) to the Occupational Health Services for the purpose of Health Surveillance and other Occupational Health review.</p>																																																																																									
Date: 01/05/22	Signature of Applicant: ELIAS		 <p>س.ت. ١٢٥٩٩٥٤ : C.R. No.: 1/25995/4 P.O. Box: 18 P.C.: 124, Rusayl Sultanate of Oman</p>																																																																																						

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										
<input checked="" type="checkbox"/>	1. Eyes & Pupils										
<input checked="" type="checkbox"/>	2. E.N.T.										
<input checked="" type="checkbox"/>	3. Teeth & Mouth										
<input checked="" type="checkbox"/>	4. Lungs & Chest										
<input checked="" type="checkbox"/>	5. Cardiovascular System										
<input checked="" type="checkbox"/>	6. Abdo. Viscera										
<input checked="" type="checkbox"/>	7. Hernial Orifices										
<input checked="" type="checkbox"/>	8. Anus & Rectum										
<input checked="" type="checkbox"/>	9. Genito-urinary										
<input checked="" type="checkbox"/>	10. Extremities										
<input checked="" type="checkbox"/>	11. Musculo-skeletal										
<input checked="" type="checkbox"/>	12. Skin & Varicose Vns.										
<input checked="" type="checkbox"/>	13. C.N.S.										
HEIGHT cm 166	WEIGHT kg 73.5	BMI 26.7	B.P. 110/70	PULSE 80 /mins.	HEARING L R Uncorrected Corrected	DISTANT R L	VISION NEAR R L	VISION			
<i>R 6/4 L 6/4</i>											
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS				N	A				
<input checked="" type="checkbox"/>	1. Urinalysis	<i>Triglycerides</i>						7. Audiogram			
<input checked="" type="checkbox"/>	2. Hb, Bloodcount, ESR	<i>Na 140 mg/dl</i>						8. Lung Function			
<input checked="" type="checkbox"/>	3. LFT, RFT, RBS	<i>Low lip (6 mm)</i>						9. Chest X-Ray			
<input checked="" type="checkbox"/>	4. Drug Screen	<i>0.400 - 3/12</i>						10. ECG			
<input checked="" type="checkbox"/>	5. Lipids (40 years +)							11. CVS risk for 40 yrs. & above			
<input checked="" type="checkbox"/>	6. Sickle Cell test							12. HIV, Hepatitis screening			

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

ASSESSMENT AND RECOMMENDATIONS:

FIT ALL AREAS FIT WITH RESTRICTION TEMPORARY UNFIT UNFIT

Date: 01/05/22 Name (Block Capitals): Dr. / Nurse



Signature: *[Signature]*



REVIEW/CONSULTATION

Date:

Name (Block Capitals): Dr. / Nurse

Signature: