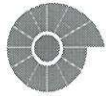




Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)



**Petroleum Development Oman
MEDICAL DEPARTMENT**

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Surname Musa Rawther		Forenames Abdul-Jabar		Address Marmul		Home telephone number 94930607	
Place of examination NMC		Date 17/10/23					
If a dependant enter employee's name here:							
Surname:				Forenames:			
Birth date:		Nationality INDIAN		Country of birth:		Religion: ISLAM	
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		<input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced		Relationship to employee <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter		Number of children: 2	
Reason for examination		Pre-Employment <input checked="" type="checkbox"/> Job: Driver		Pre-Overseas <input type="checkbox"/> Area:			
Name and address of family doctor				List your last 3 jobs			
				(1)			
				(2)			
Are you a Registered Disabled Person? (UK only) <input type="checkbox"/>				Do you belong to any Medical Insurance Scheme? <input type="checkbox"/>			
DO YOU HAVE OR HAVE YOU HAD:- (Tick "Yes" or "No" column or put a (?), if uncertain exclude minor ailments)							
Y		N		Y		N	
1. Sinus trouble		<input checked="" type="checkbox"/>		21. Cancer		<input checked="" type="checkbox"/>	
2. Neck swelling/glands		<input checked="" type="checkbox"/>		22. Heart Disease		<input checked="" type="checkbox"/>	
3. Difficulty in vision		<input checked="" type="checkbox"/>		23. Rheumatic fever		<input checked="" type="checkbox"/>	
4. Any ear discharge		<input checked="" type="checkbox"/>		24. Abnormal heartbeat		<input checked="" type="checkbox"/>	
5. Asthma/bronchitis		<input checked="" type="checkbox"/>		25. High blood pressure		<input checked="" type="checkbox"/>	
6. Hayfever /other significant allergy		<input checked="" type="checkbox"/>		26. Stroke		<input checked="" type="checkbox"/>	
7. Any skin trouble		<input checked="" type="checkbox"/>		27. Serious chest pain		<input checked="" type="checkbox"/>	
8. Tuberculosis		<input checked="" type="checkbox"/>		28. Any blood disease		<input checked="" type="checkbox"/>	
9. Shortness of breath		<input checked="" type="checkbox"/>		29. Kidney disease		<input checked="" type="checkbox"/>	
10. Coughed/vomited blood		<input checked="" type="checkbox"/>		30. Blood in urine		<input checked="" type="checkbox"/>	
11. Severe abdominal pain		<input checked="" type="checkbox"/>		31. Diabetes		<input checked="" type="checkbox"/>	
12. Stomach ulcer		<input checked="" type="checkbox"/>		32. Headaches/migraine		<input checked="" type="checkbox"/>	
13. Recurrent indigestion		<input checked="" type="checkbox"/>		33. Dizziness/fainting		<input checked="" type="checkbox"/>	
14. Jaundice or hepatitis		<input checked="" type="checkbox"/>		34. Epilepsy		<input checked="" type="checkbox"/>	
15. Gall Bladder disease		<input checked="" type="checkbox"/>		35. Joints/spinal trouble		<input checked="" type="checkbox"/>	
16. Marked change in bowel habits		<input checked="" type="checkbox"/>		36. Surgical operation		<input checked="" type="checkbox"/>	
17. Blood in stools (motions)		<input checked="" type="checkbox"/>		37. Serious accident/fracture		<input checked="" type="checkbox"/>	
18. Marked change in weight		<input checked="" type="checkbox"/>		38. Tropical disease		<input checked="" type="checkbox"/>	
19. Varicose veins		<input checked="" type="checkbox"/>		39. Fear of heights		<input checked="" type="checkbox"/>	
20. Lump in breast/armpit		<input checked="" type="checkbox"/>					
How much tobacco each day?				Average daily alcohol consumption			
Have you ever taken elicited drugs? () PDO test all new/potential employees for elicited/recreational drugs							
FAMILY HISTORY: Diabetes () Tuberculosis () Epilepsy () Asthma () Eczema () Heart disease () High blood pressure () Stroke () Blood Disease () Cancer ()							
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: 17/10/2023		Signature of Applicant: [Signature]					



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 Normal (Reacting to light)	
		2. E.N.T. N	
		3. Teeth & Mouth N	
		4. Lungs & Chest N	
		5. Cardiovascular System N	
		6. Abdo. Viscera N	
		7. Hernial Orifices N	
		8. Anus & Rectum N	
		9. Genito-urinary N	
		10. Extremities N	
		11. Musculo-skeletal N	
		12. Skin & Varicose Vns N	
		13. C.N.S.	
HEIGHT cm 179 cm	WEIGHT kg 83 145	BMI 25.9	B.P. 130 80
PULSE 64/min.		HEARING L R	VISION DISTANT R L NEAR R L Uncorrected Corrected
Colour Vision		Blood Group	
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS	
		1. Urinalysis	
		2. Hb, Bloodcount, ESR	
		3. LFT, RFT, RBS	
		4. Drug Screen	
		5. Lipids (40 years +)	
		6. Sickle Cell test	
		7. Audiogram	
		8. Lung Function	
		9. Chest X-Ray	
		10. ECG	
		11. CVS risk for 40 yrs. & above	
		12. HIV, Hepatitis screening	
OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)			
<div style="border: 2px solid blue; padding: 5px; display: inline-block; font-weight: bold; font-size: 2em;">FIT</div>			
ASSESSMENT:			
<input checked="" type="checkbox"/> FIT ALL AREAS <input type="checkbox"/> FIT WITH RESTRICTION <input type="checkbox"/> TEMPORARY UNFIT <input type="checkbox"/> UNFIT			
Date:	Name (Block Capitals): Dr. / Nurse		Signature: 1/1-25
REVIEW/CONSULTATION			
Date:	Name (Block Capitals): Dr. / Nurse		Signature: