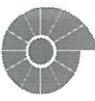
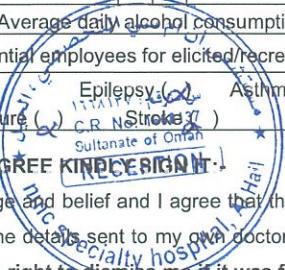
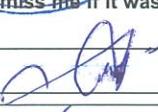




Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

 Petroleum Development Oman MEDICAL DEPARTMENT PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS		Surname AL SULAIMANI																																																					
		Forenames RAID ABDULLAH MOHAMMED																																																					
		Address																																																					
		Home telephone number																																																					
Place of examination NMC HOSPITAL Date 21/11/2022																																																							
If a dependant enter employee's name here:																																																							
Surname:		Forenames:																																																					
Birth date:	Nationality:	Country of birth:	Religion:																																																				
<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: 1																																																				
Reason for examination	Pre-Employment <input type="checkbox"/>	Job:																																																					
	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.)																																																							
<table border="1"> <thead> <tr> <th>Y</th> <th>N</th> </tr> </thead> <tbody> <tr><td><input checked="" type="checkbox"/></td><td>21. Cancer</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>22. Heart Disease</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>23. Rheumatic fever</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>24. Abnormal heartbeat</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>25. High blood pressure</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>26. Stroke</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>27. Serious chest pain</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>28. Any blood disease</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>29. Kidney disease</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>30. Blood in urine</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>31. Diabetes</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>32. Headaches/migraine</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>33. Dizziness/fainting</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>34. Epilepsy</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>35. Joints/spinal trouble</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>36. Surgical operation</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>37. Serious accident/fracture</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>38. Tropical disease</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>39. Fear of heights</td></tr> </tbody> </table>		Y	N	<input checked="" type="checkbox"/>	21. Cancer	<input checked="" type="checkbox"/>	22. Heart Disease	<input checked="" type="checkbox"/>	23. Rheumatic fever	<input checked="" type="checkbox"/>	24. Abnormal heartbeat	<input checked="" type="checkbox"/>	25. High blood pressure	<input checked="" type="checkbox"/>	26. Stroke	<input checked="" type="checkbox"/>	27. Serious chest pain	<input checked="" type="checkbox"/>	28. Any blood disease	<input checked="" type="checkbox"/>	29. Kidney disease	<input checked="" type="checkbox"/>	30. Blood in urine	<input checked="" type="checkbox"/>	31. Diabetes	<input checked="" type="checkbox"/>	32. Headaches/migraine	<input checked="" type="checkbox"/>	33. Dizziness/fainting	<input checked="" type="checkbox"/>	34. Epilepsy	<input checked="" type="checkbox"/>	35. Joints/spinal trouble	<input checked="" type="checkbox"/>	36. Surgical operation	<input checked="" type="checkbox"/>	37. Serious accident/fracture	<input checked="" type="checkbox"/>	38. Tropical disease	<input checked="" type="checkbox"/>	39. Fear of heights	<table border="1"> <thead> <tr> <th>Y</th> <th>N</th> </tr> </thead> <tbody> <tr><td><input checked="" type="checkbox"/></td><td>40. Rejected for employment or insurance for medical reasons</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>41. Awarded benefits for industrial injury/illness</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>42. Treated for a mental condition, e.g. depression</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>43. Treated for problem drinking or drug abuse</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>44. Exposed to toxic substance or noise</td></tr> </tbody> </table>		Y	N	<input checked="" type="checkbox"/>	40. Rejected for employment or insurance for medical reasons	<input checked="" type="checkbox"/>	41. Awarded benefits for industrial injury/illness	<input checked="" type="checkbox"/>	42. Treated for a mental condition, e.g. depression	<input checked="" type="checkbox"/>	43. Treated for problem drinking or drug abuse	<input checked="" type="checkbox"/>	44. Exposed to toxic substance or noise
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How much tobacco each day? <input checked="" type="checkbox"/>		Average daily alcohol consumption <input checked="" type="checkbox"/>																																																					
Have you ever taken elicited drugs? () PDO test all new/potential employees for elicited/recreational drugs																																																							
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PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN ON THE LINE. 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: 22/11/2022		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						
<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.	12/6 / 12/6 with glasses					
HEIGHT cm	WEIGHT kg	BMI	B.P.	PULSE 77/mins.			
176	85	27.41	135 / 93	HEARING L R N R			
		VISION					
		DISTANT NEAR					
		R L R L		Colour Vision			
		Uncorrected	Corrected	Blood Group			
		12/6	12/6	N			
				N			
LABORATORY AND OTHER SPECIAL INVESTIGATIONS							
N	A						
<input checked="" type="checkbox"/>	1. Urinalysis	Urine - protein +					
<input checked="" type="checkbox"/>	2. Hb, Bloodcount, ESR	ESR - high					
<input checked="" type="checkbox"/>	3. LFT, RFT, RBS						
<input checked="" type="checkbox"/>	4. Drug Screen						
<input checked="" type="checkbox"/>	5. Lipids (40 years +)						
<input checked="" type="checkbox"/>	6. Sickle Cell test						
OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)							
FIT							
ASSESSMENT:							
<input checked="" type="checkbox"/>	FIT ALL AREAS	<input type="checkbox"/>	FIT WITH RESTRICTION	<input type="checkbox"/>	TEMPORARY UNFIT	<input type="checkbox"/>	UNFIT
Date: 21/1/2022 Name (Block Capitals): Dr. / Nurse					Signature:		
REVIEW/CONSULTATION					 <div style="display: flex; justify-content: space-between;"> <div style="text-align: center;"> <p>RECEPTION</p> <p>nmc specialty hospital, Al Hail</p> </div> <div style="text-align: center;"> <p>Dr. SHIVA KUMAR SINGH General Practitioner MOH License No: 0177 nmc specialty hospital, Al Hail</p> </div> </div>		
Date: 21/1/2022 Name (Block Capitals): Dr. / Nurse					Signature:		