


## Fitness to Work Certificate

<b>Employee Data</b>		Date : 31/1/21	
Name : GURADEET SINGH		Department/Company	
I.D No : 115849009	Age : 34yrs	Occupation : Heavy vehicle driver	
<b>Type of Medical Evaluation</b>		<b>Mark those applying ✓</b>	
A1 Aircraft refueling		A6 Fire /Emergency response team work	
A2 Breathing apparatus		A7 Professional driving	
A3 Business traveler		A8 Remote location work	
A4 Catering and food preparation		A9 Transfers – group A country	
A5 Crane or forklift driving& all heavy vehicles		A10 Transfers – group B country	
<p><b>Health Advisor Statement:</b> The above named person has been examined according to the statements laid down in "Protocols and Guidance Notes on the Medical Evaluation of Fitness to Work". At this time his/her fitness to work status for the above tasks is as follows.</p>			
Fit with no restrictions			
Fit with following restriction(s)			
The employee is fit for above work but should avoid the following task(s)	Temporary restriction	Permanent restriction	
Work near moving machinery or sharp edges			
Working at height			
Pulling, pushing, or carrying weight over ____ Kg			
Ascend/descend ladders or stairs.			
Operate motor vehicles, forklifts or heavy machinery			
Use of a respirator			
Repetitive twisting of valves or wrenches			
Flying			
Other (Specify) – Working Conditions (Extreme / Interir Clinic / Confined Work Place / Noicy )			
Temporary Unfit until			
Permanently Unfit		Date	
Name of health advisor	Signature	Date : 31/1/21	


**Dr. B. VENKATESH KUMAR**  
**CARDIOLOGIST**  
**MOH NO#14581**



## 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

<b>Surname</b> <u>MURADEET SINGH</u>		<b>Forenames :</b>	
<b>Address</b>		<b>Home telephone number</b>	
<b>Place of examination</b> <b>BADR AL SAMAA</b>	<b>Date</b> <u>31/1/21</u>		
If a dependant enter employee's name here:			
<b>Surname:</b>		<b>Forenames:</b>	
<b>Birth date:</b> <u>01.09.1980</u>	<b>Nationality:</b>	<b>Country of birth:</b>	<b>Religion:</b>
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced	<b>Relationship to employee</b> <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter	
<b>Reason for examination</b> Pre-Employment Job: <input type="checkbox"/>		<b>Number of children:</b>	
<b>Pre-Overseas Area:</b> <input type="checkbox"/>			
<b>Name and address of family doctor</b>		<b>List your last 3 jobs</b>	
		(1)	
		(2)	
<b>Are you a Registered Disabled Person? (UK only)</b> <input type="checkbox"/>		<b>Do you belong to any Medical Insurance Scheme?</b> <input type="checkbox"/>	
<b>DO YOU HAVE OR HAVE YOU HAD:-</b> (Tick "Yes" or "No" column or put a (?) if uncertain exclude minor ailments.)			
	Y	N	Y
1. Sinus trouble	✓		
2. Neck swelling/glands	✓		
3. Difficulty in vision	✓		
4. Any ear discharge	✓		
5. Asthma/bronchitis	✓		
6. Hayfever/other significant allergy	✓		
7. Any skin trouble	✓		
8. Tuberculosis	✓		
9. Shortness of breath	✓		
10. Coughed/vomited blood	✓		
11. Severe abdominal pain	✓		
12. Stomach ulcer	✓		
13. Recurrent indigestion	✓		
14. Jaundice or hepatitis	✓		
15. Gall Bladder disease	✓		
16. Marked change in bowel habits	✓		
17. Blood in stools (motions)	✓		
18. Marked change in weight	✓		
19. Varicose veins	✓		
20. Lump in breast/armpit	✓		
	Y	N	Y
21. Cancer	✓		
22. Heart Disease	✓		
23. Rheumatic fever	✓		
24. Abnormal heartbeat	✓		
25. High blood pressure	✓		
26. Stroke	✓		
27. Serious chest pain	✓		
28. Any blood disease	✓		
29. Kidney disease	✓		
30. Blood in urine	✓		
31. Diabetes	✓		
32. Headaches/migraine	✓		
33. Dizziness/fainting	✓		
34. Epilepsy	✓		
35. Joints/spinal trouble	✓		
36. Surgical operation	✓		
37. Serious accident/fracture	✓		
38. Tropical disease	✓		
39. Fear of heights	✓		
<b>HAVE YOU EVER BEEN:-</b>			
40. Rejected for employment or insurance for medical reasons		Y	N
41. Awarded benefits for industrial injury/illness		Y	N
42. Treated for a mental condition, e.g. depression		Y	N
43. Treated for problem drinking or drug abuse		Y	N
44. Exposed to toxic substance or noise		Y	N
<b>FOR WOMEN ONLY</b>			
Have you ever had:-			
45. An abnormal smear		Y	N
46. Any gynaecological treatment		Y	N
47. Are you pregnant?		Y	N
48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE		Y	N
<b>How much tobacco each day?</b>		<b>Average daily alcohol consumption</b>	
<b>Have you ever taken elicited drugs?</b> (X) PDO test all new/potential employees for elicited/recreational drugs			
<b>FAMILY HISTORY:</b> Diabetes (X) Tuberculosis (X) Epilepsy (X) Asthma (X) Eczema (X)			
Heart disease (X) High blood pressure (X) Stroke (X) Blood Disease (X) Cancer (X)			
<b>PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT:-</b>			
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.			
<b>Date:</b> <u>31/1/21</u>		<b>Signature of Applicant:</b>	
<b>FOR COMPLETION BY EXAMINING DOCTOR OR NURSE</b>			
<b>Further details of medical history and recreational activities</b>			

**Dr. B. VENKATESH KUMAR**  
**CARDIOLOGIST**  
**MOH NO#14581**

