

MEDICAL FITNESS CERTIFICATE FOR TRUCK OMAN LLC

NAME **GIRISH THUVAKKAD RAMACHANDRAN**

AGE/D.O.B	41 Y, 05.01.1979	DATE	02.01.2020
PASS/ID NO:	105916232	GENDER	MALE
VISION-RT-EYE	6/6 WITHOUT GLASSES	HEIGHT	169 CM
LT-EYE	6/6 WITHOUT GLASSES	WEIGHT	73 KG
HEART	NORMAL	BP	110/72 mmHg
LUNGS	NORMAL	PULSE	78/Min
ABDOMEN	NORMAL	CNS	NORMAL
SKIN	NORMAL	ENT	NORMAL

INVESTIGATIONS

FBS	HIGH
HBa1C	9.10%
BLOOD GROUP	A POSITIVE
HAEMOGRAM	NORMAL
LIPID PROFILE	DLP
RFT	NORMAL
LFT	NORMAL
SICKLING TEST	NEGATIVE
URE	NORMAL
ECG	NORMAL
AUDIOGRAM	Normal hearing threshold with mild 4000Hz dip B/L
FRAMINGHAM REPORT	Probability of developing cardiovascular disease in next 10 years is 8.62%

COMMENTS * To use adequate ear protection in high noise environment
 * T2DM - Since 5 months on Medicines- Advised for dose modification

CONCLUSION MEDICALLY FIT

MEDICALLY FIT

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س.ت: ٥٧٩٨٨، ص.ب: ٤٤٣، الرمز البريد: ١٦٣
روي سلطنة عمان، هاتف: ٤٧٩٧٦٥، فاكس: ٤٧٩٩٧٥
الخوير: ٦٦٢٠، [٤٤٨٨٣٢٢] | صغار: ٧٤٦٢٠، [٤٥٦٧٩٩] | صالة: ٣٢٩١٨٣، [٤٥٦٧٩٩] | بركاء: ٦٦٢٠، [٤٤٨٨٩٤] | لربو: ٣٢٥٤٧٧٧٧، [٤٧٥٧٤٣] | فلح: ٦٦٢٠، [٤٤٨٨٧٧] | البريد الإلكتروني: info@badroman.com

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 **SIRISHA THUVAKKAD RAMMENDONDRAN**

Forenames :

Address

Home telephone number

Place of examination **BADR AL SAMAA** Date **02/01/20**

If a dependant enter employee's name here:

Surname:

Forenames:

Birth date:

Nationality:

Country of birth:

Religion:

Male Female

Married Single Separated /Divorced

Relationship to employee

Wife Son Daughter

Number of
children:

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.)

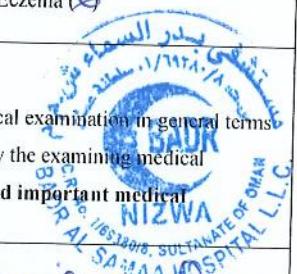
	Y	N		Y	N		Y	N
1. Sinus trouble	<input checked="" type="checkbox"/>	<input type="checkbox"/>	21. Cancer	<input checked="" type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER BEEN:-		
2. Neck swelling/glands	<input checked="" type="checkbox"/>	<input type="checkbox"/>	22. Heart Disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>	40. Rejected for employment or insurance for medical reasons		<input checked="" type="checkbox"/>
3. Difficulty in vision	<input checked="" type="checkbox"/>	<input type="checkbox"/>	23. Rheumatic fever	<input checked="" type="checkbox"/>	<input type="checkbox"/>	41. Awarded benefits for industrial injury/illness		<input checked="" type="checkbox"/>
4. Any ear discharge	<input checked="" type="checkbox"/>	<input type="checkbox"/>	24. Abnormal heartbeat	<input checked="" type="checkbox"/>	<input type="checkbox"/>	42. Treated for a mental condition, e.g. depression		<input checked="" type="checkbox"/>
5. Asthma/bronchitis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	25. High blood pressure	<input checked="" type="checkbox"/>	<input type="checkbox"/>	43. Treated for problem drinking or drug abuse		<input checked="" type="checkbox"/>
6. Hayfever/other significant allergy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	26. Stroke	<input checked="" type="checkbox"/>	<input type="checkbox"/>	44. Exposed to toxic substance or noise		<input checked="" type="checkbox"/>
7. Any skin trouble	<input checked="" type="checkbox"/>	<input type="checkbox"/>	27. Serious chest pain	<input checked="" type="checkbox"/>	<input type="checkbox"/>	FOR WOMEN ONLY		
8. Tuberculosis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	28. Any blood disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Have you ever had:-		
9. Shortness of breath	<input checked="" type="checkbox"/>	<input type="checkbox"/>	29. Kidney disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>	45. An abnormal smear		
10. Coughed/vomited blood	<input checked="" type="checkbox"/>	<input type="checkbox"/>	30. Blood in urine	<input checked="" type="checkbox"/>	<input type="checkbox"/>	46. Any gynaecological treatment		
11. Severe abdominal pain	<input checked="" type="checkbox"/>	<input type="checkbox"/>	31. Diabetes	<input checked="" type="checkbox"/>	<input type="checkbox"/>	47. Are you pregnant?		
12. Stomach ulcer	<input checked="" type="checkbox"/>	<input type="checkbox"/>	32. Headaches/migraine	<input checked="" type="checkbox"/>	<input type="checkbox"/>	48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE		
13. Recurrent indigestion	<input checked="" type="checkbox"/>	<input type="checkbox"/>	33. Dizziness/fainting	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
14. Jaundice or hepatitis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	34. Epilepsy	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
15. Gall Bladder disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>	35. Joints/spinal trouble	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
16. Marked change in bowel habits	<input checked="" type="checkbox"/>	<input type="checkbox"/>	36. Surgical operation	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
17. Blood in stools (motions)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	37. Serious accident/fracture	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
18. Marked change in weight	<input checked="" type="checkbox"/>	<input type="checkbox"/>	38. Tropical disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
19. Varicose veins	<input checked="" type="checkbox"/>	<input type="checkbox"/>	39. Fear of heights	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
20. Lump in breast/armpit	<input checked="" type="checkbox"/>	<input 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: **02/01/20**

Signature of Applicant: **Grimish**

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

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

Muthu - Team

N = Normal A = Abnormal (please describe)		PHYSICAL EXAMINATION									
<input checked="" type="checkbox"/>	1. Eyes & Pupils	Normal / Reactive									
<input checked="" type="checkbox"/>	2. E.N.T.	Normal									
<input checked="" type="checkbox"/>	3. Teeth & Mouth	Normal									
<input checked="" type="checkbox"/>	4. Lungs & Chest	Normal									
<input checked="" type="checkbox"/>	5. Cardiovascular System	Normal									
<input checked="" type="checkbox"/>	6. Abdo. Viscera	Normal									
<input checked="" type="checkbox"/>	7. Hernial Orifices	Normal									
<input checked="" type="checkbox"/>	8. Anus & Rectum	Normal									
<input checked="" type="checkbox"/>	9. Genito-urinary	Normal									
<input checked="" type="checkbox"/>	10. Extremities	Normal									
<input checked="" type="checkbox"/>	11. Musculo-skeletal	Normal									
<input checked="" type="checkbox"/>	12. Skin & Varicose Vns.	Normal									
<input checked="" type="checkbox"/>	13. C.N.S.	Normal									
HEIGHT cm	WEIGHT kg	BMI	B.P.	PULSE 48/mins.	HEARING L ✓ R ✓	DISTANT Uncorrected Corrected	VISION NEAR R L R L 6/6 6/6 N/6 N/6	Colour Vision (N)	Blood Group A+		
169	73.5	25.7	110/72								
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS				N	A				
<input checked="" type="checkbox"/>	1. Urinalysis	Mild ketosis				<input checked="" type="checkbox"/>		7. Audiogram			
<input checked="" type="checkbox"/>	2. Hb, Bloodcount, ESR	B12						8. Lung Function			
<input checked="" type="checkbox"/>	3. LFT, RFT, RBS							9. Chest X-Ray			
<input checked="" type="checkbox"/>	4. Drug Screen							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.)

Temp x 5 months on DHA.

FIT

ASSESSMENT:

FIT ALL AREAS FIT WITH RESTRICTION TEMPORARY UNFIT UNFIT

Date: 02/01/20 Name (Block Capitals): Dr. / Nurse Signature:

REVIEW/CONSULTATION

Dr. SAID
MBBS DLO
NT SPECIALIST
DENTIST NO: 9019

Date: 02/01/20 Name (Block Capitals): Dr. / Nurse Signature:

B. VENKATESH KUMAR
CARDIOLOGIST
MOH NO#14581

