



مجموعة مستشفيات ومستوصفات بدر الساماء

BADR AL SAMAA

GROUP OF HOSPITALS & POLYCLINICS

More Than Healthcare ... Humane Care



Organization Accredited
by Joint Commission International
Badr Al Samaa Hospital, Ruwi & Al Khoud

MEDICAL FITNESS CERTIFICATE FOR TRUCKOMAN

NAME	SATNAM SINGH	
AGE/D.O.B	42 Y, 23.10.1978	DATE 05.04.2021
PASS/ID NO:	10692222	GENDER MALE
VISION-RT-EYE	6/6 WITHOUT GLASSES	HEIGHT 180 CM
LT-EYE	6/6 WITHOUT GLASSES	WEIGHT 74 KG
HEART	NORMAL	BP 130/76 mmHg
LUNGS	NORMAL	PULSE 58/Min
ABDOMEN	NORMAL	CNS NORMAL
SKIN	NORMAL	ENT NORMAL
INVESTIGATIONS		
FBS	NORMAL	
BLOOD GROUP	O POSITIVE	
HAEMOGRAM	NORMAL	
LFT	NORMAL	
RFT	NORMAL	
LIPID PROFILE	NORMAL	
SICKLING TEST	NEGATIVE	
URINE ROUTINE	NORMAL	
ECG	SINUS BRADYCARDIA	
AUDIOGRAM	Normal hearing threshold with minimal dip at 4000Hz B/L	
FRAMINGHAM SCORE	Probability of developing cardiovascular disease in next 10 years is 1.4%	

COMMENTS * To use adequate ear protection in high noise environment

CONCLUSION MEDICALLY FIT

Signature:

Dr. B. VENKATESH KUMAR
CARDIOLOGIST
MOH NO#14581

FIT



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Email: info@badroman.com

المقر الرئيسي :

س. ت. : ١٦٩٣٨٠٨، ص. ب. : ٤٤٣، الرمز البريدي : ١١٢

روي سلطنة عمان، هاتف : ٢٤٧٩٩٧٦٠، فاكس : ٢٤٧٩٩٧٦٥

الخوير : ٢٤٤٨٨٣٢٢ | صحار : ٢٤٨٩٦٦٠ | الفوس : ٢٤٥٤٦٠٩٩ | صلالة : ٢٣٢٩٨٣٠

بركاء : ٢٦٨٨٤٩١٠ | صور : ٢٥٥٤٦١١٢ | نزوى : ٢٥٤٤٧٧٧ | فلج : ٢٦٥٤١٣١

البريد الإلكتروني : info@badroman.com

Fitness to Work Certificate

Employee Data		Date : 3/4/21	
Name : SATNAM SINGH		Department/Company	
I.D No : 106922222	Age : 42yrs	Occupation : Heavy vehicle driver	
Type of Medical Evaluation		Mark those applying ✓	
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>Health Advisor Statement: 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	3/4/21
Name of health advisor	Signature	Date : 3/4/21	



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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

Place of examination BADR AL SAMAA		Date 3/4/21	Surname SATNAM SINGH	
If a dependant enter employee's name here:			Forenames :	
Birth date: 25.02.1977			Address	
Nationality:			Home telephone number	
Country of birth:			Religion:	
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female <input 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	
Reason for examination Pre-Employment Job: <input type="checkbox"/>			Number of children:	
Pre-Overseas Area: <input type="checkbox"/>				
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? NU		Average daily alcohol consumption NU		
Have you ever taken elicited drugs? <input checked="" type="checkbox"/> 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: 3/4/21		Signature of Applicant: Satnam Singh		
FOR COMPLETION BY EXAMINING DOCTOR OR NURSE				
Further details of medical history and recreational activities				

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