

Medical Fitness Certificate

Name of the Examined employee: RABNAWAZ ALI GHULAM

Age: 42

ID NUMBER:

Job Title:

Date of Medical Examination: 15.02.2021

Examining Physician: DR. REHMAT

Medical Centre: APOLLO HOSPITAL MUSCAT

Company:

Assessment Result:

Fit to work without restrictions

This Certificate is valid for 2 years from the date of medical examination

Fitness Classifications:

- Fit to work without restrictions
- Fit to work with restriction
- Unfit to work Temporarily or Definitely

Restrictions List:

- R1: Unfit to work offshore, on marine vessels and in remote locations.
R2: Unfit for Lifting and strenuous efforts.
R3: Unfit to work in certain countries, check with geomarkethealth advisor.
R4: Unfit to work in jobs requiring precise color vision.
R5: Unfit to work in job with high level of noise.
R6: Unfit to work in high risk of malaria countries.
R7: Unfit to work in extreme heat.
R8: Unfit to work in extreme cold.
R9: Contact Geomarket health advisor/international medical coordinator – there exist specific restriction.
R10: Unfit to work for a temporarily of time until further notice.
R11: Unfit to work in jobs requiring good visual acuity (eg: driving company vehicle).
R12: Fit only for defined period of time (1, 3 or 6 months) and must be reassessed and fitness redefined.
R13: Unfit to drive company vehicle.
R14: Unfit to fly long haul flights.
R15: Unfit to work in heights and confined spaces.

Examining Physician Stamp and signature

Hospital/Clinic Seal

DR. REHMAT MANSOOR SOLANKI
Medical Officer
MO. No 14330
APOLLO HOSPITAL - MUSCAT



CONFIDENTIAL MEDICAL TO BE COMPLETED BY THE EMPLOYEE

Med-check History Form		Name:	Rabnawaz Ali Gihulam	
		GIN #	6920	
Place of examination	Date	Mobile #		
Apollo Hospital	15/2/2021	95749886		
Age: 42	Nationality: Pakistani	Blood Group	B+	
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated / Divorced	Number of children: 1		
DO YOU HAVE OR HAVE YOU HAD:- (Tick "Yes" or "No" column or put a (?) if uncertain exclude minor ailments.)				
	Y	N		Y
1. Sinus trouble			21. Cancer	
2. Neck swelling/glands			22. Heart Disease	
3. Difficulty in vision			23. Rheumatic fever	
4. Any ear discharge			24. Abnormal heartbeat	
5. Asthma/bronchitis			25. High blood pressure	
6. Hayfever /other significant allergy			26. Stroke	
7. Any skin trouble			27. Serious chest pain	
8. Tuberculosis			28. Any blood disease	
9. Shortness of breath			29. Kidney disease	
10. Coughed/vomited blood			30. Blood in urine	
11. Severe abdominal pain			31. Diabetes	
12. Stomach ulcer			32. Headaches/migraine	
13. Recurrent indigestion			33. Dizziness/fainting	
14. Jaundice or hepatitis			34. Epilepsy	
15. Gall Bladder disease			35. Joints/spinal trouble	
16. Marked change in bowel habits			36. Surgical operation	
17. Blood in stools (motions)			37. Serious accident/fracture	
18. Marked change in weight			38. Tropical disease	
19. Varicose veins			39. Fear of heights	
20. Lump in breast/armpit				
How much tobacco each day?		Average daily alcohol consumption		
None		None		
Have you ever taken elidited drugs? ()				
FAMILY HISTORY: Diabetes (X) Tuberculosis (X) Epilepsy (X) Asthma (X) Eczema (X)				
Heart disease (X) High blood pressure (X) Stroke (X) Blood Disease (X) Cancer (X)				
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's Doctors, and the details sent to them by the examining Doctor.				
Date: 15/2/2021				
Signature of Applicant: Rabnawaz				