

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 geomarket health 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).

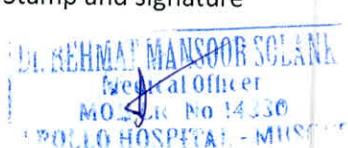
R12: Fit only for defined period of time (1, 3 or 6 months) and must be reassessed and fitness redefined.

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



CONFIDENTIAL MEDICAL TO BE COMPLETED BY THE EMPLOYEE

Med-check History Form-		Name:	Rabnawaz Ali Githulam	
		GIN #	6920	
Place of examination		Date	Mobile # 95749886	
Apollo Hospital		15/2/2021		
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.)				
1. Sinus trouble	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	21. Cancer	Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	HAVE YOU EVER BEEN:-
2. Neck swelling/glands	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	22. Heart Disease	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	40. Rejected for employment or insurance for medical reasons
3. Difficulty in vision	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	23. Rheumatic fever	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	41. Awarded benefits for industrial injury/illness
4. Any ear discharge	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	24. Abnormal heartbeat	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	42. Treated for a mental condition, e.g. depression
5. Asthma/bronchitis	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	25. High blood pressure	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	43. Treated for problem drinking or drug abuse
6. Hayfever /other significant allergy	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	26. Stroke	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	44. Exposed to toxic substance or noise
7. Any skin trouble	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	27. Serious chest pain	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	FOR WOMEN ONLY
8. Tuberculosis	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	28. Any blood disease	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	Have you ever had:-
9. Shortness of breath	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	29. Kidney disease	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	45. An abnormal smear
10. Coughed/vomited blood	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	30. Blood in urine	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	46. Any gynaecological treatment
11. Severe abdominal pain	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	31. Diabetes	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	47. Are you pregnant?
12. Stomach ulcer	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	32. Headaches/migraine	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE
13. Recurrent indigestion	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	33. Dizziness/fainting	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	
14. Jaundice or hepatitis	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	34. Epilepsy	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	
15. Gall Bladder disease	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	35. Joints/spinal trouble	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	
16. Marked change in bowel habits	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	36. Surgical operation	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	
17. Blood in stools (motions)	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	37. Serious accident/fracture	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	
18. Marked change in weight	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	38. Tropical disease	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	
19. Varicose veins	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	39. Fear of heights	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	
20. Lump in breast/armpit	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>			
How much tobacco each day?	N/C		Average daily alcohol consumption	N/C
Have you ever taken elicited drugs? ()	N/C			
FAMILY HISTORY: Diabetes <input checked="" type="checkbox"/> Tuberculosis <input type="checkbox"/> Epilepsy <input checked="" type="checkbox"/> Asthma <input checked="" type="checkbox"/> Eczema <input type="checkbox"/> Heart disease <input checked="" type="checkbox"/> High blood pressure <input checked="" type="checkbox"/> Stroke <input checked="" type="checkbox"/> Blood Disease <input checked="" type="checkbox"/> Cancer <input checked="" type="checkbox"/>				
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			
Signature of Applicant:				