

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS



Petroleum Development Oman
MEDICAL DEPARTMENT

INITIAL EXAMINATION REPORT

Place of examination <i>Badrat</i> Date: <i>24/04/2019</i>		Surname <i>AMARJEET SINGH</i>																																																																																																																	
		Forenames <i>AMARJEET SINGH</i>																																																																																																																	
		Address <i>9524174.</i>																																																																																																																	
If a dependant or partner enter employee's name here:- Surname: <i>Sonam, Alkhan</i> Forenames: <i></i>		Home Telephone Number <i></i>																																																																																																																	
Birth date <i>13/01/1968</i> Nationality <i>INDIAN</i>		Country of birth <i>INDIA</i> Religion <i>SIKH</i>																																																																																																																	
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Single <input type="checkbox"/> Widow (er)		Relationship to employee <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Fiancee		Number of Children <i></i>																																																																																																															
<input type="checkbox"/> Female <input checked="" type="checkbox"/> Married <input type="checkbox"/> Divorced/ Separated																																																																																																																			
Reason for examination <i></i>		Job:- <i></i>																																																																																																																	
<input type="checkbox"/> Pre-employment <input type="checkbox"/> Pre-overseas		Area:- <i></i>																																																																																																																	
Name and address of family doctor <i></i>		List your last 3 jobs (1) <i></i> (2) <i></i> (3) <i></i>																																																																																																																	
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.)																																																																																																																			
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PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT:- I declare 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.																																																																																																																			
Date: <i>24/04/2019.</i>		Signature of applicant: <i>Amarjeet Singh</i>																																																																																																																	



N = Normal A = Abnormal (please describe)		PHYSICAL EXAMINATION								
N	A									
		1. Eyes & Pupils <i>poesbyopia</i>								
		2. E.N.T. <i>RT:- 4KHz dip, Lt:- High & SN HL = 4KHz dip</i>								
		3. Teeth & Mouth								
		4. Lungs & Chest								
		5. Cardiovascular System								
		6. Abdo. Viscera								
		7. Hernial Orifices								
		8. Anus & Rectum								
		9. Genito-urinary								
		10. Extremities								
		11. Musculo-skeletal								
		12. Skin & Varicose Vns								
		13. C.N.S.								
		14. Breasts								
HEIGHT cm <i>185</i>	WEIGHT kg <i>65 Kgs</i>	B.P. <i>154 100/80</i>	PULSE <i>80</i>	HEARING <i>L 20dBHL R 18.3dBHL</i>	VISION Uncorrected Corrected	DISTANT <i>6/6 6/6</i>	NEAR <i>NP L6 N6 N6</i>	COLOUR VISION <i>Present</i>	BLOOD GROUP	
N	A	LABORATORY AND SPECIAL INVESTIGATIONS					N	A		
		1. Urinalysis					<input checked="" type="checkbox"/>		6. Audiogram	
		2. Hb Blood count ESR					<input checked="" type="checkbox"/>		7. Lung Function	
		3. Serum Profile					<input checked="" type="checkbox"/>		8. Chest X-Ray	
		4. Stool					<input checked="" type="checkbox"/>		9. Drug Screen	
		5. E.C.G.					<input checked="" type="checkbox"/>		10. CR Screen = Country Request (e.g. H.I.V.)	

OTHER FINDINGS (Physique, scars, disabilities, mental stability etc.)

*Hlun R.P. | Review after
1 week or
Recheck R.P. after
1 week*

ASSESSMENT

FIT ALL AREAS FIT HOME SERVICE ONLY UNFIT/UNSUITABLE MAY BE REASSESSED

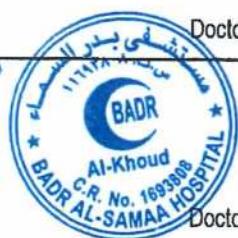
Date

Signature

Name (Block Capitals)

Doctor/Sister

REVIEW/CONSULTATION



Date

Signature

Name (Block Capitals)

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