

MEDICAL FITNESS CERTIFICATE FOR TRUCKOMAN

NAME **KALLINGAL SAHAJAN SAJEEV**

AGE/D.O.B	41 Y,02.05.1980	DATE	26.04.2021
PASS/ID NO:	69314144	GENDER	MALE
VISION-RT-EYE	6/6 WITHOUT GLASSES	HEIGHT	167 CM
LT-EYE	6/6 WITHOUT GLASSES	WEIGHT	88 KG
HEART	NORMAL	BP	144/92 mmHg
LUNGS	NORMAL	PULSE	88/ Min
ABDOMEN	NORMAL	CNS	NORMAL
SKIN	NORMAL	ENT	NORMAL

INVESTIGATIONS

FBS	NORMAL
BLOOD GROUP	B POSITIVE
HAEMOGRAHM	NORMAL
LFT	NORMAL
RFT	NORMAL
LIPID PROFILE	NORMAL
SICKLING TEST	NEGATIVE
URINE ROUTINE	NORMAL
ECG	NORMAL
AUDIOGRAM	Normal hearing threshold with dip at 4000Hz B/L
FRAMINGHAM SCORE	Probability of developing cardiovascular disease in next 10 years is 0.8%

CONCLUSION MEDICALLY FIT

Signature:

SEAL

Dr.B.VENKATESH KUMAR
CARDIOLOGIST
MOH NO#14581



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المقر الرئيسي :
 س.ت : ٥٩٣٨٨ ، ص. ب: ٤٤٣ ، الرمز البريدي : ١٢٢
 روی سلطنة عمان. هانف: ٦٧٦٧٣ ، فاكس: ٢٤٧٩٩٧٦٥
 ٢٤٣٩١٨٣ ، ٢٤٣٨٣٢٢ ، ٢٤٣٨٣٢٣ ، ٢٤٣٨٣٢٤ ، ٢٤٣٨٣٢٥
 بريكماء: ٢٤٣٨٣٢٦ ، صور: ٢٤٣٨٣٢٧ ، زوي: ٢٤٣٨٣٢٨ ، فلاح: ٢٤٣٨٣٢٩
 البريد الالكتروني: 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

Place of examination BADR AL SAMAA	Date 26/04/21	Home telephone number
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If a dependant enter employee's name here:

Surname:	Forenames:				
Birth date: 02-05-1980	Nationality: Indian				
Married	Single	Separated /Divorced	Relationship to employee	Number of children:	
<input checked="" type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/>	<input type="checkbox"/> Wife	<input type="checkbox"/> Son	<input type="checkbox"/> Daughter

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) <input type="checkbox"/>	Do you belong to any Medical Insurance Scheme? <input type="checkbox"/>
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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		
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		
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		
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		
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		
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? Nil Average daily alcohol consumption Bair creations - 90ml/week

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: 26/04/21 Signature of Applicant:

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

SHT x 1yr - Amb 5 107
T2mm x 1yr - Senior - m 507
DGP - Rosmarin x 1yr - 507.

Dr. B. VENKATESH KUMAR
CARDIOLOGIST
MOH NO#14581

N = Normal A = Abnormal (please describe)			PHYSICAL EXAMINATION								
N	A										
		1. Eyes & Pupils	Normal & Reactive								
		2. E.N.T.	Eye more atleast → normal								
		3. Teeth & Mouth	Normal								
		4. Lungs & Chest	Normal								
		5. Cardiovascular System	S.h (P) No murmur								
		6. Abdo. Viscera	soft, M (P)								
		7. Hernial Orifices	Normal								
		8. Anus & Rectum	Normal								
		9. Genito-urinary	Normal								
		10. Extremities	Normal								
		11. Musculo-skeletal	Normal								
		12. Skin & Varicose Vns.	Normal								
		13. C.N.S.	Normal								
HEIGHT cm	WEIGHT kg	BMI	B.P.	PULSE 88/mins.	HEARING L R	DISTANT Uncorrected Corrected	VISION R L R L	NEAR	Colour Vision	Blood Group	
167	88.1	31.6	144/92				6/6 6/6 6/6 6/6		(A)	B+	
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS				N	A				
✓		1. Urinalysis						7. Audiogram			
✓		2. Hb, Bloodcount, ESR						8. Lung Function			
✓		3. LFT, RFT, RBS						9. Chest X-Ray			
		4. Drug Screen						10. ECG			
✓		5. Lipids (40 years +)						11. CVS risk for 40 yrs. & above			
✓		6. Sickle Cell test						12. HIV, Hepatitis screening			
OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)											
ASSESSMENT:				Also on Regular medication x 1ygr.							
FIT ALL AREAS		<input checked="" type="checkbox"/> FIT WITH RESTRICTION		<input type="checkbox"/> TEMPORARY UNFIT		<input type="checkbox"/> UNFIT					
Date: 26/04/20 Name (Block Capitals): Dr. / Nurse Signature:											
REVIEW/CONSULTATION											
Date: 26/04/20 Name (Block Capitals): Dr. / Nurse Signature:											

Take adequate ear protection
in noisy environment

[Signature]
S. A. P.P.
M.B.B.S., D.N.B (ENT), D.L.O.
Specialist Ent Surgeon
M.H. Lic No.: 18387

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