

## MEDICAL FITNESS CERTIFICATE FOR (P.D.O)

**NAME** ZUBAIR UL HASSAN

AGE/D.O.B	32 Y, 25.05.1989	DATE	16.08.2021
PASS/ID NO:	111743523	GENDER	MALE
VISION-RT-EYE	6/6 WITHOUT GLASSES	HEIGHT	165 CM
LT-EYE	6/6 WITHOUT GLASSES	WEIGHT	81 KG
HEART	NORMAL	BP	120/70 mmHg
LUNGS	NORMAL	PULSE	78/Min
ABDOMEN	NORMAL	CNS	NORMAL
SKIN	NORMAL	ENT	NORMAL

### INVESTIGATIONS

FBS	NORMAL
BLOOD GROUP	O POSITIVE
HAEMOGRAM	NORMAL
LIPIDPROFILE	Slightly elevated triglycerides
RFT	NORMAL
LFT	NORMAL
SICKLING TEST	NEGATIVE
URE	NORMAL
AUDIOGRAM	NORMAL AUDIOMETRIC THRESHOLD

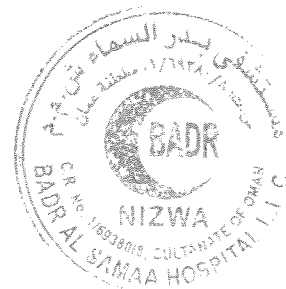
**COMMENTS** Slightly elevated triglycerides- Advised lifestyle modification

**CONCLUSION** MEDICALLY FIT

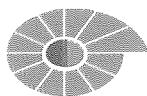
Signature: \_\_\_\_\_

DR. AMMAR ABED YAS HADAD  
 MEDICAL NO. 11174  
 BADR AL SAMAA HOSPITAL, RUWI

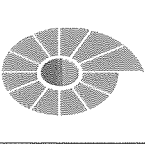
**FIT**



## INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)



PLEASE COMPLETE YOUR PERSONAL  
DETAILS IN BLOCK CAPITALS



Petroleum Development Oman

MEDICAL DEPARTMENT

PLEASE COMPLETE YOUR PERSONAL

DETAILS IN BLOCK CAPITALS

Surname

Forenames : Zubair UL Hassan

Address

Home telephone number

Place of examination BADR AL SAMAA

Date 16/8/2021

If a dependant enter employee's name here:

Surname:

Forenames:

Birth date: 22/5/1989

Nationality:

Country of birth:

Religion:

☒ Male ☐ Female

☐ Married ☐ Single ☐ Separated /Divorced

Relationship to employee

☐ Wife ☐ Son ☐ Daughter

Number of children:

Reason for examinationPre-EmploymentJob:

Pre-OverseasArea:

Name and address of family doctor

List your last 3 jobs

Are you a Registered Disabled Person? (UK only)

Do you belong to any Medical Insurance Scheme?

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"/>	21. Cancer		<input checked="" type="checkbox"/>	HAVE YOU EVER BEEN:-		
2. Neck swelling/glands		<input checked="" type="checkbox"/>	22. Heart Disease		<input checked="" type="checkbox"/>	40. Rejected for employment or insurance for medical reasons		<input checked="" type="checkbox"/>
3. Difficulty in vision		<input checked="" type="checkbox"/>	23. Rheumatic fever		<input checked="" type="checkbox"/>	41. Awarded benefits for industrial injury/illness		<input checked="" type="checkbox"/>
4. Any ear discharge		<input checked="" type="checkbox"/>	24. Abnormal heartbeat		<input checked="" type="checkbox"/>	42. Treated for a mental condition, e.g. depression		<input checked="" type="checkbox"/>
5. Asthma/bronchitis		<input checked="" type="checkbox"/>	25. High blood pressure		<input checked="" type="checkbox"/>	43. Treated for problem drinking or drug abuse		<input checked="" type="checkbox"/>
6. Hayfever/other significant allergy		<input checked="" type="checkbox"/>	26. Stroke		<input checked="" type="checkbox"/>	44. Exposed to toxic substance or noise		<input checked="" type="checkbox"/>
7. Any skin trouble		<input checked="" type="checkbox"/>	27. Serious chest pain		<input checked="" type="checkbox"/>	FOR WOMEN ONLY		
8. Tuberculosis		<input checked="" type="checkbox"/>	28. Any blood disease		<input checked="" type="checkbox"/>	Have you ever had:-		
9. Shortness of breath		<input checked="" type="checkbox"/>	29. Kidney disease		<input checked="" type="checkbox"/>	45. An abnormal smear		<input checked="" type="checkbox"/>
10. Coughed/vomited blood		<input checked="" type="checkbox"/>	30. Blood in urine		<input checked="" type="checkbox"/>	46. Any gynaecological treatment		<input checked="" type="checkbox"/>
11. Severe abdominal pain		<input checked="" type="checkbox"/>	31. Diabetes		<input checked="" type="checkbox"/>	47. Are you pregnant?		<input checked="" type="checkbox"/>
12. Stomach ulcer		<input checked="" type="checkbox"/>	32. Headaches/migraine		<input checked="" type="checkbox"/>	48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE		<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?

Average daily alcohol consumption

Have you ever taken elicited drugs? (X) PDO test all new/potential employees for elicited/recreational 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:-

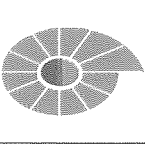
I declared these statements to be true to the best of my knowledge and belief and I agree that the result of this medical examination in general terms may be revealed to the Company if required, and the details sent to my own doctor if this is considered necessary by the examining medical officer.I am also aware that PDO reserve the right to dismiss me if it was found that I have purposely withheld important medical information.

Date: 16/8/2021

Signature of Applicant: [Signature]

FOR COMPLETION BY EXAMINING DOCTOR OR NURSE

Further details of medical history and recreational activities



Petroleum Development Oman

MEDICAL DEPARTMENT

PLEASE COMPLETE YOUR PERSONAL

DETAILS IN BLOCK CAPITALS

Surname

Forenames : Zubair UL Hassan

Address

Home telephone number

Place of examination BADR AL SAMAA

Date 16/8/2021

If a dependant enter employee's name here:

Surname:

Forenames:

Birth date: 22/5/1989

Nationality:

Country of birth:

Religion:

☒ Male ☐ Female

☐ Married ☐ Single ☐ Separated /Divorced

Relationship to employee

☐ Wife ☐ Son ☐ Daughter

Number of children:

Reason for examinationPre-EmploymentJob:

Pre-OverseasArea:

Name and address of family doctor

List your last 3 jobs

Are you a Registered Disabled Person? (UK only)

Do you belong to any Medical Insurance Scheme?

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"/>	21. Cancer		<input checked="" type="checkbox"/>	HAVE YOU EVER BEEN:-		
2. Neck swelling/glands		<input checked="" type="checkbox"/>	22. Heart Disease		<input checked="" type="checkbox"/>	40. Rejected for employment or insurance for medical reasons		<input checked="" type="checkbox"/>
3. Difficulty in vision		<input checked="" type="checkbox"/>	23. Rheumatic fever		<input checked="" type="checkbox"/>	41. Awarded benefits for industrial injury/illness		<input checked="" type="checkbox"/>
4. Any ear discharge		<input checked="" type="checkbox"/>	24. Abnormal heartbeat		<input checked="" type="checkbox"/>	42. Treated for a mental condition, e.g. depression		<input checked="" type="checkbox"/>
5. Asthma/bronchitis		<input checked="" type="checkbox"/>	25. High blood pressure		<input checked="" type="checkbox"/>	43. Treated for problem drinking or drug abuse		<input checked="" type="checkbox"/>
6. Hayfever/other significant allergy		<input checked="" type="checkbox"/>	26. Stroke		<input checked="" type="checkbox"/>	44. Exposed to toxic substance or noise		<input checked="" type="checkbox"/>
7. Any skin trouble		<input checked="" type="checkbox"/>	27. Serious chest pain		<input checked="" type="checkbox"/>	FOR WOMEN ONLY		
8. Tuberculosis		<input checked="" type="checkbox"/>	28. Any blood disease		<input checked="" type="checkbox"/>	Have you ever had:-		
9. Shortness of breath		<input checked="" type="checkbox"/>	29. Kidney disease		<input checked="" type="checkbox"/>	45. An abnormal smear		<input checked="" type="checkbox"/>
10. Coughed/vomited blood		<input checked="" type="checkbox"/>	30. Blood in urine		<input checked="" type="checkbox"/>	46. Any gynaecological treatment		<input checked="" type="checkbox"/>
11. Severe abdominal pain		<input checked="" type="checkbox"/>	31. Diabetes		<input checked="" type="checkbox"/>	47. Are you pregnant?		<input checked="" type="checkbox"/>
12. Stomach ulcer		<input checked="" type="checkbox"/>	32. Headaches/migraine		<input checked="" type="checkbox"/>	48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE		<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					

N = Normal A = Abnormal (please describe)				PHYSICAL EXAMINATION							
N	A										
/		1. Eyes & Pupils		N							
/		2. E.N.T.		N							
/		3. Teeth & Mouth		N							
/		4. Lungs & Chest		N							
/		5. Cardiovascular System		N							
/		6. Abdo. Viscera		N							
/		7. Hernial Orifices		N							
/		8. Anus & Rectum		N							
/		9. Genito-urinary		N							
/		10. Extremities		N							
/		11. Musculo-skeletal		N							
/		12. Skin & Varicose Vns.		N							
/		13. C.N.S.		N							
HEIGHT cm	WEIGHT kg	BMI	B.P.	PULSE /mins.	HEARING L R	VISION DISTANT NEAR Uncorrected Corrected				Colour Vision	Blood Group
165	81	29.8	120 70	78		R	L	R	L	N	O+
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. Sickie Cell test								12. HIV, Hepatitis screening	
OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)											
Slightly elevated triglycerides - Advise lifestyle modification											
ASSESSMENT:											
FIT ALL AREAS <input checked="" type="checkbox"/> FIT WITH RESTRICTION <input type="checkbox"/> TEMPORARY UNFIT <input type="checkbox"/> UNFIT <input type="checkbox"/>											
<div style="display: inline-block; border: 2px solid black; padding: 5px; font-size: 2em; font-weight: bold;">FIT</div>											
Date: _____ Name (Block Capitals): Dr. / Nurse _____ Signature: _____											
REVIEW/CONSULTATION											
Date: _____ Name (Block Capitals): Dr. / Nurse _____ Signature: _____											

Dr. AMMAR ABED YASER  
 INTERNIST & GASTROENTEROLOGY  
 SPECIALIST  
 MED. LIC. NO. # 1164  
 DR AL SAMAA HOSPITAL, NIZWA

