

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

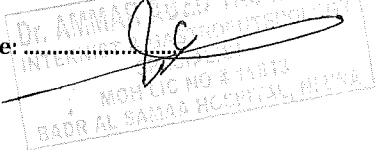
INVESTIGATIONS

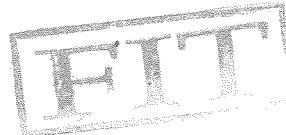
FBS	NORMAL
BLOOD GROUP	O POSITIVE
HAEMOGRAM	NORMAL
LIPID PROFILE	Slightly elevated triglycerides
RFT	NORMAL
LFT	NORMAL
SICKLING TEST	NEGATIVE
URE	NORMAL
AUDIOGRAM	NORMAL AUDIOMETRIC THRESHOLD

COMMENTS Slightly elevated triglycerides- Advised lifestyle modification

CONCLUSION

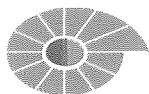
MEDICALLY FIT

Signature: 



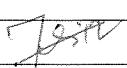
Appendix 32: EX1 Form (Initial Examination Report)

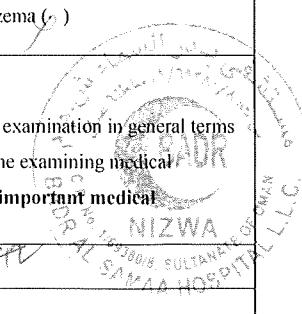
INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)



**Petroleum Development Oman
MEDICAL DEPARTMENT**

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Place of examination BADR AL SAMAA		Surname _____																																																																																																																																												
Date 16/8/2021		Forenames : Dubair UL Hassan																																																																																																																																												
Home telephone number _____		Address _____																																																																																																																																												
If a dependant enter employee's name here: Surname: _____ Forenames: _____		Birth date: 23/5/1981 Nationality: _____ Country of birth: _____ Religion: _____																																																																																																																																												
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced																																																																																																																																												
<input type="checkbox"/> Relationship to employee		<input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter																																																																																																																																												
Number of children: _____		Reason for examination Pre-Employment Job: <input type="checkbox"/>																																																																																																																																												
Pre-Overseas Area: <input type="checkbox"/>		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"/>																																																																																																																																												
DO YOU HAVE OR HAVE YOU HAD:- (Tick "Yes" or "No" column or put a (?) if uncertain exclude minor ailments.)																																																																																																																																														
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50px;"></th> <th style="width: 25px;">Y</th> <th style="width: 25px;">N</th> <th style="width: 50px;"></th> <th style="width: 25px;">Y</th> <th style="width: 25px;">N</th> <th style="width: 50px;"></th> </tr> </thead> <tbody> <tr> <td>1. Sinus trouble</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td>21. Cancer</td> <td><input type="checkbox"/></td> <td><input checked="" type="checkbox"/></td> <td>HAVE YOU EVER BEEN:-</td> </tr> <tr> <td>2. Neck swelling/glands</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td>22. Heart Disease</td> <td><input type="checkbox"/></td> <td><input checked="" type="checkbox"/></td> <td>40. Rejected for employment or insurance for medical reasons</td> </tr> <tr> <td>3. Difficulty in vision</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td>23. 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Have you ever taken elicited drugs? () PDO test all new/potential employees for elicited/recreational drugs																																																																																																																																														
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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: 																																																																																																																																												
FOR COMPLETION BY EXAMINING DOCTOR OR NURSE Further details of medical history and recreational activities																																																																																																																																														



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. 120 70	PULSE /mins. 78	HEARING L R	DISTANT Uncorrected Corrected	VISION NEAR R L R L 1/6 1/6 1/1 1/6				Colour Vision	Blood Group		
165	81	29.8								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. Sickle Cell test											12. HIV, Hepatitis screening	
OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.) Slightly elevated triglycerides - Advised 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"/>														
Date: _____ Name (Block Capitals): Dr. / Nurse _____ Signature: 														
REVIEW/CONSULTATION														

