



MEDICAL FITNESS CERTIFICATE FOR P.D.O

NAME **MUHAMMAD AMIN IRSHAD AHMAD**

AGE/D.O.B	36 Y, 20.11.1984	DATE	12.08.2021
PASS/ID NO:	74477117	GENDER	MALE
VISION-RT-EYE	6/6 WITHOUT GLASSES	HEIGHT	168 CM
LT-EYE	6/6 WITHOUT GLASSES	WEIGHT	84 KG
HEART	NORMAL	BP	120/70 mmHg
LUNGS	NORMAL	PULSE	72/Min
ABDOMEN	NORMAL	CNS	NORMAL
SKIN	NORMAL	ENT	NORMAL

INVESTIGATIONS

FBS	NORMAL
BLOOD GROUP	B NEGATIVE
HAEMOGGRAM	NORMAL
LIPID PROFILE	Slightly elevated triglycerides
RFT	NORMAL
LFT	NASH
SICKLING TEST	NEGATIVE
URE	NORMAL
AUDICGRAM	NORMAL AUDIOMETRIC THRESHOLD

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

CONCLUSION

Signature: Dr. AMMAR ABED YAS EL B.M.S
 INTERNIST & GASTROENTEROLOGY SPECIALIST
 MOH LIC NO # 11613
 BADR AL SAMAA HOSPITAL, NIZWA

FTT

بدر السماء على ٢٠١٨/١١/١٢
 CP NO. ١٦٩٣٨٠٨، سلطنة عمان
 BADR AL SAMAA HOSPITAL L.L.C.

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المقر الرئيسي:

س.ت. ١٦٩٣٨٠٨، ص. ب: ٤٤٣، الرمز البريد: ١٢

روي سلطنة عمان، هاتف: ٢٤٧٩٩٧٦١، فاكس: ٢٤٧٩٩٧٥٦

الخوب: ٢٤٤٨٦٣٢٢، ص. ج: ٢٢٧٤٢٣٢٠، ص. ب: ٢٤٥٤٦٩٩، ص. ط: ٢٤٥٤٦٣٢٣

بركاء: ٢٤٨٤٦٥٦٠، ص. ج: ٢٥٥٤٧٧٧٧٧، ص. ب: ٢٥٥٤٣٣٣، فلخ: ٢٥٥٤٣٣٣

البريد الإلكتروني: info@badroman.com

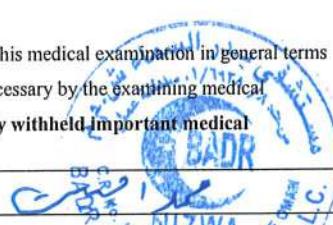
Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)



**Petroleum Development Oman
MEDICAL DEPARTMENT**

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Surname			
Forenames : <i>Muhammad Amin Itshad</i>			
Address			
Place of examination BADR AL SAMAA		Home telephone number	
If a dependant enter employee's name here:			
Surname:		Forenames:	
Birth date: <i>20.11.1984</i>		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"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter		Relationship to employee	
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.)			
Y		N	
1. Sinus trouble		21. Cancer	
2. Neck swelling/glands		22. Heart Disease	
3. Difficulty in vision		23. Rheumatic fever	
4. Any ear discharge		24. Abnormal heartbeat	
5. Asthma/bronchitis		25. High blood pressure	
6. Hayfever/other significant allergy		26. Stroke	
7. Any skin trouble		27. Serious chest pain	
8. Tuberculosis		28. Any blood disease	
9. Shortness of breath		29. Kidney disease	
10. Coughed/vomited blood		30. Blood in urine	
11. Severe abdominal pain		31. Diabetes	
12. Stomach ulcer		32. Headaches/migraine	
13. Recurrent indigestion		33. Dizziness/fainting	
14. Jaundice or hepatitis		34. Epilepsy	
15. Gall Bladder disease		35. Joints/spinal trouble	
16. Marked change in bowel habits		36. Surgical operation	
17. Blood in stools (motions)		37. Serious accident/fracture	
18. Marked change in weight		38. Tropical disease	
19. Varicose veins		39. Fear of heights	
20. Lump in breast/armpit		<input type="checkbox"/> HAVE YOU EVER BEEN:-	
<input type="checkbox"/> 40. Rejected for employment or insurance for medical reasons		<input type="checkbox"/> 41. Awarded benefits for industrial injury/illness	
<input type="checkbox"/> 42. Treated for a mental condition, e.g. depression		<input type="checkbox"/> 43. Treated for problem drinking or drug abuse	
<input type="checkbox"/> 44. Exposed to toxic substance or noise		<input type="checkbox"/> 45. An abnormal smear	
<input type="checkbox"/> 46. Any gynaecological treatment		<input type="checkbox"/> 47. Are you pregnant?	
<input type="checkbox"/> 48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE		<input type="checkbox"/> NOT MENTIONED ABOVE	
FOR WOMEN ONLY			
Have you ever had:-			
<input type="checkbox"/> 45. An abnormal smear			
<input type="checkbox"/> 46. Any gynaecological treatment			
<input type="checkbox"/> 47. Are you pregnant?			
<input type="checkbox"/> 48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE			
How much tobacco each day?		Average daily alcohol consumption	
Have you ever taken elicited drugs? <input checked="" type="checkbox"/> PDO test all new/potential employees for elicited/recreational drugs			
FAMILY HISTORY: Diabetes <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Epilepsy <input type="checkbox"/> Asthma <input type="checkbox"/> Eczema <input type="checkbox"/> Heart disease <input type="checkbox"/> High blood pressure <input type="checkbox"/> Stroke <input type="checkbox"/> Blood Disease <input type="checkbox"/> Cancer <input 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 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: <i>12.08.2021</i>		Signature of Applicant: 	
FOR COMPLETION BY EXAMINING DOCTOR OR NURSE Further details of medical history and recreational activities			
			

Muhammad J.

N = Normal A = Abnormal (please describe)			PHYSICAL EXAMINATION							
/		1. Eyes & Pupils								
/		2. E.N.T.								
/		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.								

HEIGHT cm	WEIGHT kg	BMI	B.P.	PULSE /mins.	HEARING L R	DISTANT	VISION R L Uncorrected Corrected	VISION R L Uncorrected Corrected	Colour Vision	Blood Group
168	84	29.8	120/70	72			4/60 0/60 1/60 0/60	1/60 0/60 1/60 0/60	W	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.)

NASH - Advised treatment

Slightly elevated triglycerides - Advised a lifestyle

modification

ASSESSMENT:

FIT ALL AREAS FIT WITH RESTRICTION TEMPORARY UNFIT UNFIT

Date: Name (Block Capitals): Dr. / Nurse Signature:

REVIEW/CONSULTATION

Date: Name (Block Capitals): Dr. / Nurse Signature:

