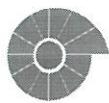




Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)



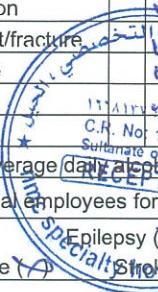
Petroleum Development Oman MEDICAL DEPARTMENT

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Petroleum Development Oman
MEDICAL DEPARTMENT

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Place of examination <u>NMC Mat</u>		Date <u>15/10/03</u>	Surname <u>Rinder</u>	
			Forenames <u>Hardeep</u>	
			Address <u>India</u>	
			Home telephone number <u>011-22345678</u>	
If a dependant enter employee's name here: Surname: <u>Hardeep</u>		Forenames: <u>Singh</u>		
Birth date: <u>15/09/75</u>		Nationality: <u>India</u>	Country of birth: <u>India</u>	Religion: <u>British</u>
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		<input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced	Relationship to employee <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter	Number of children: <u>2</u>
Reason for examination		Pre-Employment <input type="checkbox"/> Job: <u></u>		
		Pre-Overseas <input type="checkbox"/> Area: <u></u>		
Name and address of family doctor		List your last 3 jobs		
		(1) <u></u>		
		(2) <u></u>		
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.)				
1. Sinus trouble 2. Neck swelling/glands 3. Difficulty in vision 4. Any ear discharge 5. Asthma/bronchitis 6. Hayfever /other significant allergy 7. Any skin trouble 8. Tuberculosis 9. Shortness of breath 10. Coughed/vomited blood 11. Severe abdominal pain 12. Stomach ulcer 13. Recurrent indigestion 14. Jaundice or hepatitis 15. Gall Bladder disease 16. Marked change in bowel habits 17. Blood in stools (motions) 18. Marked change in weight 19. Varicose veins 20. Lump in breast/armpit		Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	21. Cancer 22. Heart Disease 23. Rheumatic fever 24. Abnormal heartbeat 25. High blood pressure 26. Stroke 27. Serious chest pain 28. Any blood disease 29. Kidney disease 30. Blood in urine 31. Diabetes 32. Headaches/migraine 33. Dizziness/fainting 34. Epilepsy 35. Joints/spinal trouble 36. Surgical operation 37. Serious accident/fracture 38. Tropical disease 39. Fear of heights	Y <input checked="" type="checkbox"/> N <input type="checkbox"/>
HAVE YOU EVER BEEN:- 40. Rejected for employment or insurance for medical reasons 41. Awarded benefits for industrial injury/illness 42. Treated for a mental condition, e.g. depression 43. Treated for problem drinking or drug abuse 44. Exposed to toxic substance or noise				
FOR WOMEN ONLY Have you ever had:- 45. An abnormal smear 46. Any gynaecological treatment 47. Are you pregnant? 48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE				
How much tobacco each day? <u>NO</u>		Average daily alcohol consumption <u>occasional</u>		
Have you ever taken elicited drugs? <input checked="" type="checkbox"/> PDO test all new/potential employees for elicited/recreational drugs				
FAMILY HISTORY: Diabetes <input checked="" type="checkbox"/> Tuberculosis <input checked="" type="checkbox"/> Heart disease <input checked="" type="checkbox"/> High blood pressure <input checked="" type="checkbox"/> Epilepsy <input checked="" type="checkbox"/> Asthma <input checked="" type="checkbox"/> Eczema <input checked="" type="checkbox"/> Stroke <input checked="" type="checkbox"/> Blood Disease <input checked="" type="checkbox"/> Cancer <input checked="" 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: <u>15/10/03</u>	Signature of Applicant: <u>Hardeep Singh</u>			



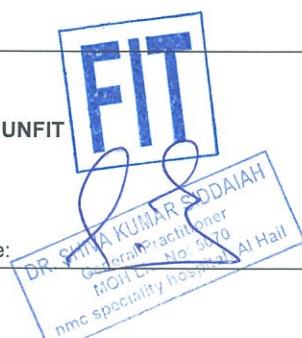
PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT:-

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: _____ 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									
		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 171	WEIGHT kg 77	BMI 26.3	B.P. 133 93	PULSE 84 /mins.	HEARING L R	VISION Uncorrected Corrected	DISTANT R L	NEAR R L	Colour Vision	Blood Group O Positive	
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS					N	A			
<input checked="" type="checkbox"/>		1. Urinalysis					<input checked="" type="checkbox"/>		7. Audiogram		
<input checked="" type="checkbox"/>		2. Hb, Bloodcount, ESR					<input checked="" type="checkbox"/>		8. Lung Function		
<input checked="" type="checkbox"/>		3. LFT, RFT, RBS					<input checked="" type="checkbox"/>		9. Chest X-Ray		
		4. Drug Screen					<input checked="" type="checkbox"/>		10. ECG		
<input checked="" type="checkbox"/>		5. Lipids (40 years +)					<input checked="" type="checkbox"/>		11. CVS risk for 40 yrs. & above		
<input checked="" type="checkbox"/>		6. Sickle Cell test					<input checked="" type="checkbox"/>		12. HIV, Hepatitis screening		
OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)											
ASSESSMENT: <input checked="" type="checkbox"/> FIT ALL AREAS <input type="checkbox"/> FIT WITH RESTRICTION <input type="checkbox"/> TEMPORARY UNFIT <input type="checkbox"/> UNFIT FIT  											
Date: 17/11/2021 Name (Block Capitals): Dr. / Nurse											
REVIEW/CONSULTATION											
Date: Name (Block Capitals): Dr. / Nurse Signature:											