

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS



Petroleum Development Oman
MEDICAL DEPARTMENT

INITIAL EXAMINATION REPORT

| Place of examination BADR AL SAMAA HOSPITAL AL KHOUJ BRANCH | | Date:- 04 / 11 / 2019 | Surname ALI MOHAMMED AL HAJRI Forenames QUSAY MUBARAK Address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| If a dependant or partner enter employee's name here:- Surname: Forenames: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Birth date 23 / 02 / 1997 Nationality OMANI | | Country of birth OMAN | Religion ISLAM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input checked="" type="checkbox"/> Male <input checked="" type="checkbox"/> Single <input type="checkbox"/> Widow (er) | | Relationship to employee <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Fiancee | | Number of Children | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Female <input type="checkbox"/> Married <input type="checkbox"/> Divorced/ Separated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Reason for examination <input type="checkbox"/> Pre-employment <input type="checkbox"/> Job:- <input type="checkbox"/> Pre-overseas <input type="checkbox"/> Area:- | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name and address of family doctor | | List your last 3 jobs (1) (2) (3) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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"> <thead> <tr> <th>Y</th> <th>N</th> <th>Y</th> <th>N</th> <th>Y</th> <th>N</th> </tr> </thead> <tbody> <tr><td>1. Sinus trouble</td><td>✓</td><td>22. Heart Disease</td><td>✓</td><td>42. Awarded benefits for industrial injury/illness</td><td>✓</td></tr> <tr><td>2. Neck swelling/glands</td><td>✓</td><td>23. Rheumatic fever</td><td>✓</td><td>43. Treated for a mental condition, eg depression</td><td>✓</td></tr> <tr><td>3. Difficulty in vision</td><td>✓</td><td>24. Abnormal heartbeat</td><td>✓</td><td>44. Treated for problem drinking or drug abuse</td><td>✓</td></tr> <tr><td>4. Any ear discharge</td><td>✓</td><td>25. High blood pressure</td><td>✓</td><td>45. Exposed to toxic substance or noise</td><td>✓</td></tr> <tr><td>5. Asthma/bronchitis</td><td>✓</td><td>26. Stroke</td><td>✓</td><td colspan="2">FOR WOMEN ONLY</td></tr> <tr><td>6. Hayfever/other allergy</td><td>✓</td><td>27. Serious chest pain</td><td>✓</td><td colspan="2">Have you ever had:-</td></tr> <tr><td>7. 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Rejected for employment</td><td>✓</td><td></td><td></td></tr> <tr> <td colspan="2">How much tobacco each day?</td> <td colspan="3">Average daily alcohol consumption</td> </tr> <tr> <td colspan="2">FAMILY HISTORY</td> <td colspan="3"> 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"/> Cancer <input type="checkbox"/> Blood Disease <input type="checkbox"/> </td> </tr> <tr> <td colspan="6">PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT:- I declare 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.</td> </tr> <tr> <td colspan="2">Date: 04.11.2019</td> <td colspan="4">Signature of applicant:</td> </tr> </tbody></table> | | Y | N | Y | N | Y | N | 1. Sinus trouble | ✓ | 22. Heart Disease | ✓ | 42. Awarded benefits for industrial injury/illness | ✓ | 2. Neck swelling/glands | ✓ | 23. Rheumatic fever | ✓ | 43. Treated for a mental condition, eg depression | ✓ | 3. Difficulty in vision | ✓ | 24. Abnormal heartbeat | ✓ | 44. Treated for problem drinking or drug abuse | ✓ | 4. Any ear discharge | ✓ | 25. High blood pressure | ✓ | 45. Exposed to toxic substance or noise | ✓ | 5. Asthma/bronchitis | ✓ | 26. Stroke | ✓ | FOR WOMEN ONLY | | 6. Hayfever/other allergy | ✓ | 27. Serious chest pain | ✓ | Have you ever had:- | | 7. Any skin trouble | ✓ | 28. Any blood disease | ✓ | 46. An abnormal smear | | 8. Tuberculosis | ✓ | 29. Kidney disease | ✓ | 47. Any gynaecological Treatment | | 9. Shortness of breath | ✓ | 30. Painful passage of urine | ✓ | 48. Are you pregnant? | | 10. Coughed/vomited blood | ✓ | 31. Blood in urine | ✓ | 49. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE | | 11. Severe abdominal pain | ✓ | 32. Diabetes | ✓ | | | 12. Stomach ulcer | ✓ | 33. Headaches/migraine | ✓ | | | 13. Recurrent indigestion | ✓ | 34. Dizziness/fainting | ✓ | | | 14. Jaundice or hepatitis | ✓ | 35. Epilepsy | ✓ | | | 15. Gall Bladder disease | ✓ | 36. Joints/spinal trouble | ✓ | | | 16. Marked change in bowel habits | ✓ | 37. Surgical operation | ✓ | | | 17. Blood in stools (motions) | ✓ | 38. Serious accident/fracture | ✓ | | | 18. Marked change in weight | ✓ | 39. Tropical disease | ✓ | | | 19. Varicose veins | ✓ | 40. Fear of heights | ✓ | | | 20. Lump in breast/armpit | ✓ | HAVE YOU EVER BEEN:- | | | | 21. Cancer | ✓ | 41. 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| Y | N | Y | N | Y | N | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Sinus trouble | ✓ | 22. Heart Disease | ✓ | 42. Awarded benefits for industrial injury/illness | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. Neck swelling/glands | ✓ | 23. Rheumatic fever | ✓ | 43. Treated for a mental condition, eg depression | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. Difficulty in vision | ✓ | 24. Abnormal heartbeat | ✓ | 44. Treated for problem drinking or drug abuse | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4. Any ear discharge | ✓ | 25. High blood pressure | ✓ | 45. Exposed to toxic substance or noise | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5. Asthma/bronchitis | ✓ | 26. Stroke | ✓ | FOR WOMEN ONLY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6. Hayfever/other allergy | ✓ | 27. Serious chest pain | ✓ | Have you ever had:- | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7. Any skin trouble | ✓ | 28. Any blood disease | ✓ | 46. An abnormal smear | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8. Tuberculosis | ✓ | 29. Kidney disease | ✓ | 47. Any gynaecological Treatment | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9. Shortness of breath | ✓ | 30. Painful passage of urine | ✓ | 48. Are you pregnant? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. Coughed/vomited blood | ✓ | 31. Blood in urine | ✓ | 49. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 11. Severe abdominal pain | ✓ | 32. Diabetes | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 12. Stomach ulcer | ✓ | 33. Headaches/migraine | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13. Recurrent indigestion | ✓ | 34. Dizziness/fainting | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. Jaundice or hepatitis | ✓ | 35. Epilepsy | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 15. Gall Bladder disease | ✓ | 36. Joints/spinal trouble | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16. Marked change in bowel habits | ✓ | 37. Surgical operation | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17. Blood in stools (motions) | ✓ | 38. Serious accident/fracture | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. Marked change in weight | ✓ | 39. Tropical disease | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19. Varicose veins | ✓ | 40. Fear of heights | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 20. Lump in breast/armpit | ✓ | HAVE YOU EVER BEEN:- | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21. Cancer | ✓ | 41. Rejected for employment | ✓ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| How much tobacco each day? | | Average daily alcohol consumption | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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"/> Cancer <input type="checkbox"/> Blood Disease <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT:- I declare 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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date: 04.11.2019 | | Signature of applicant: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |



| N = Normal A = Abnormal (please describe) | | | PHYSICAL EXAMINATION | | | | | | | | | |
|---|---|---------------------------------------|--|-------------------|-----------------------------|------------------------------------|---------------------------|-----|----------------------|---|-----------------------------|----------------|
| N | A | | | | | | | | | | | |
| ✓ | | 1. Eyes & Pupils | NORMAL | | | | | | | | | |
| ✓ | | 2. E.N.T. | RT LOW FREQUENCY CONDUCTIVE HL/LT NORMAL HEARING | | | | | | | | | |
| ✓ | | 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. | | | | | | | | | | |
| ✓ | | 14. Breasts | | | | | | | | | | |
| HEIGHT cm 170 | | WEIGHT kg 71 | B.P. 110/80 mmHG | PULSE 72/Mints | HEARING L 33.3 R 18.3 | VISION Uncorrected Corrected | DISTANT R 6/6 L 6/6 | | NEAR R N6 L N6 | | COLOUR VISION PRESENT | BLOOD GROUP |
| N | A | LABORATORY AND SPECIAL INVESTIGATIONS | | | | | | N | A | | | |
| ✓ | | 1. Urinalysis | | | | | | ✓ | | 6. Audiogram | | |
| ✓ | | 2. Hb Blood count ESR | | | | | | N/A | ✗ | 7. Lung Function | | |
| ✓ | | 3. Serum Profile | | | | | | ✓ | | 8. Chest X-Ray | | |
| | | 4. Stool | | | | | | N/A | | 9. Drug Screen | | |
| ✓ | | 5. E.C.G. | | | | | | N/A | | 10. CR Screen = Country Request (e.g. H.I.V.) | | |

OTHER FINDINGS (Physique, scars, disabilities, mental stability etc.)

ASSESSMENT

FIT ALL AREAS FIT HOME SERVICE ONLY UNFIT/UNSUITABLE MAY BE REASSESSED

04.11.2019

DR NAVEEN NAZIRUDEEN

Name (Block Capitals)

Dr. NAVEEN NAZIRUDEEN
M.B.B.S, DNB (Gen. Medicine)
INTERNIST
MOH Licence #12638

Doctor/Sister

REVIEW/CONSULTATION

Date

Signature

Name (Block Capitals)

Doctor/Sister