

Medical Certificate – Fitness to Work

Declaration by examining Health Care Professional

I ... DR. Atma S. Raj who resides and works
in Badr Al Samaa have examined and / or assessed the report of the
Hospital
Following employee prior to employment.

Client Name: Rathesh Kumar Padmakaran
PDO Company:

This certificate of fitness is valid for a period of **two years** from the date below.

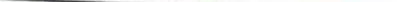
The Client is:

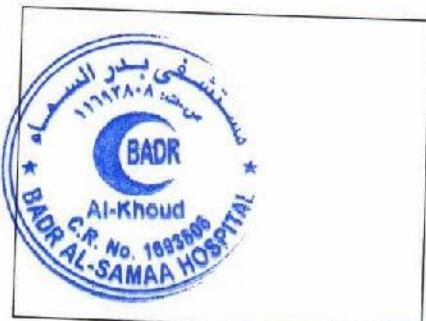
A - Fit for employment.
B - Unfit for employment.

Health Care Professional: DR. Atma Singh

Signature:  **MBBS, MD**
INTERNAL MEDICINE
MOH Lic No: 17995

Date: 31/02/2020

Company stamp: 



PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS



Petroleum Development Oman
MEDICAL DEPARTMENT

INITIAL EXAMINATION REPORT

Place of examination BADR AL SAMAA HOSPITAL Date:-
AL KHOUD BRANCH 03 /02 / 2020

If a dependant or partner enter employee's name here:-

Surname: Forenames:

Birth date 25 / 05 / 1973	Nationality INDIAN	Country of birth INDIA	Religion HINDU	
<input checked="" type="checkbox"/> Male	<input type="checkbox"/> Single	<input type="checkbox"/> Widow (er)	Relationship to employee	
<input type="checkbox"/> Female	<input checked="" type="checkbox"/> Married	<input type="checkbox"/> Divorced/ Separated	<input type="checkbox"/> Wife	<input type="checkbox"/> Son

Number of Children

Reason for examination Pre-employment Job:-
 Pre-overseas Area:-

Name and address of family doctor	List your last 3 jobs
	(1)
	(2)
	(3)

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		✓	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/axmpit		✓	HAVE YOU EVER BEEN:-					
21. Cancer		✓	41. Rejected for employment		✓			
How much tobacco each day?		✓	or insurance for medical reasons					

FAMILY HISTORY	Diabetes <input type="checkbox"/>	Tuberculosis <input type="checkbox"/>	Epilepsy <input type="checkbox"/>	Asthma <input type="checkbox"/>	Eczema <input type="checkbox"/>	Average daily alcohol consumption
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: 03.02.2020

Signature of applicant:



FOR COMPLETION BY EXAMINING DOCTOR OR SISTER
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.										
✓	14. Breasts										
HEIGHT cm 165	WEIGHT kg 77.5	B.P. 130/80 mmHg	PULSE 60/Mints	HEARING L 21.6 R 16.6	VISION Uncorrected Corrected	DISTANT R 6/12 L 6/12 6/6	NEAR R N8 L N8 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					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.)

MILD ELEVATION OF FBS, SGPT AND SGOT

ASSESSMENT

FIT ALL AREAS

FIT HOME SERVICE ONLY

UNFIT/UNSUITABLE

MAY BE REASSESSED

03.02.2020

Date

Signature

DR ATMA S RAJ
Name (Block Capitals)

Dr. ATMA S RAJ
MBBS, MD
INTERNAL MEDICINE
MOH Lic No. Doctor/Sister

REVIEW/CONSULTATION

Date

Signature

Name (Block Capitals)

Doctor/Sister

