

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS



Petroleum Development Oman
MEDICAL DEPARTMENT

INITIAL EXAMINATION REPORT

Place of examination BADR AL SAMAA HOSPITAL AL KHOUD BRANCH		Date:- 29 / 01 / 2020	Surname HAMED AL AMRI Forenames JULAND NASR Address																																																																																																																																					
If a dependant or partner enter employee's name here:- Surname: Forenames:																																																																																																																																								
Birth date 16 /09 / 1996 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		Number of Children																																																																																																																																				
[<input type="checkbox"/>] Female [<input type="checkbox"/>] Married [<input type="checkbox"/>] Divorced/ Separated		[<input type="checkbox"/>] Wife [<input type="checkbox"/>] Son [<input type="checkbox"/>] Daughter [<input type="checkbox"/>] Fiancee																																																																																																																																						
Reason for examination [<input type="checkbox"/>] Pre-employment [<input type="checkbox"/>] Pre-overseas		Job:- 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.)																																																																																																																																								
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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: 29.01.2020		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		REPORT ATTACHED								
✓	2. E.N.T.		REPORT ATTACHED								
✓	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 166	WEIGHT kg 59	B.P. 120/80 mmHG	PULSE 64/Mints	HEARING L 16.6dBHL R 16.6dBHL	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		N/A		9. Drug Screen				
✓	5. E.C.G.				N/A		10. CR Screen = Country Request (e.g. HIV,)				

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

ASSESSMENT

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

29.01.2020

Date

Signature

DR ATMA S RAJ

Name (Block Capitals)

DR. ATMA S RAJ

M.D., M.B.B.S.

Doctor/Sister

REVIEW/CONSULTATION

Date

Signature

Name (Block Capitals)

Doctor/Sister

