

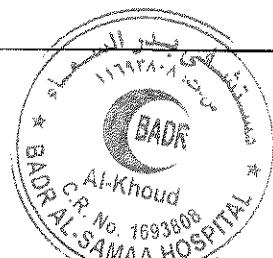
PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS



Petroleum Development Oman
MEDICAL DEPARTMENT

INITIAL EXAMINATION REPORT

Place of examination BADR AL SAMAA HOSPITAL AL KHOUJ BRANCH		Date:- 29 / 01 / 2020	Surname DARWISH AL HARRASI Forenames MOHAMMED TALIB Address																																																																																										
If a dependant or partner enter employee's name here:- Surname: Forenames:				Home Telephone Number 96172161																																																																																									
Birth date 03 / 01 / 1998		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		Job:-																																																																																											
<input type="checkbox"/> 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) <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.)																																																																																													
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How much tobacco each day? <input type="checkbox"/>		Average daily alcohol consumption																																																																																											
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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 178	WEIGHT kg 99	B.P. 130/80 mmHG	PULSE 58/Mints	HEARING L 10 dBHL R 11.6 dBHL	VISION Uncorrected Corrected	DISTANT R 6/36 L 6/36		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. H.I.V.)			

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 ATMAS RAJ

Name (Block Capitals)

DR ATMAS RAJ

Doctor/Sister

REVIEW/CONSULTATION

Date

Signature

Name (Block Capitals)

Doctor/Sister

