

MEDICAL FITNESS CERTIFICATE FOR P.D.O

NAME **SHIVA RAJU GEEDA**

AGE/D.O.B	49 Y, 22.06.1972	DATE	23.09.2021
PASS/ID NO:	81255389	GENDER	MALE
VISION-RT-EYE	6/6 WITHOUT GLASSES	HEIGHT	163 KG
LT-EYE	6/6 WITHOUT GLASSES	WEIGHT	76 KG
HEART	NORMAL	BP	124/88 mmHg
LUNGS	NORMAL	PULSE	58/Min
ABDOMEN	NORMAL	CNS	NORMAL
SKIN	NORMAL	ENT	NORMAL

INVESTIGATIONS

FBS	NORMAL
BLOOD GROUP	B POSITIVE
HAEMOGRAM	NORMAL
LIPID PROFILE	NORMAL
RFT	NORMAL
LFT	NORMAL
SICKLING TEST	NEGATIVE
URE	NORMAL
ECG	Sinus Bradycardia
AUDIOGRAM	NORMAL AUDIOMETRIC THRESHOLD
FRAMINGHAM SCORE	Probability of developing cardiovascular disease in next 10 years is 1.2%

CONCLUSION

MEDICALLY FIT

Signature:

Dr. B. VENKATESH KUMAR
CARDIOLOGIST
MOH NO#14581

FIT



Headquarters:

CR. No. 1693808, P.B No. 443, P.C. 112,

Ruwi, Sultanate of Oman, Tel: +968 24

Al Khujair : 24488322 | Sohar : 26846660 | Al Khoud : 24546099

Al Khuwail : 24488322 | Sulai : 26840000 | Al Khodd : 24346099 | Salalai : 23291850
Barka : 26884910 | Sur : 25546112 | Nizwa : 25447777 | Falai : 26754131

Barka : 26884910 | Sur : 25348112 | Nizwa : 25447777 | Falaj : 26734131
Email: info@badroman.com

Email: info@badroman.com

المقر الرئيسي:

س.ت. : ٢٣٨٨٨، ص . ب، ٤٤٣، الرمز البريد : ٢٢٢

روي سلطنة عمان. هاتف: ٤٧٩٩٧٦٠، فاكس:

الخوير، ٢٢٤٤٨٣٢٢ | صellar، ٦٧٨٤٦٦٩٩ | الخوص، ٢٤٥٤٦٩٩ | صالة، ٢٣٢٩٨٢٠

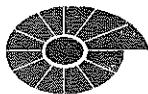
برکام: ٨٨٨٤٩٣ | صور: ٣٣٣٧٧٧ | لروي: ٧٥٥٤٣٣ | فلحن: ٣٣٣٥٦٣

البريد الإلكتروني: info@badroman.com

Digitized by srujanika@gmail.com

Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

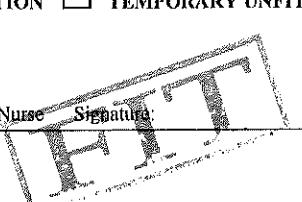
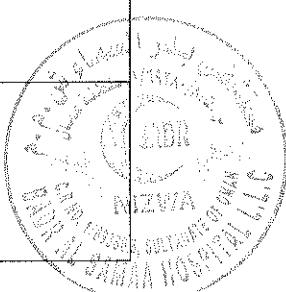


Petroleum Development Oman
MEDICAL DEPARTMENT

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Place of examination BADR AL SAMAA		Date 23/9/11	Surname SHIVANI RAJU CHERRIAH																																																																																				
			Forenames :																																																																																				
			Address																																																																																				
			Home telephone number																																																																																				
If a dependant enter employee's name here:																																																																																							
Surname:		Forenames:																																																																																					
Birth date:	Nationality:	Country of birth:	Religion:																																																																																				
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced	<input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter	Number of children:																																																																																				
Reason for examination Pre-Employment Job: <input type="checkbox"/>																																																																																							
Pre-Overseas Area: <input type="checkbox"/>																																																																																							
Name and address of family doctor		List your last 3 jobs																																																																																					
		(1)																																																																																					
		(2)																																																																																					
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"> <tr> <td><input type="checkbox"/> Y</td> <td><input type="checkbox"/> N</td> </tr> <tr> <td colspan="2">1. Sinus trouble</td> </tr> <tr> <td colspan="2">2. Neck swelling/glands</td> </tr> <tr> <td colspan="2">3. Difficulty in vision</td> </tr> <tr> <td colspan="2">4. Any ear discharge</td> </tr> <tr> <td colspan="2">5. Asthma/bronchitis</td> </tr> <tr> <td colspan="2">6. Hayfever/other significant allergy</td> </tr> <tr> <td colspan="2">7. Any skin trouble</td> </tr> <tr> <td colspan="2">8. Tuberculosis</td> </tr> <tr> <td colspan="2">9. Shortness of breath</td> </tr> <tr> <td colspan="2">10. Coughed/vomited blood</td> </tr> <tr> <td colspan="2">11. Severe abdominal pain</td> </tr> <tr> <td colspan="2">12. Stomach ulcer</td> </tr> <tr> <td colspan="2">13. Recurrent indigestion</td> </tr> <tr> <td colspan="2">14. Jaundice or hepatitis</td> </tr> <tr> <td colspan="2">15. Gall Bladder disease</td> </tr> <tr> <td colspan="2">16. Marked change in bowel habits</td> </tr> <tr> <td colspan="2">17. Blood in stools (motions)</td> </tr> <tr> <td colspan="2">18. Marked change in weight</td> </tr> <tr> <td colspan="2">19. Varicose veins</td> </tr> <tr> <td colspan="2">20. Lump in breast/armpit</td> </tr> </table>		<input type="checkbox"/> Y	<input type="checkbox"/> N	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		<table border="1"> <tr> <td><input type="checkbox"/> Y</td> <td><input type="checkbox"/> N</td> </tr> <tr> <td colspan="2">21. Cancer</td> </tr> <tr> <td colspan="2">22. Heart Disease</td> </tr> <tr> <td colspan="2">23. Rheumatic fever</td> </tr> <tr> <td colspan="2">24. Abnormal heartbeat</td> </tr> <tr> <td colspan="2">25. High blood pressure</td> </tr> <tr> <td colspan="2">26. Stroke</td> </tr> <tr> <td colspan="2">27. Serious chest pain</td> </tr> <tr> <td colspan="2">28. Any blood disease</td> </tr> <tr> <td colspan="2">29. Kidney disease</td> </tr> <tr> <td colspan="2">30. Blood in urine</td> </tr> <tr> <td colspan="2">31. Diabetes</td> </tr> <tr> <td colspan="2">32. Headaches/migraine</td> </tr> <tr> <td colspan="2">33. Dizziness/fainting</td> </tr> <tr> <td colspan="2">34. Epilepsy</td> </tr> <tr> <td colspan="2">35. Joints/spinal trouble</td> </tr> <tr> <td colspan="2">36. Surgical operation</td> </tr> <tr> <td colspan="2">37. Serious accident/fracture</td> </tr> <tr> <td colspan="2">38. Tropical disease</td> </tr> <tr> <td colspan="2">39. Fear of heights</td> </tr> </table>		<input type="checkbox"/> Y	<input type="checkbox"/> N	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		HAVE YOU EVER BEEN:-	
<input type="checkbox"/> Y	<input type="checkbox"/> N																																																																																						
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																																																																																							
<input type="checkbox"/> Y	<input type="checkbox"/> N																																																																																						
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																																																																																							
				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																																																																																			
				45. An abnormal smear																																																																																			
				46. Any gynaecological treatment																																																																																			
				47. Are you pregnant?																																																																																			
				48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE																																																																																			
					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? 0		Average daily alcohol consumption None																																																																																					
Have you ever taken elicited drugs? (<input type="checkbox"/>) PDO test all new/potential employees for elicited/recreational drugs																																																																																							
FAMILY HISTORY: Diabetes (<input type="checkbox"/>) Tuberculosis (<input type="checkbox"/>) Epilepsy (<input type="checkbox"/>) Asthma (<input checked="" type="checkbox"/>) Eczema (<input type="checkbox"/>) Heart disease (<input type="checkbox"/>) High blood pressure (<input type="checkbox"/>) Stroke (<input type="checkbox"/>) Blood Disease (<input type="checkbox"/>) Cancer (<input type="checkbox"/>)																																																																																							
PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT:- <p>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.</p>																																																																																							
Date: 23/9/11		Signature of Applicant:																																																																																					
FOR COMPLETION BY EXAMINING DOCTOR OR NURSE Further details of medical history and recreational activities																																																																																							

P. B. VENKATESH KUMAR
CARDIOLOGIST
MOH NO#14581

N = Normal A = Abnormal (please describe)			PHYSICAL EXAMINATION									
N	A											
		1. Eyes & Pupils	Normal & Reactive									
		2. E.N.T.	Ear - NL TM normal, Nose & Throat normal									
		3. Teeth & Mouth										
		4. Lungs & Chest	Normal									
		5. Cardiovascular System	Sph (A) No murmur									
		6. Abdo. Viscera	Jwh M (A)									
		7. Hernial Orifices	Normal									
		8. Anus & Rectum	Normal									
		9. Genito-urinary	Normal									
		10. Extremities	Normal									
		11. Musculo-skeletal	Normal									
		12. Skin & Varicose Vns.	Normal									
		13. C.N.S.	Normal									
HEIGHT cm	WEIGHT kg	BMI	B.P.	PULSE /mins.	HEARING L R	DISTANT	VISION NEAR	R L	R L	Colour Vision	Blood Group	
173	76.9	26.9	124 88	156		Uncorrected Corrected	6/6 6/6 N/6 N/6			(N)	B+	
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS				N	A					
/		1. Urinalysis				/		7. Audiogram B/L hearing semidyn. normal				
/		2. Hb, Bloodcount, ESR				/		8. Lung Function				
/		3. LFT, RFT, RBS				/		9. Chest X-Ray				
/		4. Drug Screen				/		10. ECG Equis Dromy, arrhythmia				
/		5. Lipids (40 years +)				/		11. CVS risk for 40 yrs. & above				
/		6. Sickle Cell test				/		12. HIV, Hepatitis screening				
OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)												
ASSESSMENT:												
<input checked="" type="checkbox"/> FIT ALL AREAS <input checked="" type="checkbox"/> FIT WITH RESTRICTION <input type="checkbox"/> TEMPORARY UNFIT <input type="checkbox"/> UNFIT <input type="checkbox"/>												
Date: 23/07/24 Name (Block Capitals): Dr. / Nurse Signature: 												
REVIEW/CONSULTATION												
Date: 23/07/24 Name (Block Capitals): Dr. / Nurse Signature: 												


 Dr. VENKATESH KUMAR
 CARDIOLOGIST
 MOH NO#14581