



MEDICAL FITNESS FORM TRUCK OMAN FOR PDO MEDICAL

NAME:	MOHAMMED SALEH ABDULLAH AL YAHYAI	DATE:	20.02.2020
DOB/ SEX:	01.09.1986/ MALE	MRN NO:	7885507
VISION RT-EYE:	6/6 N6	HEIGHT:	170 CM
VISION LT-EYE:	6/6 N6	WEIGHT:	68 KG
HEART:	NORMAL	BP:	130/90mmHG
LUNGS:	NORMAL	PULSE:	60/Mins
ABDOMEN:	NORMAL	CNS:	NORMAL
SKIN:	NORMAL	ENT	NORMAL

INVESTIGATIONS:

CBC/ ESR	NORMAL
URINE ANALYSIS:	NORMAL
FBS/RBS	NORMAL
LFT,RFT	NORMAL
AUDIOMETRY:	B/L NORMAL HEARING
CHEST X RAY:	NORMAL
ECG:	BRADICARDIA NORMAL

COMMENTS: MEDICALLY FIT

Doctor's Signature:

DR. ATMA S RAJ
MBBS, MD
INTERNAL MEDICINE
MOH Lic No.: 17995



Medical Certificate – Fitness to Work

Declaration by examining Health Care Professional

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

Client Name: Mohammed Saleh Abdullah Al Yahya
PDO Company: _____

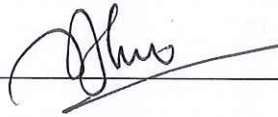
This certificate of fitness is valid for a period of two years from the date below.

The Client is:

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

Health Care Professional: DR Atma S Raj

Signature: _____



Date: _____

20/02/2020

Dr. ATMA S RAJ
MBBS, MD
INTERNAL MEDICINE
MOH Lic No.: 17995

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 AL KHOUD BRANCH		Date:- 20 / 02 / 2020		Surname ABDULLAH AL YAHYAI	
				Forenames MOHAMMED SALEH	
				Address	
				Home Telephone Number 99299588	
If a dependant or partner enter employee's name here:- Surname: Forenames:					
Birth date 01 / 09 / 1986		Nationality OMANI		Country of birth OMAN	
Religion ISLAM					
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Divorced/ Separated		Relationship to employee <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) <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.)					
	Y	N		Y	N
1. Sinus trouble		✓	22. Heart Disease		✓
2. Neck swelling/glands		✓	23. Rheumatic fever		✓
3. Difficulty in vision		✓	24. Abnormal heartbeat		✓
4. Any ear discharge		✓	25. High blood pressure		✓
5. Asthma/bronchitis		✓	26. Stroke		✓
6. Hayfever/other allergy		✓	27. Serious chest pain		✓
7. Any skin trouble		✓	28. Any blood disease		✓
8. Tuberculosis		✓	29. Kidney disease		✓
9. Shortness of breath		✓	30. Painful passage of urine		✓
10. Coughed/vomited blood		✓	31. Blood in urine		✓
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		✓	41. Rejected for employment		✓
21. Cancer		✓	or insurance for medical reasons		
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: 20.02.2020		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		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 170		WEIGHT kg 68		B.P. 130/90 mmHG		PULSE 60/Mints		HEARING L R		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.)

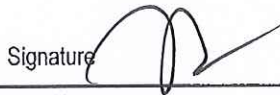
ASSESSMENT

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

20.02.2020

Date

Signature



DR ATMA S RAJ

Name (Block Capitals)

Dr. ATMA S RAJ
MBBS, MD
INTERNAL MEDICINE
MOH Lic No.: 17995

REVIEW/CONSULTATION

Date

Signature

Name (Block Capitals)

Doctor/Sister

