

MEDICAL FITNESS FORM
TRUCK OMAN FOR PDO MEDICAL

NAME:	SULTAN SAID SAIF AL RUBAII	DATE:	19.02.2020
DOB/ SEX:	01.01.1981/ MALE	MRN NO:	7885386
VISION RT-EYE:	6/9 N6	HEIGHT:	164 CM
VISION LT-EYE:	6/6 N6	WEIGHT:	94 KG
HEART:	NORMAL	BP:	130/80mmHG
LUNGS:	NORMAL	PULSE:	80/Mins
ABDOMEN:	NORMAL	CNS:	NORMAL
SKIN:	NORMAL	ENT	NORMAL

INVESTIGATIONS:

CBC/ ESR	NORMAL
URINE ANALYSIS:	NORMAL
FBS/RBS	NORMAL
LFT,RFT	NORMAL
AUDIOOMETRY:	RT NORMAL HEARING EXCEPT AT 8 KHz LT 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 ..D.R.. 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: Sultan said Saiyf Al Rubaii

PDO

Company: _____

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

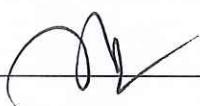
The Client is:

A - Fit for employment.

B - Unfit for employment.

Health Care Professional: DR Atma S Raj

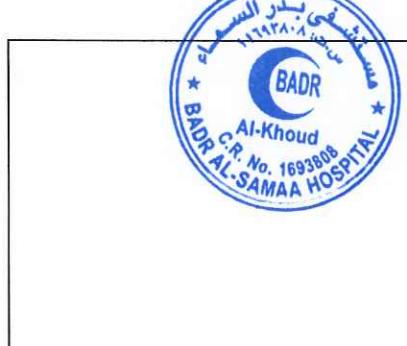
Signature: _____



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

Date: 20/02/2020

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 AL KHOUJ BRANCH		Date:- 19 /02 /2020	Home Telephone Number 99418977	
If a dependant or partner enter employee's name here:- Surname: Forenames:				
Birth date 01 /01 /1981	Nationality OMANI		Country of birth OMAN	Religion ISLAM
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Single <input type="checkbox"/> Widow (er)		Relationship to employee		Number of Children
<input type="checkbox"/> Female <input checked="" 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.)				
1. Sinus trouble	<input checked="" type="checkbox"/>	22. Heart Disease	<input checked="" type="checkbox"/>	42. Awarded benefits for industrial injury/illness
2. Neck swelling/glands	<input checked="" type="checkbox"/>	23. Rheumatic fever	<input checked="" type="checkbox"/>	43. Treated for a mental condition, eg depression
3. Difficulty in vision	<input checked="" type="checkbox"/>	24. Abnormal heartbeat	<input checked="" type="checkbox"/>	44. Treated for problem drinking or drug abuse
4. Any ear discharge	<input checked="" type="checkbox"/>	25. High blood pressure	<input checked="" type="checkbox"/>	45. Exposed to toxic substance or noise
5. Asthma/bronchitis	<input checked="" type="checkbox"/>	26. Stroke	<input checked="" type="checkbox"/>	46. An abnormal smear
6. Hayfever/other allergy	<input checked="" type="checkbox"/>	27. Serious chest pain	<input checked="" type="checkbox"/>	47. Any gynaecological treatment
7. Any skin trouble	<input checked="" type="checkbox"/>	28. Any blood disease	<input checked="" type="checkbox"/>	48. Are you pregnant?
8. Tuberculosis	<input checked="" type="checkbox"/>	29. Kidney disease	<input checked="" type="checkbox"/>	49. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE
9. Shortness of breath	<input checked="" type="checkbox"/>	30. Painful passage of urine	<input checked="" type="checkbox"/>	
10. Coughed/vomited blood	<input checked="" type="checkbox"/>	31. Blood in urine	<input checked="" type="checkbox"/>	
11. Severe abdominal pain	<input checked="" type="checkbox"/>	32. Diabetes	<input checked="" type="checkbox"/>	
12. Stomach ulcer	<input checked="" type="checkbox"/>	33. Headaches/migraine	<input checked="" type="checkbox"/>	
13. Recurrent indigestion	<input checked="" type="checkbox"/>	34. Dizziness/fainting	<input checked="" type="checkbox"/>	
14. Jaundice or hepatitis	<input checked="" type="checkbox"/>	35. Epilepsy	<input checked="" type="checkbox"/>	
15. Gall Bladder disease	<input checked="" type="checkbox"/>	36. Joints/spinal trouble	<input checked="" type="checkbox"/>	
16. Marked change in bowel habits	<input checked="" type="checkbox"/>	37. Surgical operation	<input checked="" type="checkbox"/>	
17. Blood in stools (motions)	<input checked="" type="checkbox"/>	38. Serious accident/fracture	<input checked="" type="checkbox"/>	
18. Marked change in weight	<input checked="" type="checkbox"/>	39. Tropical disease	<input checked="" type="checkbox"/>	
19. Varicose veins	<input checked="" type="checkbox"/>	40. Fear of heights	<input checked="" type="checkbox"/>	
20. Lump in breast/armpit	<input checked="" type="checkbox"/>	HAVE YOU EVER BEEN:-		
21. Cancer	<input checked="" type="checkbox"/>	41. Rejected for employment		<input checked="" type="checkbox"/>
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: 19.02.2020		Signature of applicant:		

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: 19.02.2020

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 164		WEIGHT kg 94	B.P. 130/80 mmHG	PULSE 80/Mints	HEARING L 10dBHL R 11.6dBHL	VISION Uncorrected Corrected	DISTANT R 6/9 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. H.I.V.)			

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

ASSESSMENT

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

19.02.2020

Date

Signature

DR ATMA S RAJ

Name (Block Capitals)

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

REVIEW/CONSULTATION

Date

Signature

Name (Block Capitals)

