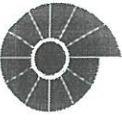


## 1.1 Appendix 32: EX1 Form (Initial Examination Report)

### INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

 <p>Petroleum Development Oman MEDICAL DEPARTMENT</p> <p>PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS</p>		<p>Surname <u>HUSSAIN</u></p> <p>Forenames <u>TARIQ HUSSAIN MEHBOOB</u></p> <p>Address</p> <p>Home telephone number <u>92628340</u></p> <p>Employment No #</p>																																																																																																																																																																																														
Place of examination <u>NMC AL-HAIL</u>	Date:- <u>07/11/2022</u>																																																																																																																																																																																															
<p>If a dependant enter employee's name here:</p> <table border="1"> <tr> <td>Surname</td> <td>Forenames</td> </tr> <tr> <td>Birth date: <u>28/02/1969</u></td> <td>Nationality: <u>PAKISTANI</u></td> </tr> <tr> <td><input checked="" type="checkbox"/> Male <input type="checkbox"/> Female</td> <td><input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced</td> </tr> <tr> <td colspan="2"> <input type="checkbox"/> Relationship to employee  <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter         </td> </tr> </table>				Surname	Forenames	Birth date: <u>28/02/1969</u>	Nationality: <u>PAKISTANI</u>	<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced	<input type="checkbox"/> Relationship to employee <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter																																																																																																																																																																																						
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<p>Name and address of family doctor</p>		<p>List your last 3 jobs          (1)          (2)</p>																																																																																																																																																																																														
<p>Are you a Registered Disabled Person? (UK only) <input type="checkbox"/></p>		<p>Do you belong to any Medical Insurance Scheme? <input type="checkbox"/></p>																																																																																																																																																																																														
<p>DO YOU HAVE OR HAVE YOU HAD:- (Tick "Yes" or "No" column or put a (?) if uncertain exclude minor ailments.)</p> <table border="1"> <thead> <tr> <th></th> <th>Y</th> <th>N</th> <th></th> <th>Y</th> <th>N</th> <th></th> <th>Y</th> <th>N</th> </tr> </thead> <tbody> <tr> <td>1. Sinus trouble</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td>21. Cancer</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td colspan="3"><b>HAVE YOU EVER BEEN:-</b></td> </tr> <tr> <td>2. Neck swelling/glands</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td>22. Heart Disease</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td>40. Rejected for employment or insurance for medical reasons</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>3. 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<p>PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT:-</p> <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: <u>07/11/2022</u>	Signature of Applicant: <u>T. Al-Hail</u>																																																																																																																																																																																															

FOR COMPLETION BY EXAMINING DOCTOR OR NURSE  
Further details of medical history and recreational activities

N = Normal A = Abnormal (please describe)		PHYSICAL EXAMINATION										
N	A											
<input checked="" type="checkbox"/>	1. Eyes & Pupils											
<input checked="" type="checkbox"/>	2. E.N.T.											
<input checked="" type="checkbox"/>	3. Teeth & Mouth											
<input checked="" type="checkbox"/>	4. Lungs & Chest											
<input checked="" type="checkbox"/>	5. Cardiovascular System											
<input checked="" type="checkbox"/>	6. Abdo, Viscera											
<input checked="" type="checkbox"/>	7. Hernial Orifices											
<input checked="" type="checkbox"/>	8. Anus & Rectum											
<input checked="" type="checkbox"/>	9. Genito-urinary											
<input checked="" type="checkbox"/>	10. Extremities											
<input checked="" type="checkbox"/>	11. Musculo-skeletal											
<input checked="" type="checkbox"/>	12. Skin & Varicose Vns.											
<input checked="" type="checkbox"/>	13. C.N.S.											
HEIGHT 175 cm	WEIGHT 96 kg	BM 31.35	B.P. 139/93	PULSE 71	HEARING L (N) R (N)	VISION DISTANT Uncorrected 6/6 Corrected 6/6	NEAR R (N) L (N)	Colour Vision (N)	Blood Group (N)			
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS					N	A				
<input checked="" type="checkbox"/>	1. Urinalysis						<input checked="" type="checkbox"/>	7. Audiogram				
<input checked="" type="checkbox"/>	2. Hb, Blood count, ESR						<input checked="" type="checkbox"/>	8. Lung Function				
<input checked="" type="checkbox"/>	3. LFT, RFT, RBS						<input checked="" type="checkbox"/>	9. Chest X-Ray				
<input checked="" type="checkbox"/>	4. Drug Screen						<input checked="" type="checkbox"/>	10. ECG				
<input checked="" type="checkbox"/>	5. Lipids (40 years +)						<input checked="" type="checkbox"/>	11. CVS risk for 40 yrs. & above				
<input checked="" type="checkbox"/>	6. Sickle Cell test						<input checked="" type="checkbox"/>	12. HIV, Hepatitis screening				

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

ASSESSMENT:

- FIT ALL AREAS
- FIT WITH SPECIFIC RESTRICTION
- TEMPORARY UNFIT
- AWAITING SPECIALIST ASSESSMENT



REVIEW/CONSULTATION

DATE:

DOCTOR NAME: Dr. Christa

