



## MEDICAL FITNESS CERTIFICATE FOR TRUCKOMAN

**NAME** **AJISH BHASKARAN KUMAR**

**AGE/D.O.B** **41 Y,01.05.1979**

**DATE** **04.04.2021**

**PASS/ID NO:** **85385274**

**GENDER** **MALE**

**VISION-RT-EYE** **6/6 WITHOUT GLASSES**

**HEIGHT** **161 CM**

**LT-EYE** **6/6 WITHOUT GLASSES**

**WEIGHT** **72 KG**

**HEART** **NORMAL**

**BP** **128/78 mmHg**

**LUNGS** **NORMAL**

**PULSE** **76/ Min**

**ABDOMEN** **NORMAL**

**CNS** **NORMAL**

**SKIN** **NORMAL**

**ENT** **NORMAL**

### INVESTIGATIONS

**FBS**

**ELEVATED**

**HbA1c**

**8.00%**

**BLOOD GROUP**

**A POSITIVE**

**HAEMOGRAM**

**NORMAL**

**LFT**

**NORMAL**

**RFT**

**NORMAL**

**LIPID PROFILE**

**DLP**

**SICKLING TEST**

**NEGATIVE**

**URINE ROUTINE**

**HEMATURIA**

**ECG**

**NORMAL**

**AUDIOGRAM**

**Normal hearing threshold with mild moderate dip at 4000Hz in Rt ear & sloping SNHL at high frequency in Lt ear.**

**FRAMINGHAM SCORE**

**Probability of developing cardiovascular disease in next 10 years is 2.3%**

**COMMENTS**

- \* To use adequate ear protection in high noise environment
- \* DLP- Advised treatment
- \* HEMATURIA- Advised treatment if symptomatic
- \* Newly detected T2DM- Advised to start medication
- \* To repeat FBS & PPBS after 2 weeks

**CONCLUSION**

**MEDICALLY FIT**

**Dr.B.VENKATESH KUMAR**  
**CARDIOLOGIST**  
**MOH NO#14581**

**FIT**



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المقر الرئيسي:

س.ت. : ١٦٩٣٨٠٨، ص.ب. : ٤٤٣، الرمز البريدي : ١١٢

روي سلطنة عمان، هاتف : ٢٤٧٩٩٧٦٠، فاكس : ٢٤٧٩٩٧٦٥

الخوير : ٢٤٤٨٨٣٢٢ | صحار : ٢٣٨٤٦٦٠ | الخوض : ٢٤٥٤٦٩٩ | صلالة : ٢٣٩١٨٣٠

برشاء : ٢٦٨٨٤٩٠ | صور : ٢٥٥٤١١٢ | اللوي : ٢٥٤٤٧٧٧ | فلح : ٢٦٥٤١٣١

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# 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 <b>BADR AL SAMAA</b>                                                                                                                                                                                                                                                                                                                                                                                                         |  | Date <b>04/04/19</b>                               | Surname<br><b>AJITH BHASKARAN NAM</b>                                   |                               |  |
| If a dependant enter employee's name here:<br>Surname:                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                    | Forenames:                                                              |                               |  |
| Birth date:                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                    | Address                                                                 |                               |  |
| Nationality:                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                    | Home telephone number                                                   |                               |  |
| Relationship to employee<br><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                                                   |                               |  |
| 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                                                                       |                               |  |
| 1. Sinus trouble                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                    |                                                                         | 21. Cancer                    |  |
| 2. Neck swelling/glands                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                    |                                                                         | 22. Heart Disease             |  |
| 3. Difficulty in vision                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                    |                                                                         | 23. Rheumatic fever           |  |
| 4. Any ear discharge                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                    |                                                                         | 24. Abnormal heartbeat        |  |
| 5. Asthma/bronchitis                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                    |                                                                         | 25. High blood pressure       |  |
| 6. Hayfever/other significant allergy                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                    |                                                                         | 26. Stroke                    |  |
| 7. Any skin trouble                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                    |                                                                         | 27. Serious chest pain        |  |
| 8. Tuberculosis                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                    |                                                                         | 28. Any blood disease         |  |
| 9. Shortness of breath                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                    |                                                                         | 29. Kidney disease            |  |
| 10. Coughed/vomited blood                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                    |                                                                         | 30. Blood in urine            |  |
| 11. Severe abdominal pain                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                    |                                                                         | 31. Diabetes                  |  |
| 12. Stomach ulcer                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                    |                                                                         | 32. Headaches/migraine        |  |
| 13. Recurrent indigestion                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                    |                                                                         | 33. Dizziness/fainting        |  |
| 14. Jaundice or hepatitis                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                    |                                                                         | 34. Epilepsy                  |  |
| 15. Gall Bladder disease                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                    |                                                                         | 35. Joints/spinal trouble     |  |
| 16. Marked change in bowel habits                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                    |                                                                         | 36. Surgical operation        |  |
| 17. Blood in stools (motions)                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                    |                                                                         | 37. Serious accident/fracture |  |
| 18. Marked change in weight                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                    |                                                                         | 38. Tropical disease          |  |
| 19. Varicose veins                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                    |                                                                         | 39. Fear of heights           |  |
| 20. Lump in breast/armpit                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                    |                                                                         |                               |  |
| How much tobacco each day? <b>(2-3/week) Cg</b>                                                                                                                                                                                                                                                                                                                                                                                                   |  | Average daily alcohol consumption <b>90ml/week</b> |                                                                         |                               |  |
| Have you ever taken elicited drugs? ( ) PDO test all new potential employees for elicited/recreational drugs                                                                                                                                                                                                                                                                                                                                      |  |                                                    |                                                                         |                               |  |
| FAMILY HISTORY: Diabetes ( ) Tuberculosis ( ) Epilepsy ( ) Asthma ( ) Eczema ( )                                                                                                                                                                                                                                                                                                                                                                  |  |                                                    |                                                                         |                               |  |
| Heart disease ( ) High blood pressure ( ) Stroke ( ) Blood Disease ( ) Cancer ( )                                                                                                                                                                                                                                                                                                                                                                 |  |                                                    |                                                                         |                               |  |
| PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT:-                                                                                                                                                                                                                                                                                                                                                                             |  |                                                    |                                                                         |                               |  |
| 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. |  |                                                    |                                                                         |                               |  |
| Date: <b>04/04/19</b>                                                                                                                                                                                                                                                                                                                                                                                                                             |  | Signature of Applicant: <b>Ajith</b>               |                                                                         |                               |  |
| FOR COMPLETION BY EXAMINING DOCTOR OR NURSE                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                    |                                                                         |                               |  |
| Further details of medical history and recreational activities                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                    |                                                                         |                               |  |

**father - oral Cancer**

**Dr. B. VENKATESH KUMAR**  
**CARDIOLOGIST**  
**MOH NO#14581**



| N = Normal A = Abnormal (please describe)                                                                                                                                                    |        |                                             |        | PHYSICAL EXAMINATION                                                                                                                                                                                            |         |             |                 |                                  |       |  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|---------------------------------------------|--------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|-------------|-----------------|----------------------------------|-------|--|--|
| N                                                                                                                                                                                            | A      |                                             |        | <p>Normal &amp; Reactive</p> <p>ear, nose, throat - normal</p> <p>mm</p> <p>slit @ for mm</p> <p>h.p. m @</p> <p>normal</p> <p>normal</p> <p>normal</p> <p>normal</p> <p>normal</p> <p>normal</p> <p>normal</p> |         |             |                 |                                  |       |  |  |
|                                                                                                                                                                                              |        | 1. Eyes & Pupils                            |        |                                                                                                                                                                                                                 |         |             |                 |                                  |       |  |  |
|                                                                                                                                                                                              |        | 2. E.N.T.                                   |        |                                                                                                                                                                                                                 |         |             |                 |                                  |       |  |  |
|                                                                                                                                                                                              |        | 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.                                  |        |                                                                                                                                                                                                                 |         |             |                 |                                  |       |  |  |
| HEIGHT                                                                                                                                                                                       | WEIGHT | BMI                                         | B.P.   | PULSE                                                                                                                                                                                                           | HEARING | VISION      |                 | Colour                           | Blood |  |  |
| cm                                                                                                                                                                                           | kg     |                                             |        | /mins.                                                                                                                                                                                                          | L       | DISTANT     | NEAR            | Vision                           | Group |  |  |
| 161                                                                                                                                                                                          | 72     | 27.8                                        | 128/78 | 76                                                                                                                                                                                                              | L       | Uncorrected | R L R L         |                                  | A+    |  |  |
|                                                                                                                                                                                              |        |                                             |        |                                                                                                                                                                                                                 | R       | Corrected   | 6/6 6/6 6/6 6/6 |                                  |       |  |  |
| N                                                                                                                                                                                            | A      | LABORATORY AND OTHER SPECIAL INVESTIGATIONS |        |                                                                                                                                                                                                                 |         | N           | A               |                                  |       |  |  |
|                                                                                                                                                                                              |        | 1. Urinalysis                               |        |                                                                                                                                                                                                                 |         |             |                 | 7. Audiogram                     |       |  |  |
|                                                                                                                                                                                              |        | 2. Hb, Bloodcount, ESR                      |        |                                                                                                                                                                                                                 |         |             |                 | 8. Lung Function                 |       |  |  |
|                                                                                                                                                                                              |        | 3. LFT, RFT, RBS                            |        |                                                                                                                                                                                                                 |         |             |                 | 9. Chest X-Ray                   |       |  |  |
|                                                                                                                                                                                              |        | 4. Drug Screen                              |        |                                                                                                                                                                                                                 |         |             |                 | 10. ECG                          |       |  |  |
|                                                                                                                                                                                              |        | 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.)                                                                                                   |        |                                             |        |                                                                                                                                                                                                                 |         |             |                 |                                  |       |  |  |
| <p>DLP - Advised treatment</p> <p>Hematuria - Advised treatment if symptomatic</p> <p>Newly detected 7.2 Dm - Advised to start medication</p> <p>To repeat FBS &amp; PPBS after 2 weeks.</p> |        |                                             |        |                                                                                                                                                                                                                 |         |             |                 |                                  |       |  |  |
| ASSESSMENT:                                                                                                                                                                                  |        |                                             |        |                                                                                                                                                                                                                 |         |             |                 |                                  |       |  |  |
| <p>FIT ALL AREAS <input checked="" type="checkbox"/> FIT WITH RESTRICTION <input type="checkbox"/> TEMPORARY UNFIT <input type="checkbox"/> UNFIT <input type="checkbox"/></p>               |        |                                             |        |                                                                                                                                                                                                                 |         |             |                 |                                  |       |  |  |
| Date: 04/01/21 Name (Block Capitals): Dr. / Nurse Signature:                                                                                                                                 |        |                                             |        |                                                                                                                                                                                                                 |         |             |                 |                                  |       |  |  |
| REVIEW/CONSULTATION                                                                                                                                                                          |        |                                             |        |                                                                                                                                                                                                                 |         |             |                 |                                  |       |  |  |
| Date: 04/02/21 Name (Block Capitals): Dr. / Nurse Signature:                                                                                                                                 |        |                                             |        |                                                                                                                                                                                                                 |         |             |                 |                                  |       |  |  |

Take ear protection in noisy environment.

Dr. SAJILA P.P  
MBBS., DNB (ENT), DLO.  
Specialist Ent Surgeon  
MOH Lic No.: 18387

Dr. B. VENKATESH KUMAR NIZWA  
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