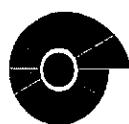


## 1.1 Appendix 32: EX1 Form (Initial Examination Report)

## INITIAL EXAMINATION REPORT (MEDICAL - CONFIDENTIAL)

Petroleum Development Oman  
MEDICAL DEPARTMENTPLEASE COMPLETE YOUR PERSONAL  
DETAILS IN BLOCK CAPITALS

Place of examination		Date <u>29/3/19</u>		Surname <u>R Kulwinder Singh</u>																																																																			
				Forenames																																																																			
				Address																																																																			
				Home telephone number																																																																			
				Employment No # <u>6376</u>																																																																			
If a dependant enter employee's name here:																																																																							
Surname:		Forenames:																																																																					
Birth date: <u>24/4/1974</u>		Nationality: <u>Indian</u>		Country of birth:																																																																			
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced		Relationship to employee <input checked="" type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter																																																																			
Number of children: <u>2</u>																																																																							
Reason for examination		Pre-Employment <input type="checkbox"/> Job:		<u>Driver</u>																																																																			
Pre-Overseas		<input type="checkbox"/> Area:																																																																					
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.)																																																																							
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How much tobacco each day? <u>no</u>		Average daily alcohol consumption <u>no</u>																																																																					
Have you ever taken elicited drugs? <input checked="" type="checkbox"/> PDO test all new/potential employees for elicited/recreational drugs																																																																							
<b>FAMILY HISTORY:</b> Diabetes <input checked="" type="checkbox"/> Tuberculosis <input checked="" type="checkbox"/> Epilepsy <input checked="" type="checkbox"/> Asthma <input checked="" type="checkbox"/> Eczema <input checked="" type="checkbox"/> Heart disease <input checked="" type="checkbox"/> High blood pressure <input checked="" type="checkbox"/> Stroke <input checked="" type="checkbox"/> Blood Disease <input checked="" type="checkbox"/> Cancer <input checked="" type="checkbox"/>																																																																							
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: <u>29/3/19</u>		Signature of Applicant: <u>RK</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	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 cm		WEIGHT kg	BM	B.P. 140 /90	PULSE /mins.	HEARING L R	VISION DISTANT R L				Colour Vision	Blood Group			
174	103			18		Uncorrected Corrected	6   6	6   6	6   6	N					
N	A				LABORATORY AND OTHER SPECIAL INVESTIGATIONS			N	A						
		1. Urinalysis								7. Audiogram					
		2. Hb, Blood count, 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.)

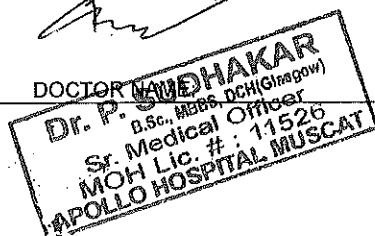
Frailty/Nutrition Risk Score : 4.0 %

ASSESSMENT:

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

REVIEW/CONSULTATION

DATE: 02/04/19



SIGNATURE: