

MEDICAL FITNESS CERTIFICATE FOR TRUCKMAN

NAME **KULWINDER SINGH RATTAN SINGH**

AGE/D.O.B	46 Y,24.04.1974	DATE	13.03.2021
PASS/ID NO:	85662956	GENDER	MALE
VISION-RT-EYE	6/6 WITHOUT GLASSES	HEIGHT	178 CM
LT-EYE	6/6 WITHOUT GLASSES	WEIGHT	108 KG
HEART	NORMAL	BP	160/102 mmHg
LUNGS	NORMAL	PULSE	78/ Min
ABDOMEN	NORMAL	CNS	NORMAL
SKIN	NORMAL	ENT	NORMAL

INVESTIGATIONS

RBS	NORMAL
BLOOD GROUP	B POSITIVE
HAEMOGRAM	NORMAL
LFT	NORMAL
RFT	NORMAL
LIPID PROFILE	NORMAL
SICKLING TEST	NEGATIVE
URINE ROUTINE	NORMAL
ECG	NORMAL
AUDIOGRAM	Normal hearing threshold with severe high frequency SNHL followed by normal hearing at low frequency B/L
FRAMINGHAM SCORE	Probability of developing cardiovascular disease in next 10 years is 2.5%
COMMENTS	<ul style="list-style-type: none"> * To use adequate ear protection in high noise environment * Known HTN since 1 year on Telmisartan -Am 40/5 * Bp mildly elevated/ Drug modified

CONCLUSION

MEDICALLY FIT

Signature:

Dr.B.VENKATESH KUMAR
CARDIOLOGIST
MOH NO#14581

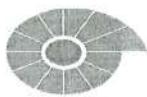
FIT

SEAI

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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 BADR AL SAMAA	Date 13/03/18
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If a dependant enter employee's name here:

Surname:

Birth date: **24.04.1971**

Nationality:

Surname

Forenames :

Address

Home telephone number

BULWINDR Smita RANI Smeij

<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	Number of children:
		<input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter	

Reason for examination Pre-Employment Job:

Pre-Overseas Area:

Name and address of family doctor

List your last 3 jobs

(1)

(2)

Are you a Registered Disabled Person? (UK only)

Do you belong to any Medical Insurance Scheme?

DO YOU HAVE OR HAVE YOU HAD:- (Tick "Yes" or "No" column or put a (?) if uncertain exclude minor ailments.)

	Y	N		Y	N		Y	N
1. Sinus trouble	<input checked="" type="checkbox"/>		21. Cancer	<input checked="" type="checkbox"/>		HAVE YOU EVER BEEN:-		
2. Neck swelling/glands	<input checked="" type="checkbox"/>		22. Heart Disease	<input checked="" type="checkbox"/>		40. Rejected for employment or insurance for medical reasons		
3. Difficulty in vision	<input checked="" type="checkbox"/>		23. Rheumatic fever	<input checked="" type="checkbox"/>		41. Awarded benefits for industrial injury/illness		
4. Any ear discharge	<input checked="" type="checkbox"/>		24. Abnormal heartbeat	<input checked="" type="checkbox"/>		42. Treated for a mental condition, e.g. depression		
5. Asthma/bronchitis	<input checked="" type="checkbox"/>		25. High blood pressure	<input checked="" type="checkbox"/>		43. Treated for problem drinking or drug abuse		
6. Hayfever/other significant allergy	<input checked="" type="checkbox"/>		26. Stroke	<input checked="" type="checkbox"/>		44. Exposed to toxic substance or noise		
7. Any skin trouble	<input checked="" type="checkbox"/>		27. Serious chest pain	<input checked="" type="checkbox"/>		FOR WOMEN ONLY		
8. Tuberculosis	<input checked="" type="checkbox"/>		28. Any blood disease	<input checked="" type="checkbox"/>		Have you ever had:-		
9. Shortness of breath	<input checked="" type="checkbox"/>		29. Kidney disease	<input checked="" type="checkbox"/>		45. An abnormal smear		
10. Coughed/vomited blood	<input checked="" type="checkbox"/>		30. Blood in urine	<input checked="" type="checkbox"/>		46. Any gynaecological treatment		
11. Severe abdominal pain	<input checked="" type="checkbox"/>		31. Diabetes	<input checked="" type="checkbox"/>		47. Are you pregnant?		
12. Stomach ulcer	<input checked="" type="checkbox"/>		32. Headaches/migraine	<input checked="" type="checkbox"/>		48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE		
13. Recurrent indigestion	<input checked="" type="checkbox"/>		33. Dizziness/fainting	<input checked="" type="checkbox"/>				
14. Jaundice or hepatitis	<input checked="" type="checkbox"/>		34. Epilepsy	<input checked="" type="checkbox"/>				
15. Gall Bladder disease	<input checked="" type="checkbox"/>		35. Joints/spinal trouble	<input checked="" type="checkbox"/>				
16. Marked change in bowel habits	<input checked="" type="checkbox"/>		36. Surgical operation	<input checked="" type="checkbox"/>				
17. Blood in stools (motions)	<input checked="" type="checkbox"/>		37. Serious accident/fracture	<input checked="" type="checkbox"/>				
18. Marked change in weight	<input checked="" type="checkbox"/>		38. Tropical disease	<input checked="" type="checkbox"/>				
19. Varicose veins	<input checked="" type="checkbox"/>		39. Fear of heights	<input checked="" type="checkbox"/>				
20. Lump in breast/armpit	<input checked="" type="checkbox"/>							

How much tobacco each day? Average daily alcohol consumption

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: **13/03/18**

Signature of Applicant:

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



HFW

on

multi section

o 1 yr

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