

Medical Fitness Certificate

Name of the Examined employee: RASHID IQBAL KHAN

Age: 46

ID NUMBER:

Job Title:

Date of Medical Examination: 05.08.2023

Examining Physician:

Medical Centre: APOLLO HOSPITAL MUSCAT

Company:

Assessment Result:

Fit to work without restrictions

This Certificate is valid for 2 years from the date of medical examination

Fitness Classifications:

- Fit to work without restrictions
- Fit to work with restriction
- Unfit to work Temporarily or Definitely

Restrictions List:


- R1: Unfit to work offshore, on marine vessels and in remote locations.
R2: Unfit for Lifting and strenuous efforts.
R3: Unfit to work in certain countries, check with geomarkethealth advisor.
R4: Unfit to work in jobs requiring precise color vision.
R5: Unfit to work in job with high level of noise.
R6: Unfit to work in high risk of malaria countries.
R7: Unfit to work in extreme heat.
R8: Unfit to work in extreme cold.
R9: Contact Geomarket health advisor/international medical coordinator – there exist specific restriction.
R10: Unfit to work for a temporarily of time until further notice.
R11: Unfit to work in jobs requiring good visual acuity (eg: driving company vehicle).
R12: Fit only for defined period of time (1, 3 or 6 months) and must be reassessed and fitness redefined.
R13: Unfit to drive company vehicle.
R14: Unfit to fly long haul flights.
R15: Unfit to work in heights and confined spaces.

Examining Physician Stamp and signature

Hospital/Clinic Seal



CONFIDENTIAL MEDICAL TO BE COMPLETED BY THE EMPLOYEE

| | | | | | |
|--|--|---------------------|-----------------------------------|---|---|
| Med-check History Form | | Name: | Rashid IQBAL Khan | | |
| | | GIN # | 105364536 | | |
| Place of examination | Date | Mobile # | | | |
| Apollo Hospital | 5/08/2023 | 94961200 | | | |
| Age: 46 | Nationality: Pakistani | Blood Group | | | |
| <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female | <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated / Divorced | Number of children: | | | |
| DO YOU HAVE OR HAVE YOU HAD:- (Tick "Yes" or "No" column or put a (?) if uncertain exclude minor ailments.) | | | | | |
| | Y | N | | 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? 4-5 cigs/day | | | Average daily alcohol consumption | | |
| Have you ever taken elicited drugs? <input checked="" type="checkbox"/> | | | | | |
| 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's Doctors, and the details sent to them by the examining Doctor. | | | | | |
| Date: 5/08/2023 | | | | | |
| Signature of Applicant:  | | | | | |