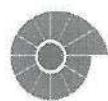




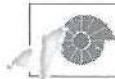
## Appendix 32: EX1 Form (Initial Examination Report)

## INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

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

Place of examination <i>Hail</i>		Date <i>10/07/2023</i>	Surname <i>Mohamed</i>																																																																	
			Forenames <i>Mohamed Radhees</i>																																																																	
			Address <i>Hail</i>																																																																	
			Home telephone number <i>92567541</i>																																																																	
If a dependant enter employee's name here: Surname: <i>Mohamed</i>		Forenames: <i>Radhees</i>																																																																		
Birth date: <i>10/07/1980</i>		Nationality: <i>Saudi</i>	Country of birth: <i>Hail</i> Religion: <i>Islam</i>																																																																	
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		<input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced	Relationship to employee <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter																																																																	
Number of children: <i>3</i>																																																																				
Reason for examination Pre-Employment <input type="checkbox"/>		Job: <i>DRIVER</i>																																																																		
Pre-Overseas <input type="checkbox"/>		Area: <i></i>																																																																		
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.)																																																																				
<table border="1"> <thead> <tr> <th>Y</th> <th>N</th> </tr> </thead> <tbody> <tr><td><input checked="" type="checkbox"/></td><td>21. Cancer</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>22. Heart Disease</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>23. Rheumatic fever</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>24. Abnormal heartbeat</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>25. High blood pressure</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>26. Stroke</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>27. Serious chest pain</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>28. Any blood disease</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>29. Kidney disease</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>30. Blood in urine</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>31. Diabetes</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>32. Headaches/migraine</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>33. Dizziness/fainting</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>34. Epilepsy</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>35. Joints/spinal trouble</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>36. Surgical operation</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>37. Serious accident/fracture</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>38. Tropical disease</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>39. Fear of heights</td></tr> </tbody> </table>		Y	N	<input checked="" type="checkbox"/>	21. Cancer	<input checked="" type="checkbox"/>	22. Heart Disease	<input checked="" type="checkbox"/>	23. Rheumatic fever	<input checked="" type="checkbox"/>	24. Abnormal heartbeat	<input checked="" type="checkbox"/>	25. High blood pressure	<input checked="" type="checkbox"/>	26. Stroke	<input checked="" type="checkbox"/>	27. Serious chest pain	<input checked="" type="checkbox"/>	28. Any blood disease	<input checked="" type="checkbox"/>	29. Kidney disease	<input checked="" type="checkbox"/>	30. Blood in urine	<input checked="" type="checkbox"/>	31. Diabetes	<input checked="" type="checkbox"/>	32. Headaches/migraine	<input checked="" type="checkbox"/>	33. Dizziness/fainting	<input checked="" type="checkbox"/>	34. Epilepsy	<input checked="" type="checkbox"/>	35. Joints/spinal trouble	<input checked="" type="checkbox"/>	36. Surgical operation	<input checked="" type="checkbox"/>	37. Serious accident/fracture	<input checked="" type="checkbox"/>	38. Tropical disease	<input checked="" type="checkbox"/>	39. Fear of heights	<table border="1"> <thead> <tr> <th>Y</th> <th>N</th> </tr> </thead> <tbody> <tr><td><input checked="" type="checkbox"/></td><td>HAVE YOU EVER BEEN:-</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>40. Rejected for employment or insurance for medical reasons</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>41. Awarded benefits for industrial injury/illness</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>42. Treated for a mental condition, e.g. depression</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>43. Treated for problem drinking or drug abuse</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>44. Exposed to toxic substance or noise</td></tr> <tr><td colspan="2">FOR WOMEN ONLY</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>45. An abnormal smear</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>46. Any gynaecological treatment</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>47. Are you pregnant?</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE</td></tr> </tbody> </table>		Y	N	<input checked="" type="checkbox"/>	HAVE YOU EVER BEEN:-	<input checked="" type="checkbox"/>	40. Rejected for employment or insurance for medical reasons	<input checked="" type="checkbox"/>	41. Awarded benefits for industrial injury/illness	<input checked="" type="checkbox"/>	42. Treated for a mental condition, e.g. depression	<input checked="" type="checkbox"/>	43. Treated for problem drinking or drug abuse	<input checked="" type="checkbox"/>	44. Exposed to toxic substance or noise	FOR WOMEN ONLY		<input checked="" type="checkbox"/>	45. An abnormal smear	<input checked="" type="checkbox"/>	46. Any gynaecological treatment	<input checked="" type="checkbox"/>	47. Are you pregnant?	<input checked="" type="checkbox"/>	48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE	Y N
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How much tobacco each day? <i>10-12 cigarettes</i> Average daily alcohol consumption <i>NO</i>																																																																				
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 <b>purposely withheld</b> important medical information.																																																																				
Date: <i>09-07-23</i>		Signature of Applicant: <i>Mohamed Radhees</i>																																																																		





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

		PHYSICAL EXAMINATION											
N	A												
	1. Eyes & Pupils	Normal											
	2. E.N.T.	Poor oral hygiene.											
	3. Teeth & Mouth	Wear and tear.											
	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	BMI	B.P. 110 90	PULSE 68 /mins.	HEARING L R	VISION Uncorrected Corrected	DISTANT R L	NEAR R L	Colour Vision	Blood Group		
172		28.73	70							28	A positive.		
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, Bloodcount, 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:		DR TUFAN GHODJANI Specialist - Cardiology MOH LIC. No: 21459 nmc specialty hospital, Al Ghoubra		FIT		Ref to Internist for further assessment (High Risk).	
<input checked="" type="checkbox"/> FIT ALL AREAS		<input type="checkbox"/> FIT WITH RESTRICTION		<input type="checkbox"/> TEMPORARY UNFIT		<input type="checkbox"/> UNFIT	

Date: 09/7/23 Name (Block Capitals): Dr. / Nurse

Masood Siddique

Signature:

DR. MASOOD SIDDIQUE  
General Practitioner  
MOH LIC. No: 1004  
nmc specialty hospital, Al Hall

REVIEW/CONSULTATION

Date:

Name (Block Capitals): Dr. / Nurse

Signature:



Page 80

Specification

The controlled version of this CMF Document resides online in Livelink®. Printed copies are UNCONTROLLED.

FIT to Work  
DR TUFAN GHODJANI  
Specialist - Cardiology  
MOH LIC. No: 21459  
nmc specialty hospital, Al Ghoubra

## Fitness to Work Certificate for drivers

Employee Data		Date <b>09-07-23</b>	
Name <b>MUHAMMAD SUDEEN KHAN</b>		Department/Company <b>TRUCK OMAN</b>	
I.D No. <b>110754321</b>	Age <b>53</b>	Occupation <b>DRIVER</b>	
Type of Medical Evaluation		Mark those applying <input checked="" type="checkbox"/>	
A5- HVD- Crane or forklift driving & all heavy vehicles		A7- Professional driving-light vehicles	
<p><b>Health Advisor Statement:</b> The above named person has been examined according to the statements laid down in "Protocols and Guidance Notes on the Medical Evaluation of Fitness to Work". At this time his/her fitness to work status for the above tasks is as follows.</p>			
Fit with no restrictions		<input checked="" type="checkbox"/>	
Fit with following restriction(s)			
The employee is fit for above work but should avoid the following task(s)		Temporary restriction	Permanent restriction
Work near moving machinery or sharp edges		<input type="checkbox"/>	<input type="checkbox"/>
Operate Heavy motor vehicles, forklifts or heavy machinery		<input type="checkbox"/>	<input type="checkbox"/>
Other (Specify)		<input type="checkbox"/>	<input type="checkbox"/>
Temporary Unfit until			
Permanently Unfit			
Name of health advisor	Signature	Date	

