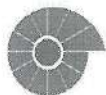




Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)



**Petroleum Development Oman
MEDICAL DEPARTMENT**

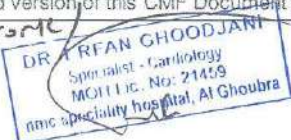
PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Surname: <u>Wah</u>		Forenames: <u>Mohammed Redwan</u>	
Address: <u></u>		Home telephone number: <u>92567541</u>	
Place of examination: <u>Nineh bail</u>	Date: <u>19/07/2022</u>		
If a dependant enter employee's name here:			
Surname: <u></u>		Forenames: <u></u>	
Birth date: <u>01/01/1988</u>	Nationality: <u>Polish</u>	Country of birth: <u>Poland</u>	Religion: <u></u>
<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: <u>3</u>
Reason for examination Pre-Employment <input type="checkbox"/> Job: <u>DRIVER</u> Pre-Overseas <input type="checkbox"/> Area: <u></u>			
Name and address of family doctor		List your last 3 jobs	
		(1) <u></u>	
		(2) <u></u>	
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		Y N	
1. Sinus trouble	<input checked="" type="checkbox"/>	21. Cancer	<input checked="" type="checkbox"/>
2. Neck swelling/glands	<input checked="" type="checkbox"/>	22. Heart Disease	<input checked="" type="checkbox"/>
3. Difficulty in vision	<input checked="" type="checkbox"/>	23. Rheumatic fever	<input checked="" type="checkbox"/>
4. Any ear discharge	<input checked="" type="checkbox"/>	24. Abnormal heartbeat	<input checked="" type="checkbox"/>
5. Asthma/bronchitis	<input checked="" type="checkbox"/>	25. High blood pressure	<input checked="" type="checkbox"/>
6. Hayfever /other significant allergy	<input checked="" type="checkbox"/>	26. Stroke	<input checked="" type="checkbox"/>
7. Any skin trouble	<input checked="" type="checkbox"/>	27. Serious chest pain	<input checked="" type="checkbox"/>
8. Tuberculosis	<input checked="" type="checkbox"/>	28. Any blood disease	<input checked="" type="checkbox"/>
9. Shortness of breath	<input checked="" type="checkbox"/>	29. Kidney disease	<input checked="" type="checkbox"/>
10. Coughed/vomited blood	<input checked="" type="checkbox"/>	30. Blood in urine	<input checked="" type="checkbox"/>
11. Severe abdominal pain	<input checked="" type="checkbox"/>	31. Diabetes	<input checked="" type="checkbox"/>
12. Stomach ulcer	<input checked="" type="checkbox"/>	32. Headaches/migraine	<input checked="" type="checkbox"/>
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"/>		
		HAVE YOU EVER BEEN:-	
		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 <input checked="" type="checkbox"/>	
		FOR WOMEN ONLY	
		Have you ever had:-	
		45. An abnormal smear <input type="checkbox"/>	
		46. Any gynaecological treatment <input type="checkbox"/>	
		47. Are you pregnant? <input type="checkbox"/>	
		48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE <input type="checkbox"/>	
How much tobacco each day? <u>10-12 cig/30 years</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			
FAMILY HISTORY: 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>09-07-23</u>	Signature of Applicant: <u>[Signature]</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	BMI	B.P.	PULSE	HEARING	VISION	Colour Vision	Blood Group
172	90	28.73	110/70	68 /mins.	L (A) R (A)	DISTANT R L NEAR R L Uncorrected Corrected 6/9 6/9	38	A positive
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS				N	A	
✓		1. Urinalysis	Framingham Risk Score is 21.6% (High Risk)				✓	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.)								
* Ref to Internist for further Assessment (High Risk).								
* Fitness Pending								
ASSESSMENT: <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: Masood Siddique								
REVIEW/CONSULTATION								
Date: Name (Block Capitals): Dr. / Nurse Signature:								



Fitness to Work Certificate for drivers

Employee Data		Date	
Name MUHAMMAD SUDEEN KHAN		Date 09-07-23	
I.D No. 110754321		Age 53	
Occupation DRIVER		Department/Company TRUCKOMAN	
Type of Medical Evaluation		Mark those applying ✓	
A5- HVD- Crane or forklift driving & all heavy vehicles		A7- Professional driving-light vehicles	
<p>Health Advisor Statement: 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		✓	
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			
Operate Heavy motor vehicles, forklifts or heavy machinery			
Other (Specify)			
Temporary Unfit until			
Permanently Unfit			
Name of health advisor Signature Date			