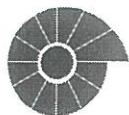


1.1 Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)



Petroleum Development Oman
MEDICAL DEPARTMENT

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Place of examination NML AL HAIR		Date: 09/08/2021	Surname MUHAMMAD YAR Forenames SHEHAR YAR Address Home telephone number Employment No #																																																																																																																													
If a dependant enter employee's name here: Surname: 		Forenames: 																																																																																																																														
Birth date: 02/11/1994 Nationality: PAKISTAN		Country of birth: 		Religion: 																																																																																																																												
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female <input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced		<input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter		Relationship to employee Number of children: 																																																																																																																												
Reason for examination Pre-Employment Pre-Overseas		Job: 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.)																																																																																																																																
<table border="1"> <tr> <th></th> <th>Y</th> <th>N</th> </tr> <tr> <td>1. Sinus trouble</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>2. Neck swelling/glands</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>3. Difficulty in vision</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>4. Any ear discharge</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>5. Asthma/bronchitis</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>6. Hayfever /other significant allergy</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>7. Any skin trouble</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>8. 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Dizziness/fainting</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>34. Epilepsy</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>35. Joints/spinal trouble</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>36. Surgical operation</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>37. Serious accident/fracture</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>38. Tropical disease</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>39. Fear of heights</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>			Y	N	21. Cancer	<input checked="" type="checkbox"/>	<input type="checkbox"/>	22. 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How much tobacco each day? NA.		Average daily alcohol consumption NA.																																																																																																																														
Have you ever taken elicited drugs? (NO) PDO test all new/potential employees for elicited/recreational drugs																																																																																																																																
FAMILY HISTORY: Diabetes (X) Tuberculosis (X) Epilepsy (X) Asthma (✓ Father) Eczema (X) Heart disease (X) High blood pressure (X) Stroke (X) Blood Disease (X) Cancer (X)																																																																																																																																
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: 09/08/21		Signature of Applicant: 1,6,9/21																																																																																																																														

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 168	WEIGHT kg 60	BM I 212	B.P. 118 68	PULSE 98/mins.	HEARING L → N R → N	VISION DISTANT Uncorrected Corrected	R 66	L 66	VISION NEAR R L		Colour Vision Normal	Blood Group B +ve			
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.)															
ASSESSMENT:															
<input checked="" type="checkbox"/> FIT ALL AREAS <input type="checkbox"/> FIT WITH SPECIFIC RESTRICTION <input type="checkbox"/> TEMPORARY UNFIT <input type="checkbox"/> AWAITING SPECIALIST ASSESSMENT															
REVIEW/CONSULTATION															

DATE: 10/8/21

DOCTOR NAME: Dr. MASOOD

SIGNATURE:



DR. MASOOD
General Practitioner
MOH Lic. No. 11064
nmc speciality hospital, Al-Hail