

Medical Fitness Certificate

Name of the Examined employee: MUHAMMAD KASHIF UMAR HAYAT

Age: 31

ID NUMBER:

Job Title:

Date of Medical Examination: 12.08.2023

Examining Physician:

Medical Centre: APOLLO HOSPITAL MUSCAT

Company:

Assessment Result:

Fit to work without restrictions

This Certificate is valid for 3 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

DR. LABEES KIZHAKKELVEETIL ABDO
GENERAL PRACTITIONER
MOH Licence No.: 22090
APOLLO HOSPITAL MUSCAT



CONFIDENTIAL MEDICAL TO BE COMPLETED BY THE EMPLOYEE

Med-check History Form		Name:	Muhammad Kashif		
		GIN #	121716976		
Place of examination	Date	Mobile #			
Apollo Hospital	12/8/23	79538478			
Age: 31	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		<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"/>			
How much tobacco each day?		10 / DAY	Average daily alcohol consumption		NIL
Have you ever taken elicited drugs? () NIL					
FAMILY HISTORY: Diabetes (X) Tuberculosis (X) Epilepsy (X) Asthma (X) 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's Doctors, and the details sent to them by the examining Doctor.					
Date:					
Signature of Applicant:					