



MEDICAL FITNESS CERTIFICATE FOR P.D.O

NAME

GURJANT SINGH

AGE/D.O.B

51 Y, 28.03.1970

DATE

07.11.2021

SS/ID NO:

89640409

GENDER

MALE

VISION-RT-EYE

6/6 WITHOUT GLASSES

HEIGHT

176 CM

-EYE

6/6 WITHOUT GLASSES

WEIGHT

72 KG

ART

NORMAL

BP

132/76 mmHg

NGS

NORMAL

PULSE

62/Min

DOMEN

NORMAL

CNS

NORMAL

N

NORMAL

ENT

NORMAL

ESTIGATIONS

OD GROUP

MOGRAM

OPROFILE

LING TEST

OGRAM

IENTS

ELUSION

re:

B. VENKATESH KUMAR
CARDIOLOGIST
MOH NO#14581

IFG
A POSITIVE
NORMAL
NORMAL
Hyperuricemia
NORMAL
NEGATIVE
NORMAL
NORMAL

NEGATIVE FOR STRESS INDUCED ISCHAEMIC
Normal hearing threshold with mild dip at 4000HZ B/L

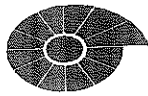
FBS - IFG - Advised diabetic diet
To use adequate ear protection in high noise environment
Hyperuricemia - Advised followup

MEDICALLY FIT



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 BADR AL SAMAA		Date 7/11/11	Surname CAURJANT SINGH		
If a dependant enter employee's name here:			Forenames:		
Surname:			Address		
Birth date:			Home telephone number		
Nationality:			Country of birth:		
Religion:			Relationship to employee		
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced		
<input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter			Number of children:		
Reason for examination Pre-Employment Job: <input type="checkbox"/>					
Pre-Overseas Area: <input type="checkbox"/>					
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.)					
		Y	N	Y	N
1. Sinus trouble			<input checked="" type="checkbox"/>	HAVE YOU EVER BEEN:-	
2. Neck swelling/glands			<input checked="" type="checkbox"/>	40. Rejected for employment or insurance for medical reasons	
3. Difficulty in vision			<input checked="" type="checkbox"/>	41. Awarded benefits for industrial injury/illness	
4. Any ear discharge			<input checked="" type="checkbox"/>	42. Treated for a mental condition, e.g. depression	
5. Asthma/bronchitis			<input checked="" type="checkbox"/>	43. Treated for problem drinking or drug abuse	
6. Hayfever/other significant allergy			<input checked="" type="checkbox"/>	44. Exposed to toxic substance or noise	
7. Any skin trouble			<input checked="" type="checkbox"/>	FOR WOMEN ONLY	
8. Tuberculosis			<input checked="" type="checkbox"/>	Have you ever had:-	
9. Shortness of breath			<input checked="" type="checkbox"/>	45. An abnormal smear	
10. Coughed/vomited blood			<input checked="" type="checkbox"/>	46. Any gynaecological treatment	
11. Severe abdominal pain			<input checked="" type="checkbox"/>	47. Are you pregnant?	
12. Stomach ulcer			<input checked="" type="checkbox"/>	48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE	
13. Recurrent indigestion			<input checked="" type="checkbox"/>		
14. Jaundice or hepatitis			<input checked="" type="checkbox"/>		
15. Gall Bladder disease			<input checked="" type="checkbox"/>		
16. Marked change in bowel habits			<input checked="" type="checkbox"/>		
17. Blood in stools (motions)			<input checked="" type="checkbox"/>		
18. Marked change in weight			<input checked="" type="checkbox"/>		
19. Varicose veins			<input checked="" type="checkbox"/>		
20. Lump in breast/armpit			<input checked="" type="checkbox"/>		
How much tobacco each day? Nil		Average daily alcohol consumption Nil			
Have you ever taken elicited drugs? (X) PDO test all new/potential employees for elicited/recreational drugs					
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 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: 7/11/11			Signature of Applicant:		
FOR COMPLETION BY EXAMINING DOCTOR OR NURSE					
Further details of medical history and recreational activities					

VENKATESH KUMAR
CARDIOLOGIST
MOH NO#14581

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 L R	VISION DISTANT NEAR R L R L Uncorrected Corrected		Colour Vision	Blood Group			
176	72.5	23.4	132 76	62/min.		6/6 6/6 N6 N6		(N)	Atve			
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS				N	A					
		1. Urinalysis	<div style="border: 1px solid black; padding: 5px; display: inline-block;"> Tm - Negative for Hem Andu Bchewing. </div>						7. Audiogram	B/L hearing regularly normal with mild dip @ 4 kHz		
		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. Sickie Cell test							12. HIV, Hepatitis screening			
OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)												
ASSESSMENT:												
FIT ALL AREAS <input checked="" type="checkbox"/> FIT WITH RESTRICTION <input type="checkbox"/> TEMPORARY UNFIT <input type="checkbox"/> UNFIT <input type="checkbox"/>												
Date: 7/1/21 Name (Block Capitals): Dr. / Nurse												
REVIEW/CONSULTATION												
Date: 9/1/21 Name (Block Capitals): Dr. / Nurse												

Signature

Signature
VENKATESH KUMAR
 CARDIOLOGIST
 MOH NO#14581

