



## MEDICAL FITNESS CERTIFICATE FOR P.D.O

NAME **AMRIK SINGH**

AGE/D.O.B	<b>38 Y, 20.10.2021</b>	DATE	<b>03.11.2021</b>
PASS/ID NO:	<b>103657942</b>	GENDER	<b>MALE</b>
VISION-RT-EYE	<b>6/6 WITHOUT GLASSES</b>	HEIGHT	<b>181 CM</b>
LT-EYE	<b>6/6 WITHOUT GLASSES</b>	WEIGHT	<b>73 KG</b>
HEART	<b>NORMAL</b>	BP	<b>136/84 mmHg</b>
LUNGS	<b>NORMAL</b>	PULSE	<b>82/Min</b>
ABDOMEN	<b>NORMAL</b>	CNS	<b>NORMAL</b>
SKIN	<b>NORMAL</b>	ENT	<b>NORMAL</b>

### INVESTIGATIONS

FBS	<b>NORMAL</b>
BLOOD GROUP	<b>A POSITIVE</b>
HAEMOGGRAM	<b>Eosinophilia</b>
LIPID PROFILE	<b>NORMAL</b>
RFT	<b>NORMAL</b>
LFT	<b>NORMAL</b>
SICKLING TEST	<b>NEGATIVE</b>
URE	<b>NORMAL</b>
AUDIOGRAM	<b>Normal hearing threshold</b>

COMMENTS \* **Eosinophilia - Advised treatment if symptomatic**

CONCLUSION **MEDICALLY FIT**

Signature: .....

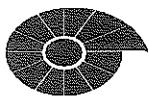
Dr. S. VENKATESH KUMAR  
 CARDIOLOGIST  
 MOH NO: 944581

**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

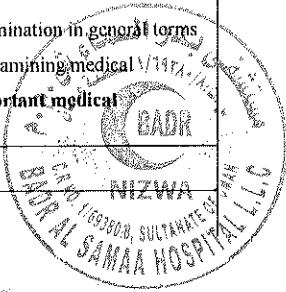
Place of examination <b>BADR AL SAMAA</b>		Date <b>3/11/11</b>	Surname <b>ANDRI SINHAI</b>		
			Forenames :		
			Address		
			Home telephone number		
If a dependant enter employee's name here: Surname: _____ Forenames: _____					
Birth date:	Nationality:	Country of birth:	Religion:		
<input checked="" 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		Y N	
1. Sinus trouble		21. Cancer		HAVE YOU EVER BEEN:-	
2. Neck swelling/glands		22. Heart Disease		40. Rejected for employment or insurance for medical reasons	
3. Difficulty in vision		23. Rheumatic fever		41. Awarded benefits for industrial injury/illness	
4. Any ear discharge		24. Abnormal heartbeat		42. Treated for a mental condition, e.g. depression	
5. Asthma/bronchitis		25. High blood pressure		43. Treated for problem drinking or drug abuse	
6. Hayfever/other significant allergy		26. Stroke		44. Exposed to toxic substance or noise	
7. Any skin trouble		27. Serious chest pain		FOR WOMEN ONLY	
8. Tuberculosis		28. Any blood disease		Have you ever had:-	
9. Shortness of breath		29. Kidney disease		45. An abnormal smear	
10. Coughed/vomited blood		30. Blood in urine		46. Any gynaecological treatment	
11. Severe abdominal pain		31. Diabetes		47. Are you pregnant?	
12. Stomach ulcer		32. Headaches/migraine		48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE	
13. Recurrent indigestion		33. Dizziness/fainting			
14. Jaundice or hepatitis		34. Epilepsy			
15. Gall Bladder disease		35. Joints/spinal trouble			
16. Marked change in bowel habits		36. Surgical operation			
17. Blood in stools (motions)		37. Serious accident/fracture			
18. Marked change in weight		38. Tropical disease			
19. Varicose veins		39. Fear of heights			
20. Lump in breast/armpit					
How much tobacco each day? <b>Nil</b>		Average daily alcohol consumption <b>Nil</b>			
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.					

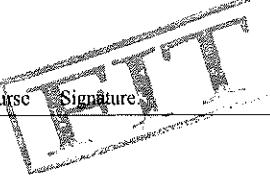
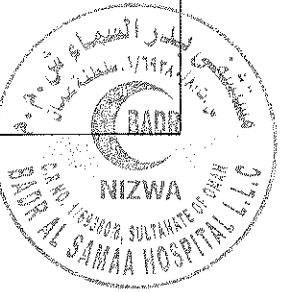
Date: **3/11/11**

Signature of Applicant:

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

**B. VENKATESH KUMAR**  
CARDIOLOGIST  
MOH NO#14581



N = Normal A = Abnormal (please describe)			PHYSICAL EXAMINATION										
N	A												
		1. Eyes & Pupils	Normal & Reactive										
		2. E.N.T.	Clear - N/C TM normal, nose throat normal										
		3. Teeth & Mouth	Normal										
		4. Lungs & Chest	Normal										
		5. Cardiovascular System	S.M (+), No murmur										
		6. Abdo. Viscera	Soft, M (+)										
		7. Hernial Orifices	Normal										
		8. Anus & Rectum	Normal										
		9. Genito-urinary	Normal										
		10. Extremities	Normal										
		11. Musculo-skeletal	Normal										
		12. Skin & Varicose Vns.	Normal										
		13. C.N.S.	Normal										
HEIGHT cm		WEIGHT kg	BMI	B.P.	PULSE 82/mins.	HEARING L R	DISTANT Uncorrected Corrected	VISION NEAR		Colour Vision N	Blood Group A+		
181		73.1	22.3	136 84				R L R L	b/b b/b N/b N/b				
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS				N	A						
/	/	1. Urinalysis				/	/	7. Audiogram N/C hearing sensitivity					
/	/	2. Hb, Bloodcount, ESR						8. Lung Function Normal limit					
/	/	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 RESTRICTION <input type="checkbox"/> TEMPORARY UNFIT <input type="checkbox"/> UNFIT <input type="checkbox"/>													
Date: 3/1/15		Name (Block Capitals): Dr. / Nurse		Signature:									
REVIEW/CONSULTATION													
Date: 3/1/15		Name (Block Capitals): Dr. / Nurse		Signature:									

*Dr. Venkatesh Kumar*  
VENKATESH KUMAR  
CARDIOLOGIST  
MOH NO#14584

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