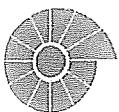
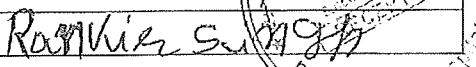
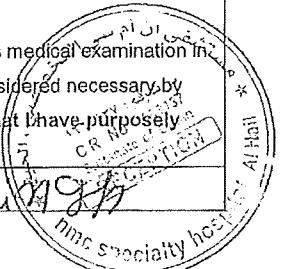


1995

1.1 Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

 <p>Petroleum Development Oman MEDICAL DEPARTMENT</p> <p>Please COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS</p>		Surname _____ Forenames _____ Address _____ Home telephone number _____ Employment No # _____																																																																																																																																																																																														
Place of examination	Date:-																																																																																																																																																																																															
MNC - HAIL 23/11/2022																																																																																																																																																																																																
If a dependant enter employee's name here: Surname: _____ Forenames: _____ Birth date: 19/05/1989 Nationality: INDIA Country of birth: INDIA Religion: ISLAM <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Married <input checked="" 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 <input checked="" type="checkbox"/> Job: Pre-Overseas <input type="checkbox"/> Area:																																																																																																																																																																																																
Name and address of family doctor (1) (2)		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.) <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;"></th> <th style="width: 10%; text-align: center;">Y</th> <th style="width: 10%; text-align: center;">N</th> <th style="width: 25%;"></th> <th style="width: 10%; text-align: center;">Y</th> <th style="width: 10%; text-align: center;">N</th> <th style="width: 25%;"></th> <th style="width: 10%; text-align: center;">Y</th> <th style="width: 10%; text-align: center;">N</th> </tr> </thead> <tbody> <tr> <td>1. Sinus trouble</td> <td></td> <td></td> <td>21. Cancer</td> <td></td> <td></td> <td>HAVE YOU EVER BEEN:-</td> <td></td> <td></td> </tr> <tr> <td>2. Neck swelling/glands</td> <td><input checked="" type="checkbox"/></td> <td></td> <td>22. Heart Disease</td> <td><input checked="" type="checkbox"/></td> <td></td> <td>40. 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Coughed/vomited blood</td> <td><input checked="" type="checkbox"/></td> <td></td> <td>30. Blood in urine</td> <td><input checked="" type="checkbox"/></td> <td></td> <td>46. Any gynaecological treatment</td> <td></td> <td></td> </tr> <tr> <td>11. Severe abdominal pain</td> <td><input checked="" type="checkbox"/></td> <td></td> <td>31. Diabetes</td> <td><input checked="" type="checkbox"/></td> <td></td> <td>47. Are you pregnant?</td> <td></td> <td></td> </tr> <tr> <td>12. Stomach ulcer</td> <td><input checked="" type="checkbox"/></td> <td></td> <td>32. Headaches/migraine</td> <td><input checked="" type="checkbox"/></td> <td></td> <td>48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE</td> <td></td> <td></td> </tr> <tr> <td>13. Recurrent indigestion</td> <td><input checked="" type="checkbox"/></td> <td></td> <td>33. Dizziness/fainting</td> <td><input checked="" type="checkbox"/></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>14. 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Have you ever taken elicited drugs? () PDO test all new/potential employees for elicited/recreational drugs <input type="checkbox"/>																																																																																																																																																																																																
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PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT:- <p>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.</p>																																																																																																																																																																																																
Date:	Signature of Applicant:  																																																																																																																																																																																															

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

		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	BM	B P	PULSE bpm	HEARING L R	VISION DISTANT R L				Colour Vision	Blood Group			
168		76	24	165 98	85	Uncorrected Corrected	R L	R L		1	AB Positive				
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:

- FIT ALL AREAS
- FIT WITH SPECIFIC RESTRICTION
- TEMPORARY UNFIT
- AWAITING SPECIALIST ASSESSMENT

REVIEW/CONSULTATION

DATE.

24/01/2022 DOCTOR NAME.

Dr. Nadeem Farhan

SIGNATURE.

