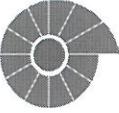
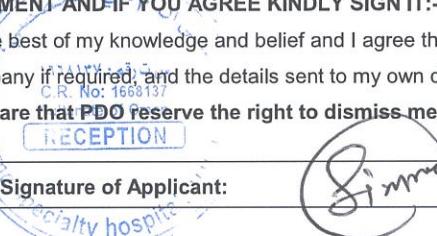


1.1 Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

 Petroleum Development Oman MEDICAL DEPARTMENT		Surname Forenames <i>SIMRANJIT SINGH</i>																																																																																			
PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS		Address Home telephone number Employment No #																																																																																			
Place of examination <i>NML AL HAIL</i>	Date:- <i>08/05/2021</i>																																																																																				
If a dependant enter employee's name here: Surname: _____ Forenames: _____																																																																																					
Birth date:	Nationality: <i>INDIAN</i>	Country of birth:	Religion:																																																																																		
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married <input checked="" type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced	Relationship to employee <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter	Number of children:																																																																																		
Reason for examination	Pre-Employment	<input type="checkbox"/> Job:																																																																																			
	Pre-Overseas	<input type="checkbox"/> Area:																																																																																			
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.)																																																																																					
<table border="1"> <thead> <tr> <th>Y</th> <th>N</th> </tr> </thead> <tbody> <tr><td><input checked="" type="checkbox"/></td><td>1. Sinus trouble</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>2. Neck swelling/glands</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>3. Difficulty in vision</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>4. Any ear discharge</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>5. Asthma/bronchitis</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>6. Hayfever /other significant allergy</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>7. Any skin trouble</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>8. Tuberculosis</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>9. Shortness of breath</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>10. Coughed/vomited blood</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>11. Severe abdominal pain</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>12. Stomach ulcer</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>13. Recurrent indigestion</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>14. Jaundice or hepatitis</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>15. Gall Bladder disease</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>16. Marked change in bowel habits</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>17. Blood in stools (motions)</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>18. Marked change in weight</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>19. Varicose veins</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>20. Lump in breast/armpit</td></tr> </tbody> </table>		Y	N	<input checked="" type="checkbox"/>	1. Sinus trouble	<input checked="" type="checkbox"/>	2. Neck swelling/glands	<input checked="" type="checkbox"/>	3. 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Blood in urine</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>31. Diabetes</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>32. Headaches/migraine</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>33. Dizziness/fainting</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>34. Epilepsy</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>35. Joints/spinal trouble</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>36. Surgical operation</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>37. Serious accident/fracture</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>38. Tropical disease</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>39. Fear of heights</td></tr> </tbody> </table>		Y	N	<input checked="" type="checkbox"/>	21. Cancer	<input checked="" type="checkbox"/>	22. Heart Disease	<input checked="" type="checkbox"/>	23. Rheumatic fever	<input checked="" type="checkbox"/>	24. 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How much tobacco each day? <i>Occasional</i>		Average daily alcohol consumption <i>Occasional</i>																																																																																			
Have you ever taken elicited drugs? () PDO test all new/potential employees for elicited/recreational drugs																																																																																					
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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: <i>5-5-21</i>	Signature of Applicant: <i>Simranjit Singh</i> 																																																																																				

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											
<input checked="" type="checkbox"/>		1. Eyes & Pupils										
<input checked="" type="checkbox"/>		2. E.N.T.										
<input checked="" type="checkbox"/>		3. Teeth & Mouth										
<input checked="" type="checkbox"/>		4. Lungs & Chest										
<input checked="" type="checkbox"/>		5. Cardiovascular System										
<input checked="" type="checkbox"/>		6. Abdo. Viscera										
<input checked="" type="checkbox"/>		7. Hernial Orifices										
<input checked="" type="checkbox"/>		8. Anus & Rectum										
<input checked="" type="checkbox"/>		9. Genito-urinary										
<input checked="" type="checkbox"/>		10. Extremities										
<input checked="" type="checkbox"/>		11. Musculo-skeletal										
<input checked="" type="checkbox"/>		12. Skin & Varicose Vns.										
<input checked="" type="checkbox"/>		13. C.N.S.										
HEIGHT 160 cm		WEIGHT 65.6 kg	BM 33	B.P. 116/78	PULSE 81/mins.	HEARING L N R N	VISION				Colour Vision	Blood Group
						Uncorrected Corrected	DISTANT R L	NEAR R L				
							6/6	6/6				
							6/6	6/6				
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS				N	A					
<input checked="" type="checkbox"/>		1. Urinalysis				<input checked="" type="checkbox"/>		7. Audiogram				
<input checked="" type="checkbox"/>		2. Hb, Blood count, ESR				<input checked="" type="checkbox"/>		8. Lung Function				
<input checked="" type="checkbox"/>		3. LFT, RFT, RBS				<input checked="" type="checkbox"/>		9. Chest X-Ray				
		4. Drug Screen						10. ECG				
		5. Lipids (40 years +)						11. CVS risk for 40 yrs. & above				
<input checked="" type="checkbox"/>		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: 09/05/2021 DOCTOR NAME: DR. MUHAMMAD KAMRAN												
SIGNATURE:												

