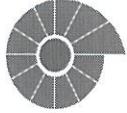


## 1.1 Appendix 32: EX1 Form (Initial Examination Report)

### INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

 <b>Petroleum Development Oman MEDICAL DEPARTMENT</b> <b>PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS</b>	<b>Surname</b> <u>TAHIR JAMIL</u>																																																																																				
	<b>Forenames</b> <u>MUHAMMAD</u>																																																																																				
<b>Address</b>  Home telephone number  Employment No #																																																																																					
<b>Place of examination</b> <u>NMC AL HAIR</u>	<b>Date:-</b> <u>05/05/2021</u>																																																																																				
If a dependant enter employee's name here: <b>Surname:</b> _____ <b>Forenames:</b> _____																																																																																					
<b>Birth date:</b> <u>20/02/1985</u> <b>Nationality:</b> <u>PAKISTAN</u>	<b>Country of birth:</b> _____	<b>Religion:</b> _____																																																																																			
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced	<b>Relationship to employee</b> <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter	<b>Number of children:</b> _____																																																																																		
<b>Reason for examination</b>  Pre-Employment	<input type="checkbox"/> Job:  Pre-Overseas	<input type="checkbox"/> Area:																																																																																			
<b>Name and address of family doctor</b>  (1)  (2)		<b>List your last 3 jobs</b>  (1)  (2)																																																																																			
<b>Are you a Registered Disabled Person? (UK only)</b> <input type="checkbox"/>		<b>Do you belong to any Medical Insurance Scheme?</b> <input type="checkbox"/>																																																																																			
<b>DO YOU HAVE OR HAVE YOU HAD:-</b> (Tick "Yes" or "No" column or put a (?) if uncertain exclude minor ailments.)																																																																																					
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		Have you ever had:-  40. Rejected for employment or insurance for medical reasons  41. Awarded benefits for industrial injury/illness  42. Treated for a mental condition, e.g. depression  43. Treated for problem drinking or drug abuse  44. Exposed to toxic substance or noise																																																																																			
		45. An abnormal smear  46. Any gynaecological treatment  47. Are you pregnant?  48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE																																																																																			
How much tobacco each day? <u>NO</u> Average daily alcohol consumption <u>NO</u>																																																																																					
Have you ever taken elicited drugs? <input checked="" type="checkbox"/> PDC test all new/potential employees for elicited/recreational drugs																																																																																					
<b>FAMILY HISTORY:</b> 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"/>																																																																																					
<b>PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT:-</b>  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.																																																																																					
<b>Date:</b> <u>5-5-2021</u> <b>Signature of Applicant:</b> <u>Tahir</u>																																																																																					

**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 177 cm	WEIGHT 120.5 kg	BM 38	B.P. 135/80	PULSE 88/mins.	HEARING L N R N	Uncorrected Corrected	VISION DISTANT R L 6/6 6/6	NEAR R L 6/6 6/6	Colour Vision Normal	Blood Group O +ve		
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:												



DR. MUHAMMAD KAMRAN  
General Practitioner  
MOH Lic. No: 7638  
nmc specialty hospital, Al Hail