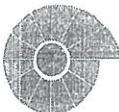


## 1.1 Appendix 32: EX1 Form (Initial Examination Report)

### INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

 <p><b>Petroleum Development Oman MEDICAL DEPARTMENT</b></p> <p>PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS</p>		<p>Surname</p> <p>Forenames <i>SATTAR</i></p> <p>Address</p> <p>Home telephone number</p> <p>Employment No #</p>																																																																																																																																																				
Place of examination <i>Home - Mail</i>	Date:- <i>15/09/05</i>																																																																																																																																																					
<p>If a dependant enter employee's name here:</p> <p>Surname:</p>		<p>Forenames:</p>																																																																																																																																																				
Birth date: <i>10/10/1965</i>	Nationality: <i>BANGLADESH</i>	Country of birth: <i>BANGLADESH</i>	Religion: <i>ISLAM</i>																																																																																																																																																			
<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 type="checkbox"/>	Job: <input type="checkbox"/>																																																																																																																																																				
	Pre-Overseas <input type="checkbox"/>	Area: <input type="checkbox"/>																																																																																																																																																				
Name and address of family doctor		<p>List your last 3 jobs</p> <p>(1)</p> <p>(2)</p>																																																																																																																																																				
Are you a Registered Disabled Person? (UK only) <input type="checkbox"/>		Do you belong to any Medical Insurance Scheme? <input type="checkbox"/>																																																																																																																																																				
<p>DO YOU HAVE OR HAVE YOU HAD:- (Tick "Yes" or "No" column or put a (?) if uncertain/exclude minor ailments.)</p> <table border="1"> <thead> <tr> <th></th> <th>Y</th> <th>N</th> <th></th> <th>Y</th> <th>N</th> <th></th> </tr> </thead> <tbody> <tr><td>1. Sinus trouble</td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td><td>21. Cancer</td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td><td><b>HAVE YOU EVER BEEN:-</b></td></tr> <tr><td>2. Neck swelling/glands</td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td><td>22. Heart Disease</td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td><td>40. Rejected for employment or insurance for medical reasons</td></tr> <tr><td>3. Difficulty in vision</td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td><td>23. 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Exposed to toxic substance or noise</td></tr> <tr><td>7. Any skin trouble</td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td><td>27. Serious chest pain</td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td><td><b>FOR WOMEN ONLY</b></td></tr> <tr><td>8. Tuberculosis</td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td><td>28. Any blood disease</td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td><td>Have you ever had:-</td></tr> <tr><td>9. Shortness of breath</td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td><td>29. Kidney disease</td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td><td>45. An abnormal smear</td></tr> <tr><td>10. Coughed/vomited blood</td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td><td>30. 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Have you ever taken elicited drugs? ( ) PDO test all new/potential employees for elicited/recreational drugs <i>No</i>																																																																																																																																																						
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<p><b>PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT:-</b></p> <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: <i>15/09/05</i>	Signature of Applicant: <i>Li Fouad</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										
		1. Eyes & Pupils									
		2. E.N.T.									
		3. Teeth & Mouth									
		4. Lungs & Chest									
		5. Cardiovascular System									
		6. Abdo. Viscera									
		7. Hernial Orifices	WNL								
		8. Anus & Rectum									
		9. Genito-urinary									
		10. Extremities									
		11. Musculo-skeletal									
		12. Skin & Varicose Vns.									
		13. C.N.S.									
HEIGHT cm		WEIGHT kg	BM I	B.P. /min	PULSE /mins.	HEARING L R	VISION			Colour Vision	Blood Group
158		63	47	121 81			DISTANT R L	NEAR R L			
						Uncorrected	66	66			
						Corrected					
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: 19/04/2023

DOCTOR NAME: DR. SHIVA KUMAR SIDDAAIAH

SIGNATURE: DR. SHIVA KUMAR SIDDAAIAH  
General Practitioner  
MOH Lic. No. 5470  
nmc specialty hospital, Al Hall