


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

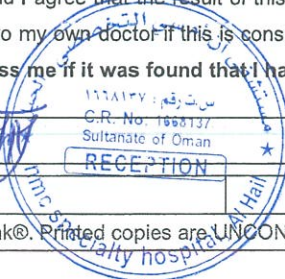
### INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)



**Petrochem Development Oman  
MEDICAL DEPARTMENT**



PLEASE COMPLETE YOUR PERSONAL  
DETAILS IN BLOCK CAPITALS

Surname <b>JOHNY</b>																																																																																																																												
Forenames <b>SREEJITH ARKUKATTIL</b>																																																																																																																												
Address																																																																																																																												
Home telephone number																																																																																																																												
Place of examination <b>NML AL HAIL</b>	Date <b>27/09/22</b>																																																																																																																											
If a dependant enter employee's name here:																																																																																																																												
Surname:	Forenames:																																																																																																																											
Birth date: <b>15/10/1987</b>	Nationality: <b>INDIAN</b>																																																																																																																											
Country of birth:	Religion:																																																																																																																											
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input checked="" type="checkbox"/> Married <input 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.)																																																																																																																												
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How much tobacco each day?      Average daily alcohol consumption																																																																																																																												
Have you ever taken elicited drugs? <input checked="" type="checkbox"/> <b>NOTE</b> test all new/potential employees for elicited/recreational drugs																																																																																																																												
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<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.																																																																																																																												
Date:	Signature of Applicant: 																																																																																																																											







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											
✓		8. Anus & Rectum											
✓		9. Genito-urinary											
✓		10. Extremities											
✓		11. Musculo-skeletal											
✓		12. Skin & Varicose Vns.											
✓		13. C.N.S.											
HEIGHT cm 160		WEIGHT 78kg		BMI 30.5	B.P. 122 93	PULSE 66 /mins.	HEARING L R	VISION DISTANT R L NEAR R L Uncorrected Corrected 6/6 6/6 N N		Colour Vision	Blood Group		
N	A			LABORATORY AND OTHER SPECIAL INVESTIGATIONS				N	A				
✓		1. Urinalysis						✓		7. Audiogram			
✓		2. Hb, Bloodcount, 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. Sickie Cell test								12. HIV, Hepatitis screening			
OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)													
Liver Enzyme 5 GPT High. ESR High.													
ASSESSMENT:													
<input checked="" type="checkbox"/> FIT ALL AREAS <input type="checkbox"/> FIT WITH RESTRICTION <input type="checkbox"/> TEMPORARY UNFIT <input type="checkbox"/> UNFIT													
Date: 27/09/2022 - DR. MUHAMMAD KAMRAN Name (Block Capitals): Dr. / Nurse Signature:													
REVIEW/CONSULTATION													
Date: _____ Name (Block Capitals): Dr. / Nurse _____   DR. MUHAMMAD KAMRAN General Practitioner MOH Lic. No: 7638 nmc speciality hospital, Al-Hail													