



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

## INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

Petroleum Development Oman  
MEDICAL DEPARTMENTPLEASE COMPLETE YOUR PERSONAL  
DETAILS IN BLOCK CAPITALS

Place of examination <b>NMC AL HAIL</b>		Date <b>29/09/22</b>	Surname: <b>SHAHZAD</b>																																																																																																																																																																																											
			Forenames: <b>RUSTAM</b>																																																																																																																																																																																											
			Address																																																																																																																																																																																											
			Home telephone number <b>97665458</b>																																																																																																																																																																																											
If a dependant enter employee's name here: Surname: <b>SHAHZAD</b>		Forenames: <b>RUSTAM</b>																																																																																																																																																																																												
Birth date: <b>22/10/1985</b>		Nationality: <b>PAKISTANI</b>	Country of birth: <b>PAKISTAN</b>	Religion: <b>MUSLIM</b>																																																																																																																																																																																										
<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.)																																																																																																																																																																																														
<table border="1"> <tr> <th></th> <th>Y</th> <th>N</th> <th></th> <th>Y</th> <th>N</th> <th></th> <th>Y</th> <th>N</th> </tr> <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 colspan="3">HAVE YOU EVER BEEN:-</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> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>3. Difficulty in vision</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td>23. Rheumatic fever</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td>41. Awarded benefits for industrial injury/illness</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>4. Any ear discharge</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td>24. Abnormal heartbeat</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td>42. Treated for a mental condition, e.g. depression</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>5. Asthma/bronchitis</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td>25. High blood pressure</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td>43. Treated for problem drinking or drug abuse</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>6. Hayfever /other significant allergy</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td>26. Stroke</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td>44. Exposed to toxic substance or noise</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></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></td> <td></td> <td></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></td> <td></td> <td></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></td> <td></td> <td></td> </tr> <tr> <td>10. Coughed/vomited blood</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td>30. Blood in urine</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td></td> <td></td> </tr> <tr> <td>11. Severe abdominal pain</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td>31. Diabetes</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td></td> <td></td> </tr> <tr> <td>12. Stomach ulcer</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td>32. Headaches/migraine</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td colspan="3">FOR WOMEN ONLY</td> </tr> <tr> <td>13. 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How much tobacco each day? <b>No</b>		Average daily alcohol consumption <b>1</b>																																																																																																																																																																																												
Have you ever taken elicited drugs? ( <input checked="" type="checkbox"/> ) 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: <b>29/09/2022</b>		Signature of Applicant: <b>R. Rehman</b>																																																																																																																																																																																												
Page 79		Specification																																																																																																																																																																																												
The controlled version of this CMF Document resides online in Livelink®. Printed copies are UNCONTROLLED.																																																																																																																																																																																														

C.R. No: 1668137  
Sultanate of Oman  
RECEPTION



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 172	WEIGHT kg 87	BMI 29.4	B.P. 141 87	PULSE 77 mins.	HEARING L R	VISION Uncorrected Corrected	DISTANT R L	NEAR R L	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. 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 RESTRICTION		<input type="checkbox"/> TEMPORARY UNFIT		<input type="checkbox"/> UNFIT		<div style="border: 1px solid black; padding: 5px; display: inline-block;">           DR. CHRISTINE MANDOUH LOTFY ABDALLA            General Practitioner            MOH Lic No: 17978            Speciality: hospital, Al-Hall         </div> <div style="border: 1px solid black; padding: 2px; display: inline-block; margin-top: 5px;">           Signature: _____         </div>			
<div style="border: 1px solid black; padding: 10px; display: inline-block; text-align: center;"> <b>FIT</b> </div>		Date: 31/12/2021 Name (Block Capitals): Dr. / Nurse Dr. Christine									
REVIEW/CONSULTATION											
Date:		Name (Block Capitals): Dr. / Nurse									
<div style="border: 1px solid black; border-radius: 50%; width: 50px; height: 50px; margin: 0 auto; position: relative;"> <div style="position: absolute; left: 0; top: 0; width: 100%; height: 100%; background: repeating-linear-gradient(45deg, transparent, transparent 2px, black 2px, black 4px);"></div> <div style="position: absolute; left: 50%; top: 50%; transform: translate(-50%, -50%);">           نموذج التفاصيل : العيادة            C.R. No: 1666137            Sultanate of Oman            Signature: _____            RECEPTION         </div> </div>											