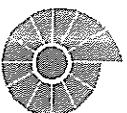


1.1 Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

 <p>Petrolium Development Oman MEDICAL DEPARTMENT</p> <p>PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS</p>		<p>Surname <u>AL BUSHIAD</u> Forenames <u>AMMAR KIAQID MOHAMMED</u> Address _____ Home telephone number _____ Employment No # _____</p>																																																																																																																																																																																														
Place of examination <u>AL MUSAIL</u>	Date:- <u>02/11/2022</u>																																																																																																																																																																																															
<p>If a dependant enter employee's name here:</p> <table border="1"> <tr> <td>Surname _____</td> <td>Forenames _____</td> </tr> <tr> <td>Birth date: <u>28/04/1974</u></td> <td>Nationality: <u>OMAN</u></td> </tr> <tr> <td><input checked="" type="checkbox"/> Male <input type="checkbox"/> Female</td> <td><input type="checkbox"/> Married <input checked="" type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced</td> </tr> <tr> <td colspan="2"> <input type="checkbox"/> Relationship to employee <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter </td> </tr> <tr> <td colspan="2">Number of children: <u>0</u></td> </tr> </table>				Surname _____	Forenames _____	Birth date: <u>28/04/1974</u>	Nationality: <u>OMAN</u>	<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"/> Relationship to employee <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter		Number of children: <u>0</u>																																																																																																																																																																																				
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<p>Are you a Registered Disabled Person? (UK only) <input type="checkbox"/></p>		<p>Do you belong to any Medical Insurance Scheme? <input type="checkbox"/></p>																																																																																																																																																																																														
<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> <th>Y</th> <th>N</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>HAVE YOU EVER BEEN:-</td> <td></td> <td></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></td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>3. 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<p>PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT:-</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: _____		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. F.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 179 cm	WEIGHT 70 kg	BM 21.8	B.P. 126/82	PULSE 60/mins.	HEARING L Normal R Normal Uncorrected Corrected	VISION DISTANT R L 6/9 6/6 Corrected NEAR R L N N	Colour Vision Normal	Blood Group

N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS		N	A
✓		1. Urinalysis	sickle cell (+ve)	✓	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:	DR. NISANTH KALLINKEEL Specialist - Internal Medicine MOH Lic. No: 16847 nmc speciality hospital, Al-Hail	sickle cell (+ve) require Hb electrophoresis follow up with SFC Galist.
<input checked="" type="checkbox"/> FIT ALL AREAS	17/12/2022	7/1/2022
<input type="checkbox"/> FIT WITH SPECIFIC RESTRICTION		
<input type="checkbox"/> TEMPORARY UNFIT		
<input checked="" type="checkbox"/> AWAITING SPECIALIST ASSESSMENT		Reviewed the patient
		- Hb electrophoresis - sickle cell trait - No medication required - Avoid dehydration, monitor Hb. - Pt to continue work
REVIEW/CONSULTATION		
DATE: 6/11/2022	DOCTOR NAME: Dr. Christie	SIGNATURE: DR. NISANTH KALLINKEEL Specialist - Internal Medicine MOH Lic. No: 16847 nmc speciality hospital, Al-Hail