

CANDIDATE / EMPLOYEE IDENTIFICATION

| | | | |
|-----------------------|--------------|-------------|-------------------|
| Civil ID / Passport # | Company ID # | Name | Position |
| 103122944 | 2054 | RAHUL KUMAR | FORKLIFT OPERATOR |
| Nationality | Age | Sex | Company |
| INDIAN | 314 | M | TRUCKOMAN NORTH |
| | | | Location |
| | | | HADIMAH |

EXAMINATION TYPE

Examination: Pre-employment Periodic Exit

VITAL SIGNS & BODY MEASURES

Blood Pressure Category: 130/80 Normal Prehypertension Hypertension Stage 1 Hypertension Stage 2 Hypertension Crisis

BMI Category: 26.1 Underweight Normal Overweight Obese Morbid Obesity

Remarks:

VISUAL TEST

Visual Acuity Test: RT 6/6 LT 6/6 Visual Field Test: Normal Abnormal

Colour Vision Test: Normal Abnormal Not Required Stereoscopic Vision Test: Normal Abnormal Not Required

Pre-existing condition:

Remarks:

RESPIRATORY SYSTEM

Spirometry Test: Normal Abnormal Not Required Chest X-Ray: Normal Abnormal Not Required

Pre-existing condition: Physical Assessment: Normal Abnormal

Remarks:

ENT SYSTEM

Audiometry Test: Normal Abnormal Not Required Otoscopy: Normal Abnormal Not Required

Pre-existing condition: Physical Assessment: Normal Abnormal (Weisspar, Weber & Rinne Tests)

Remarks:

CARDIOVASCULAR SYSTEM

ECG Test: Normal Abnormal Not Required Physical Assessment: Normal Abnormal Frisighan: Low Moderate High

Pre-existing condition:

Remarks:

NEUROLOGICAL SYSTEM

Physical Assessment: Normal Abnormal

Pre-existing condition:

Remarks:

MUSCULOSKELETAL SYSTEM

Physical Assess: Normal Abnormal Lumbar X-Ray: Normal Abnormal Not Required

Pre-existing condition:

Remarks:

LABORATORY INVESTIGATIONS

Lab Tests: Normal Abnormal If abnormal, please specify below: Blood Grouping: B+

Pre-existing condition:

Remarks:

Glucose Level Category: 92 Normal 80 - 100 mg/dl Pre-diabetic 100 - 125 mg/dl Diabetic > 125 mg/dl

Cholesterol Risk Category: 129 Low Risk LDL is less 130 mg/dl Moderate Risk LDL 130-159 mg/dl High Risk LDL > 160 mg/dl

Routine Urine Analysis: Normal Abnormal Not Required Stool Analysis: Normal Abnormal Not Required

QUESTIONNAIRES

| | |
|--|---------|
| Medical & Surgical History Questionnaire | Remarks |
| Respiratory Protection Questionnaire | Remarks |
| Hearing Conservation Questionnaire | Remarks |
| Screening Questionnaire | Remarks |

Fagerstrom Test - Smoking: Non-smoker Low dependence Low to Mod dependence Moderate dependence High dependence

CAGE Questionnaire Alcohol Use: No use of alcohol Screening positive Clinically significant

SRQ-20 Self-reported Questionnaire: No positive answers Positive answers Factor I (1 to 6) Positive answers Factor II (7 to 12) Positive answers Factor III (13 to 16) Positive answers Factor IV (17 to 20)

| | | | | |
|--------------------|-----------|----------|---------------------------------|------------|
| Clinic Doctor Name | License # | Hospital | Doctor Signature & Clinic Stamp | Issue Date |
|--------------------|-----------|----------|---------------------------------|------------|



[Handwritten Signature]

15-12-2025



**OQEP Occupational Health
FITNESS TO WORK CERTIFICATE [CONTRACTOR]**

OQEP-COR-HSE-HEL-FRM-00021
Classification: External Use
Review: 03-31/08/2024

EMPLOYEE IDENTIFICATION

| | | | | | |
|-----------------|-----|-----------------------|------------|-------------|-------------------|
| Company | | Identification Number | | Name | |
| TRUEKOMAN NORTH | | 103128944 | | RAHUL KUMAR | |
| Nationality | Age | Sex | Entry Date | Location | Job Title |
| INDIA | 31Y | M | 15/12/2025 | HAIMA | FORKLIFT OPERATOR |

MEDICAL SUITABILITY FOR WORK

Medical Evaluation Type: Pre-employment Periodic Exit Job Transfer Post-absence Cause Triggered

Medical Suitability for Work: Fit to Work Unfit Fit with Restrictions



Restrictions

| | | |
|--|--|---|
| <input type="checkbox"/> Working at height | <input type="checkbox"/> Heavy lifting operation | <input type="checkbox"/> Pulling, pushing or carrying weight |
| <input type="checkbox"/> Working in confined space | <input type="checkbox"/> Emergency response duty | <input type="checkbox"/> Ascend/descend ladders and stairs |
| <input type="checkbox"/> Working with electricity | <input type="checkbox"/> Manual cargo handling | <input type="checkbox"/> Walking or standing for long distance/period |
| <input type="checkbox"/> Working near rotating machinery | <input type="checkbox"/> Deep excavation | <input type="checkbox"/> Repetitive movements |
| <input type="checkbox"/> Driving vehicles | <input type="checkbox"/> Food handling | <input type="checkbox"/> Handling chemical products |
| <input type="checkbox"/> Mobile machinery operation | <input type="checkbox"/> Working in noise area | <input type="checkbox"/> Working in extreme heat |

Other, specify

Restriction Type: Temporary until ____/____/____ Permanent

Annotations: _____



DR. HAMMAD MD ISMAIL
GENERAL PRACTITIONER
MOH License No: 20078

[Handwritten Signature]

| | | | |
|-------------|-----------------|----------|------------------|
| Doctor Name | Medical License | Hospital | Doctor Signature |
| | | | |



OQEP Occupational Health PHYSICAL ASSESSMENT FORM

OQEP-COR-HSE-HEL-FRM-00021

Classification: External Use

Review: 03-31/08/2024

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|-----------------------|--------------|-------------------|--------------------|---------------------|
| Civil ID / Passport # | Company ID # | Patient: 28019 | Reg Dt: 15/12/2025 | Position |
| 103122944 | 2054 | Name: RAHUL KUMAR | Gender: Male | Nationality: INDIAN |
| Nationality | Age | Sex | Address | Mar. Status: Single |
| | | | | Location |
| | | | | HAIMA |

VITAL SIGNS

Height: 166 cm Weight: 72 Kg BMI: 26.1 Blood Pressure: 130/80 mmHg

Pulse: 77 /min

Medical Practitioner Name: DR. HAMMAD MD ISMAIL
GENERAL PRACTITIONER
MOH License No: 20078

Signature: [Signature]

VISUAL SYSTEM

| | | | | | |
|-------------------|------------------|-----------------|----------------|------------------|----------------|
| Right Uncorrected | Left Uncorrected | Right Corrected | Left Corrected | Both Uncorrected | Both Corrected |
| 6/6 | 6/6 | | | 6/6 | |

Colour Vision Test Ishihara: # of Plates passed: [] Inform the Plates # failed: [] Normal Abnormal

Stereoscopic Vision Test: Normal Abnormal

Date of Examination: 15-12-2025 Medical Practitioner Name: DR. HAMMAD MD ISMAIL
GENERAL PRACTITIONER
MOH License No: 20078

Signature: [Signature]

RESPIRATORY SYSTEM

[1] Spirometry Test

Smoking Status: Never Ever Used Current Patient's Posture During Test: Standing Sitting Nose Clips Used: Yes No

Diagnosis: Asthma COPD Other

| | |
|--|--|
| Acceptability Criteria (select all that is applicable) | Repeatability Criteria (select all that is applicable) |
| <input type="checkbox"/> Free from artifacts | <input type="checkbox"/> >3 acceptable curves FEV1 values AND FVC values within 0.15L (150 ml) |
| <input type="checkbox"/> Good start | <input type="checkbox"/> Total of THREE to EIGHT tests performed |
| <input type="checkbox"/> Satisfactory expiration | <input type="checkbox"/> The patient CAN NOT or SHOULD NOT continue |
| <input type="checkbox"/> NOT satisfactory | |

The Patient Demonstrated: Good Effort Difficulty following instructions Ability to obtain only one good effort Poor Effort Cooperation

Date of Examination: _____ Medical Practitioner Name: _____ Signature: _____

[2] Chest Shape and Movement

Normal if abnormal, describe below: _____

[3] Chest Percussion

Normal if abnormal, describe below: _____

[3] Air Entry in Both Lungs

Normal if abnormal, describe below: _____

[4] Breath sounds

Normal if abnormal, describe below: _____

Date of Examination: 15-12-2025 Physician Name: DR. HAMMAD MD ISMAIL
GENERAL PRACTITIONER
MOH License No: 20078

Signature: [Signature]

ENT SYSTEM

[1] Otoscopy

| | | | | | |
|-------------|--|---|---------------------|---|--|
| Ear Canal | Right: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Exam | Left: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Exam | Eardrum Position | Right: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Retracted <input type="checkbox"/> Bulging <input type="checkbox"/> Not Exam | [2] Hearing Test |
| Colobae | | | | Whisper Test | <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Exam |
| Drainage | Right: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Exam | Left: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | Eardrum Vascularity | Left: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Retracted <input type="checkbox"/> Bulging <input type="checkbox"/> Not Exam | Rinne Test |
| Perforation | Right: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Exam | Left: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Exam | | Right: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Considerable <input type="checkbox"/> Mild <input type="checkbox"/> Not Exam | Weber Test |
| Cerumen | Right: <input type="checkbox"/> None <input type="checkbox"/> Some <input type="checkbox"/> Impacted | Left: <input type="checkbox"/> None <input type="checkbox"/> Some <input type="checkbox"/> Impacted | | Left: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Considerable <input type="checkbox"/> Mild <input type="checkbox"/> Not Exam | Audiometry Done |
| | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | | Hearing Questionnaire filled |
| | | | | | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |

DR. HAMMAD MD ISMAIL
GENERAL PRACTITIONER
MOH License No: 20078

Signature: [Signature]

ENT SYSTEM

[2] Nose Assessment

Normal
 Abnormal
 Not Examined

If abnormal, describe below:

[3] Throat Assessment

Normal
 Abnormal
 Not Examined

If abnormal, describe below:

CARDIOVASCULAR SYSTEM

[1] Heart Sounds

Normal
 Abnormal
 Not Examined

If abnormal, describe below:

[2] Heart Murmurs

Present
 Absent
 Not Examined

If present, describe below:

[3] Peripheral Pulses

Normal
 Abnormal
 Not Examined

If abnormal, describe below:

[4] Peripheral Veins

Normal
 Abnormal
 Not Examined

If abnormal, describe below:

NEUROLOGICAL SYSTEM

[1] Mental Status

Normal
 Abnormal
 Not Examined

If abnormal, describe below:

[2] Cranial Nerves

Normal
 Abnormal
 Not Examined

If abnormal, describe below:

[3] Motor System

Normal
 Abnormal
 Not Examined

If abnormal, describe below:

[4] Reflexes

Normal
 Abnormal
 Not Examined

If abnormal, describe below:

[5] Sensory System

Normal
 Abnormal
 Not Examined

If abnormal, describe below:

[6] Coordination, Station, Gait

Normal
 Abnormal
 Not Examined

If abnormal, describe below:

MUSCULOSKELETAL SYSTEM

[1] Hand and Wrist

Normal
 Abnormal
 Not Examined

If abnormal, describe below:

[2] Elbow and Shoulder

Normal
 Abnormal
 Not Examined

If abnormal, describe below:

[3] Hip

Normal
 Abnormal
 Not Examined

If abnormal, describe below:

[4] Knee

Normal
 Abnormal
 Not Examined

If abnormal, describe below:

[5] Foot and Ankle

Normal
 Abnormal
 Not Examined

If abnormal, describe below:

[6] Spine and Back

Normal
 Abnormal
 Not Examined

If abnormal, describe below:

OTHER

[1] Skin, Extremities

Normal
 Abnormal
 Not Examined

If abnormal, describe below:

[2] Head & Neck

Normal
 Abnormal
 Not Examined

If abnormal, describe below:

[3] Mouth and Teeth

Normal
 Abnormal
 Not Examined

If abnormal, describe below:

[4] Hemial Orifices

Normal
 Abnormal
 Not Examined

If abnormal, describe below:

[5] Abdominal Organs

Normal
 Abnormal
 Not Examined

If abnormal, describe below:

[6] Lymph Nodes

Normal
 Abnormal
 Not Examined

If abnormal, describe below:



Date of Examination:

15/12/2025

Physician Name:


 Signature: [Signature]

CANDIDATE / EMPLOYEE IDENTIFICATION

| | | | | |
|-----------------------|--------------|--|---|--------------------------------------|
| Civil ID / Passport # | Company ID # | Patient 28019 Name: RAHUL KUMAR KUMAR Gender: Male Age: 37Y Address: | Reg. Dt: 15/12/2025 Nationality: INDIAN Mar. Status: Single | Position FORKLIFT OPERATOR |
| Nationality | Age | Sex | | Location HAIMA |

PERSONAL HEALTH HISTORY

Have you ever, or do you currently suffer from any of the following?

| | |
|---|---|
| <p>Congenital heart disease or Valvular heart disease or Coronary artery disease <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Myocardial insufficiency or infarction (heart attack) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Coronary bypass surgery (CABS) and angioplasty <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Heart arrhythmias (heart beats too fast, too slow or irregularly) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>High blood pressure (hypertension) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Shortness of breath after exertion <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Varicose veins associated with varicose eczema, ulcers or other complications <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Arteriolectrotic or other vascular disease <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Anemias, especially Sickle Cell Disease or Sickle Cell Trait or Thalassemia, GSPD <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Haemorrhage disorders i.e. bleeding disorders <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Leukaemia, polycythaemia and disorders of the reticulo-endothelial system <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Recurrent headaches or migraine <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Epilepsy and recurrent seizures <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Blackouts, dizziness, fainting, memory loss, unconsciousness (vertigo/syncope) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Sleep disorders, such as insomnia, hypersomnia, sleep apnea, narcolepsy <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Chronic anxiety states and/or recurrent depression <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Phobias such as fear of heights, fear of confined spaces, fear of flying <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Lung disease e.g. bronchitis, asthma, dyspnea, Tuberculosis (TB) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Phlegm production (excess mucus production) or tight chest <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Immuno suppression due to cancer or human immunodeficiency virus <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Lump in breast or armpit <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> | <p>Muscle problems e.g. weakness of your arms or twitchy muscles <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Joint problems, e.g. plantar warts, joint pain or swelling <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Problems with limb, neck or spine mobility <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Extremities (feet or hands) deformities or problems <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Experienced back problem, arthritis, slipped disc <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Pain in neck or back or hands or legs <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Thyroid disease or any other glandular diseases <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Diabetes mellitus or Hypoglycaemia <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Experienced unintentional weight loss or gain > 5kg over the past year <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Informed about being overweight or obese <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Skin disorders e.g. severe acne, dermatitis, eczema or allergy <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Allergies e.g. dust, medication, insect bites, chemicals <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Disorders of the digestive tract e.g. ulcers, recurrent diarrhea, gastritis <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Haemorrhoids, fistulae and fissures causing pain, or recurrent bleeding <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Liver and pancreas diseases (e.g. pancreatitis, Hepatitis, Jaundice) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Kidney or bladder diseases e.g. recurrent infection, renal stones <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Ear, nose or throat problems (e.g. otitis, hearing loss, sinusitis, tonsillitis) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Eye disease or visual defect (e.g. glaucoma, color blindness, monocular vision) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Treated for infectious diseases (e.g. malaria, COVID19, dengue) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Treated for mental health problems, such as depression, stress, anxiety <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Treated for substance or alcohol abuse <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> |
|---|---|

Any other diseases not recorded in the above list? No Yes, please specify: _____

Any disabilities and compensations received? No Yes, please specify: _____

Have you visited a doctor in the last year? Yes No

Are you taking any medication at present? Yes No

Are you pregnant? EDD: ___/___/___ Yes No

List any previous injuries or operations

| Previous injuries or operations | Date |
|---------------------------------|------|
| | |
| | |
| | |

Date: 15/12/2025

Candidate/Employee Signature
RAHUL

CANDIDATE / EMPLOYEE IDENTIFICATION

| | | | | |
|-----------------------|--------------|-------------------------|---------------------|-------------------|
| Civil ID / Passport # | Company ID # | Patient: 28019 | Reg Dt: 15/12/2025 | Position |
| 103122944 | 2054 | Name: RAHUL KUMAR KUMAR | | FORKLIFT OPERATOR |
| Nationality | Age | Gender: Male | Nationality: INDIAN | HAIMA |
| | | Age: 27 | Mar. Status: Single | |
| | | Address: | | |

FAGERSTROM TEST

Do you smoke? Yes No *If YES, Please answer the following:*

How soon after waking up do you smoke your first cigarette? >60min 31-60min 6-30min < 5 minutes

Do you find it difficult to avoid smoking where is forbidden, such as work places, cinemas, shopping etc.? Yes No

What's the most difficult cigarette to quit or not to smoke? Anyone The first in the morning

How many cigarettes do you smoke per day? <10 11-20 21-30 >31

Do you smoke more frequently the first hours of the day than the rest of the day? Yes No

Do you smoke even when you're sick and have to stay in the bed most part of the day? Yes No

CAGE QUESTIONNAIRE

Do you drink alcohol? Yes No *If YES, Please answer the following:*

Did you ever feel that you should decrease the amount of drinks or cut down (stop) drinking? Yes No

Do people bother you because they criticize the way you drink? Yes No

Do you feel guilty or upset with yourself with the way you use to drink? Yes No

Do you drink in the morning to feel less nervous or decrease the hang over? Yes No

Have you had any problems related to alcohol? Yes No

Did you drink in the last 24 hours? Yes No

FATIGUE QUESTIONNAIRE

Have you noticed that you are feeling tired recently? Yes No

Have you been feeling a lack of energy? Yes No *If YES, Please answer the following:*

For how many days did you feel tired or with lack of energy in the last week? 1 day 2 days 3 days > 3 days

Did you feel tired or with lack of energy for more than 3 hrs in some days last week? 1 hour 2 hours 3 hours > 3 hours

Did you feel so tired that you had to make some effort to do things last week? Yes No

Did you feel tired or with lack of energy doing things you like last week? Yes No

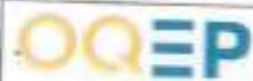
SELF-REPORTING QUESTIONNAIRE (SRQ-20)

| | | | | | |
|---|------------------------------|--|--|------------------------------|--|
| 1. Do you have trouble thinking clearly? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | 11. Is your digestion not good? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| 2. Do you find it hard to like your daily work? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | 12. Do you have unpleasant sensations in your stomach? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| 3. Do you find difficult taking decisions? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | 13. Do you get scared easily? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| 4. Is your daily work a suffering? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | 14. Do you feel nervous, tense or worried? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| 5. Do you feel tired all the time? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | 15. Do you feel unhappy? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| 6. Are you easily tired? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | 16. Do you cry more than usual? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| 7. Do you have frequent headaches? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | 17. Has the thought of ending your life been on your mind? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| 8. Do you feel lack of energy? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | 18. Do you find it difficult to perform your work? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| 9. Do you sleep badly? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | 19. Have you lost interest in things? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| 10. Do your hands tremble? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | 20. Do you feel you're worthless? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |



Date: 15/12/2025

Candidate/Employee Signature
RAHUL



OQEP Occupational Health RESPIRATORY PROTECTION QUESTIONNAIRE

OQEP-COR-HSE-HEL-FRM-00021

Classification: External Use

Revision: 03-31/08/2024

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| Civil ID / Passport # | Company ID # | Patient: 28019 | Reg Dt: 15/12/2025 | |
| 103122 | 944 205A | Name: RAHUL KUMAR KUMAR | Gender: Male | Position |
| Nationality | Age | Sex | Nationality: INDIAN | FORKLIFT OPERATOR |
| | | | Age: 31Y | Location |
| | | | Mar. Status: Single | HAIMA |
| | | | Address: | |
| | | | | |

RESPIRATORY PROTECTION MEDICAL EVALUATION QUESTIONNAIRE - OSHA

Do you use a respirator? YES NO What type: Disposable mask Cartridge Mask SCBA

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? YES NO

2. Have you ever had any of the following conditions?

| | | |
|---|--|--|
| <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO a. Seizures | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Trouble smelling odors | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO e. Claustrophobia (fear of closed in places) |
| <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. Diabetes (sugar disease) | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO d. Allergic reactions that interfere with your breathing | |

3. Have you ever had any of the following pulmonary or lung problems?

| | | |
|---|---|---|
| <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO a. Asbestosis | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO e. Pneumonia | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO i. Broken ribs |
| <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. Asthma | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO f. Tuberculosis | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO j. Pneumothorax (collapsed lung) |
| <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. Chronic bronchitis | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO g. Silicosis | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO k. Any chest injuries or surgeries |
| <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO d. Emphysema | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO h. Lung cancer | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO l. Any other lung problem that you have been told about |

4. Do you currently have any of the following symptoms of pulmonary or lung illness?

| | |
|---|--|
| <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO a. Shortness of breath | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO h. Coughing that wakes you early in the morning |
| <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO i. Coughing that occurs mostly when you are lying down |
| <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. Shortness of breath when walking with other people at an ordinary pace on level ground | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO j. Coughing up blood in the last month |
| <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO d. Have to stop for breath when walking at your own pace on level ground | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO k. Wheezing |
| <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO e. Shortness of breath when washing or dressing yourself | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO l. Wheezing that interferes with your job |
| <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO f. Shortness of breath that interferes with your job | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO m. Chest pain when you breathe deeply |
| <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO g. Coughing that produces phlegm (thick sputum) | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO n. Any other symptoms that you think may be related to lung problems |

5. Have you ever had any of the following cardiovascular or heart problems?

| | |
|--|--|
| <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO a. Heart attack | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO e. Swelling in your legs or feet (not caused by walking) |
| <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. Stroke | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO f. Heart arrhythmia |
| <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. Angina | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO g. High blood pressure |
| <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO d. Heart failure | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO h. Any other heart problems that you've been told about |

6. Have you ever had any of the following cardiovascular or heart symptoms?

| | |
|--|--|
| <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO a. Frequent pain or tightness in your chest | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO e. Heartburn or indigestion that is not related to eating |
| <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. Pain or tightness in your chest during physical activity | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO f. Any other symptoms that you think might be related to heart |
| <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. Pain or tightness in your chest that interferes with your job | |
| <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO d. In the past two years, have you noticed your heart skipping or missing a beat | |

7. Do you currently take medication for any of the following problems?

| | |
|---|--|
| <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO a. Allergies or lung problems | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. Blood pressure |
| <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. Heart trouble | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO d. Seizures (fits) |

8. If you've used a respirator, have you ever had any of the following problems?

| | |
|---|---|
| <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO a. Eye irritation | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO d. General weakness or fatigue |
| <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. Skin allergies or rashes | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO e. Any other problem that interfere with your use of a respirator |
| <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. Anxiety | |

Date: 15/12/2025

Candidate/Employee Signature
RAHUL



OQEP Occupational Health HEARING CONSERVATION QUESTIONNAIRE

OQEP-COR-HSE-HEL-FRM-00021

Classification: External Use

Review: 03-31/08/2024

CANDIDATE / EMPLOYEE IDENTIFICATION

| | | | | |
|-----------------------|--------------|--|---|--------------------------------------|
| Civil ID / Passport # | Company ID # | Patient: 28019 Name: RAHUL KUMAR ALUMAR Gender: Male Age: 31Y Address: | Reg. Dt: 15/12/2025 Nationality: INDIAN Mar. Status: Single | Position FORKLIFT OPERATOR |
| Nationality | Age | Sex | | Location HAIMA |

HEARING CONSERVATION MEDICAL EVALUATION QUESTIONNAIRE - OSHA

Do you use hearing protection? YES NO What type: Earplugs Ear Muffs Double HP

1 - Have you been out of noise for the past 14-16 hours? YES NO
If NO, did you use hearing protection while in the noise? YES NO

2 - Check ALL of the following activities that you have done or do:

| | | | | |
|---------------------------------------|---------------------------------------|---|-----------------------------------|--|
| <input type="checkbox"/> Hunting | <input type="checkbox"/> Car races | <input type="checkbox"/> Skeet shooting | <input type="checkbox"/> Woodwork | <input type="checkbox"/> Target shooting |
| <input type="checkbox"/> Power tools | <input type="checkbox"/> Mower | <input type="checkbox"/> Concerts / Band | <input type="checkbox"/> Welding | <input type="checkbox"/> Air compressor |
| <input type="checkbox"/> Construction | <input type="checkbox"/> Scuba diving | <input type="checkbox"/> Tractor (open or closed cab) | | |

Have you ALWAYS used hearing protection when participating in the above activities? YES NO

3 - Check ALL that you have experienced:

| | | | | |
|--|---|---|--|--|
| <input type="checkbox"/> Ear Fullness | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Ear Surgery | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Ear Pain | <input type="checkbox"/> Earwax buildup | <input type="checkbox"/> Intravenous Antibiotics | <input type="checkbox"/> Hole in the Eardrum |
| <input type="checkbox"/> Ear Drainage | <input type="checkbox"/> Dizziness | | | |

4 - Check ALL that you have had/suffered from:

| | | | | | | |
|---------------------------------------|--|---------------------------------------|---|---|--|---|
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Measles | <input type="checkbox"/> Syphilis | <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Mumps | <input type="checkbox"/> Chronic ear infections |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Renal Failure | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Previous surgery | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Trauma to head/ ear canal / tympanic membrane | |

5 - Check ALL that you are currently suffering from:

| | | | |
|------------------------------------|-----------------------------------|--|--|
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Cold/Flu | <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Allergic rhinitis |
|------------------------------------|-----------------------------------|--|--|

6 - Do you have documented Hearing Loss? YES NO
If Yes: Which Ear(s)? Right Ear Left Ear Both Ear Who performed your hearing test?

7 - Have you EVER worn Hearing Aids? YES NO
If Yes: Which Ear(s) Right Ear Left Ear Both Ear
What Size? Behind-the-ear In-the-ear In-the-canal Completely-in-the-canal
What Type? Analog Digital
Who fit your hearing aids? Licensed Audiologist Hearing Aid Dealer Don't Know
When did you receive your hearing aids?

8 - Have you ever served in the military? YES NO
If yes, check division Army Navy Air Force Marines National Guard Date: / /
Do you have medical disability through the Veterans Administration (VA) for hearing loss or tinnitus? YES NO
If yes, how much? % What is your TOTAL VA disability? %

9 - Are you currently using any medication YES NO Which one?

10 - What kind of transport do you regularly use? Car Bus Motorcycle Walking



Date: 15/12/2025

Candidate/Employee Signature
RAHUL



Peace Land Medical Service LLC, Mukhaizna
CR No.:2/13627/9, P.O.Box: 1403,
Postal Code: 133,
Occidental Camp Mukhaizna, Sultanate of Oman

PATIENT DETAILS :

| | |
|--------------------------|---|
| Patient ID : 28019 | Doc No : 16585 |
| Name : RAHUL KUMAR KUMAR | Doc Date : 2025-12-15T11:53:00 |
| Age : 31Y | Bill No : 39371 |
| Gender : Male | Date : 15/12/2025 11:53 AM |
| Nationality : INDIAN | Customer : TRUCKOMAN OIL & GAS SERVICES |
| GSM No : 72034875 | Ref.by : DR.HAMMAD ISMAIL |

TEST RESULT : OQ-001 OQ MEDICAL CHECKUP

| Test | Result | Normal Range | Detailed Description |
|-------------------------|-----------------|---|----------------------|
| OQ MEDICAL CHECKUP | | | |
| BLOOD GROUP & Rh TYPING | ' B ' Positive | | |
| COMPLETE BLOOD COUNT | | | |
| RBC | 5.6 Million/c | Male 4.5 - 6.0 million /cu Female 4.5 - 5.5 million/cu | |
| HAEMOGLOBIN | 15 gm % | Male 13 - 18 gm % Female 11 - 15 gm % | |
| HCT | 43 % | Male 42 -52 % Female 37 -47 % | |
| MCV | 77 fl | 76 - 96 fl | |
| MCH | 27 pg | 27 - 33 pg | |
| MCHC | 34 % | 32 36 % | |
| WBC COUNT | 8200 cells/cumm | 4000 - 11 000 cells / cu mm | |
| DIFFERENTIAL COUNT | | | |
| NEUTROPHIL | 56 % | 40-75 % | |
| LYMPHOCYTE | 33 % | 20-45 % | |
| EOSINOPHIL | 3 % | 1-6 % | |
| MONOCYTE | 8 % | 2-8% | |
| BASOPHIL | 0 % | 0-1% | |
| ESR | 6 | Male 0 - 15 mm / 1st hour Female 0 - 20 mm / 1st hour | |
| PLATELET | 2.9 lakhs/cumm | 1.5 - 4.5 lakhs / cu mm | |
| Sickle cells (Screen) | Negative | | |

Reported By:
Lab Technician

Sr. Lab Technologist



Verified By:
Lab Technician

Sr. Lab Technologist

Approved By:
Lab Technician

Sr. Lab Technologist

Printed at: 15/12/2025 12:06:35

Signed at: 15/12/2025 11:55:40

| Test | Result | Normal Range | Detailed Description |
|-------------------------------|-------------|---|----------------------|
| LIVER FUNCTION TEST | | | |
| ALKALINE PHOSPHATASE | 106 u/l | 44-147 U/L | |
| T. BILIRUBIN | 1.1 mg / dl | up to 2.0 mg/dl | |
| DIRECT BILIRUBIN | 0.4 mg / dl | up to 0.4 mg /dl | |
| IINDIRECT BILIRUBIN | 0.7 mg / dl | up to 1.6 mg /dl | |
| S.G.O.T. | 23 u/l | Male 0-50 u/l Female 0-41 u/l | |
| S.G.P.T. | 33 u/l | Male 0-45 u/l Female 0-32 u/l | |
| T. PROTEIN | 8 g /dl | New born 5.2 - 9.1 g /dl Children 5.4 - 8.7 g /dl Adult 6.7 - 8.7 g /dl | |
| ALBUMIN | 5 g / dl | 3.6 - 5.5 g/dl | |
| RENAL FUNCTION TEST | | | |
| UREA | 18 mg / dl | 10-50 mg /dl | |
| S.CREATININE | 0.7 mg / dl | 0.7 - 1.2 mg /dl | |
| S.URIC ACID | 6.6 mg / dl | 3.4 - 7.2 mg /dl | |
| LIPID PROFILE | | | |
| Total Cholesterol | 198 mg/dl | Normal < 200 mg/dl Border line : 200 -239 mg / dl High > 240 mg / dl | |
| Triglyceride | 146 mg/dl | Normal 0.0 - 150 mg/dl | |
| HDL - CHOL | 66 mg/dl | 35.0 - 79.0 mg /dl | |
| LDL - CHOL | 129 mg/dl | < 130 mg/dl | |
| VLDL | 29 mg/dl | 2-30 mg/dl | |
| FASTING BLOOD SUGAR | 92 mg/dl | 70 - 110 mg/dl | |
| URINE ROUTINE ANALYSIS | | | |
| PHYSICAL | | | |
| Quantity | 5 ml | | |
| Colour | Pale yellow | | |
| Sp. Gravity | 1.005 | | |
| pH | Acidic | | |
| Appearance | Clear | | |
| CHEMICAL | | | |
| Nitrite | Negative | | |
| Protein | Negative | | |
| Glucose | Negative | | |
| Ketones | Negative | | |
| Urobilinogen | Normal | | |
| Billrubin | Negative | | |
| Blood | Negative | | |
| MICROSCOPIC. | | | |



(Handwritten signature)

| Test | Result | Normal Range | Detailed Description |
|-------------------------------------|----------|--------------|----------------------|
| PUS_CELLS | 1-2 | | |
| EPITHELIAL CELLS. | 1-2 | | |
| RBCS | 1-2 | | |
| CASTS | NIL | | |
| CRYSTALS | NIL | | |
| BACTERIA. | NIL | | |
| OTHERS. | NIL | | |
| URINE DRUG SCREEN | | | |
| OPIATE (URINE) | Negative | | |
| MORPHINE (URINE) | Negative | | |
| COCAINE (URINE) | Negative | | |
| AMPHETAMINE (URINE) | Negative | | |
| BENZODIAZEPINES (URINE) | Negative | | |
| PHENCYCLIDINE (URINE) | Negative | | |
| METHAMPHETAMINE (URINE) | Negative | | |
| TRAMADOL (URINE) | Negative | | |
| BARBITURATES (URINE) | Negative | | |
| TRICYCLIC ANTIDEPRESSANTS (URINE) | Negative | | |
| METHADONE (URINE) | Negative | | |
| ALCOHOL TEST | Negative | | |

Remarks:



Patient: 28019 Reg Dt: 13/12/2022
 Name: FAN-UL-KHUMAR KUMAR
 Gender: Male Nationality: W/PAK
 Age: 31 Mar Status: Single
 Address:

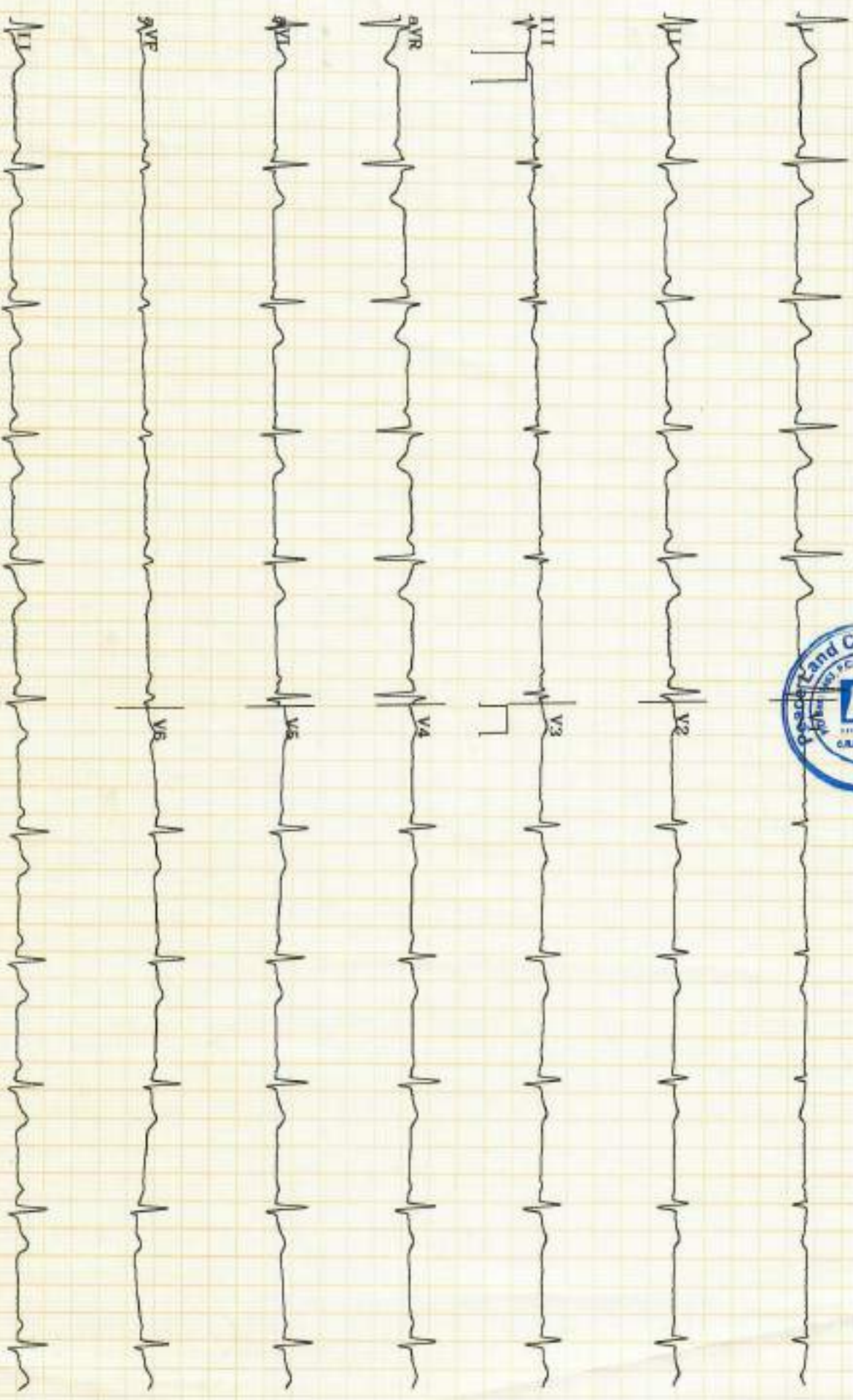


Heart Rate: 63 bpm
 PR/RR Int.: 148/952 ms
 QRS Dur: 108 ms
 QT/QTc: 406/410 ms
 P-R-T axes: 46 15 14
 SV1/RV5/R+S: 0.40/1.04/1.44mV

6 Channel + 1 Rhythm Report
 ** Analysis Result ** (To be finally confirmed by physician)
 Normal Sinus Rhythm
 [Normal ECG]



Hosp: Prescribed by:

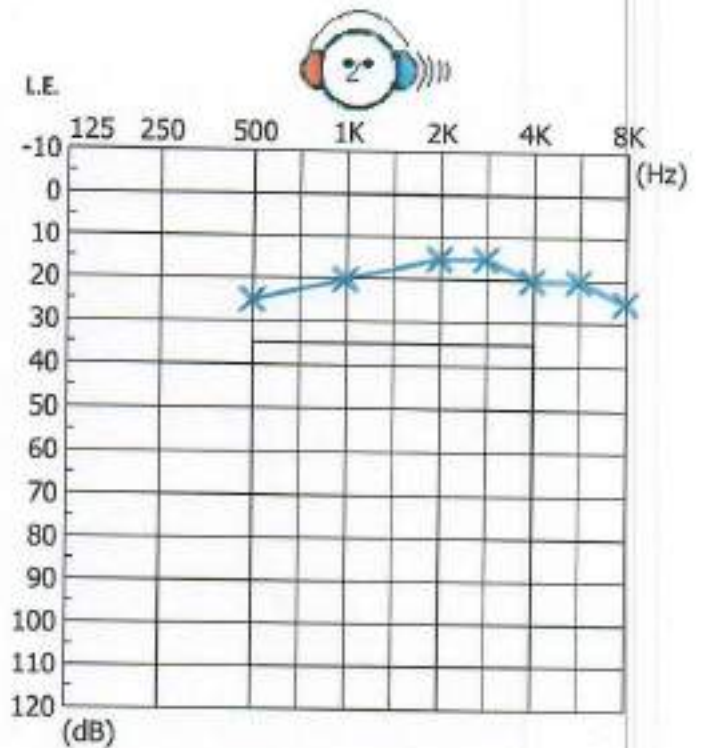
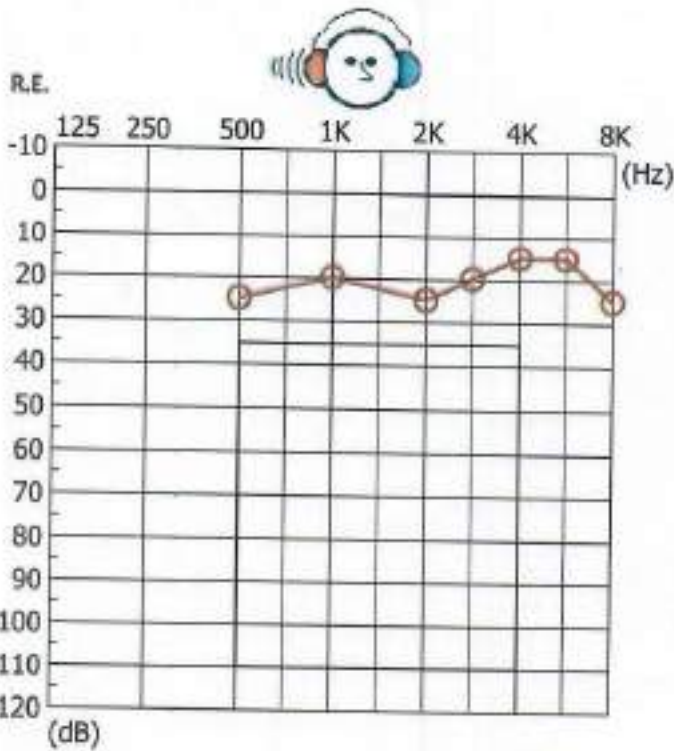


AUDIOMETRY REPORT

Name: RAHUL KUMAR
 Age(y): 31
 Sex: Man
 Height (cm): 0
 Weight(Kg): 0
 BMI:

SIBELMED W50

Test date: 15/12/2025
 Reference: 103122944
 Technician:
 Reason:
 Origin:
 Equipment:
 Device serial numb.:
 Flash Version:



MINISTRY OF LABOUR AND SOCIAL AFFAIRS

| | R.E. | L.E. |
|--------------------|------|------|
| Hearing Loss (%) | 0.0 | 0.0 |
| Average dBs | 22.5 | 18.8 |
| Bilateral Loss (%) | 0.0 | |

| No Masking | R.E. | L.E. | With Masking | R.E. | L.E. |
|-------------|------|------|--------------|------|------|
| Air | ○ | × | Air | △ | □ |
| Bone | < | > | Bone | = | = |
| F.Field | ⊙ | ⊗ | | | |
| No response | ⊕ | ⊗ | | | |

Right ear Normal
 Left ear Normal

COMMENTS: Normal
 R.E.
 L.E.

DR. HAMMAD MD ISMAIL
 GENERAL PRACTITIONER
 MOH License No: 20078



| Patient Id | Patient Name | Age/Sex | Procedure Date | Referring Dr |
|------------|-------------------|---------|----------------|--------------|
| 28019 | RAHUL KUMAR KUMAR | 31Y/M | 15-12-2025 | |

DIGITAL X-RAY CHEST PA VIEW

FINDINGS:

Trachea and mediastinum in midline.

Both lung fields show normal bronchovascular markings.

Cardiothoracic ratio is within normal limits.

Both cardiophrenic and costophrenic angles are free.

Both domes of diaphragm are normally placed.

Bony ribcage and soft tissue structures appear normal.

IMPRESSION:

- **NO ABNORMALITIES DETECTED**

-

- **X-RAY LUMBO-SACRAL SPINE (AP AND LATERAL)**

Lumbar curvature appears normal.

Visualized spine shows normal density.

Vertebral bodies appear normal in size and height. No focal lytic sclerotic lesion noted.

Vertebral posterior appendages appear normal in outline. Bony canal is normal.

Pre and paravertebral soft tissue shadows are normal.

IMPRESSION:

- **No significant abnormality detected.**





Dr. WAJDY JARBOU
MD, ABR
SPECIALIST RADIOLOGIST
MOH LIC # 19061



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