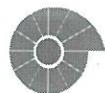


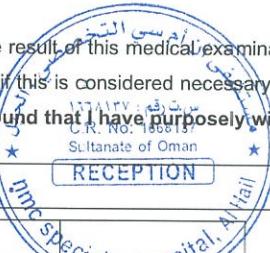


## Appendix 32: EX1 Form (Initial Examination Report)

## INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

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

Place of examination <b>NMC HAIL</b>		Date	Surname <b>ANKOLLA</b>																																																								
			Forenames <b>SUDHAKAR</b>																																																								
			Address																																																								
			Home telephone number <b>78910859</b>																																																								
If a dependant enter employee's name here: Surname: <b>ANKOLLA</b>		Forenames: <b>SUDHAKAR</b>																																																									
Birth date:	Nationality: <b>INDIAN</b>	Country of birth: <b>INDIA</b>	Religion: <b>HINDUISM</b>																																																								
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married <input checked="" type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced	Relationship to employee		Number of children:																																																							
		<input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter																																																									
Reason for examination		Pre-Employment <input checked="" 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> <td><input checked="" type="checkbox"/> Y</td> <td><input type="checkbox"/> N</td> </tr> <tr> <td>1. Sinus trouble</td> <td><input checked="" type="checkbox"/> 21. Cancer</td> </tr> <tr> <td>2. Neck swelling/glands</td> <td><input checked="" type="checkbox"/> 22. Heart Disease</td> </tr> <tr> <td>3. Difficulty in vision</td> <td><input checked="" type="checkbox"/> 23. Rheumatic fever</td> </tr> <tr> <td>4. Any ear discharge</td> <td><input checked="" type="checkbox"/> 24. Abnormal heartbeat</td> </tr> <tr> <td>5. Asthma/bronchitis</td> <td><input checked="" type="checkbox"/> 25. High blood pressure</td> </tr> <tr> <td>6. Hayfever /other significant allergy</td> <td><input checked="" type="checkbox"/> 26. Stroke</td> </tr> <tr> <td>7. Any skin trouble</td> <td><input checked="" type="checkbox"/> 27. Serious chest pain</td> </tr> <tr> <td>8. Tuberculosis</td> <td><input checked="" type="checkbox"/> 28. Any blood disease</td> </tr> <tr> <td>9. Shortness of breath</td> <td><input checked="" type="checkbox"/> 29. Kidney disease</td> </tr> <tr> <td>10. Coughed/ vomited blood</td> <td><input checked="" type="checkbox"/> 30. Blood in urine</td> </tr> <tr> <td>11. Severe abdominal pain</td> <td><input checked="" type="checkbox"/> 31. Diabetes</td> </tr> <tr> <td>12. Stomach ulcer</td> <td><input checked="" type="checkbox"/> 32. Headaches/migraine</td> </tr> <tr> <td>13. Recurrent indigestion</td> <td><input checked="" type="checkbox"/> 33. Dizziness/fainting</td> </tr> <tr> <td>14. Jaundice or hepatitis</td> <td><input checked="" type="checkbox"/> 34. Epilepsy</td> </tr> <tr> <td>15. Gall Bladder disease</td> <td><input checked="" type="checkbox"/> 35. Joints/spinal trouble</td> </tr> <tr> <td>16. Marked change in bowel habits</td> <td><input checked="" type="checkbox"/> 36. Surgical operation</td> </tr> <tr> <td>17. Blood in stools (motions)</td> <td><input checked="" type="checkbox"/> 37. Serious accident/fracture</td> </tr> <tr> <td>18. Marked change in weight</td> <td><input checked="" type="checkbox"/> 38. Tropical disease</td> </tr> <tr> <td>19. Varicose veins</td> <td><input checked="" type="checkbox"/> 39. Fear of heights</td> </tr> <tr> <td>20. Lump in breast/armpit</td> <td></td> </tr> </table>		<input checked="" type="checkbox"/> Y	<input type="checkbox"/> N	1. Sinus trouble	<input checked="" type="checkbox"/> 21. Cancer	2. Neck swelling/glands	<input checked="" type="checkbox"/> 22. Heart Disease	3. Difficulty in vision	<input checked="" type="checkbox"/> 23. Rheumatic fever	4. Any ear discharge	<input checked="" type="checkbox"/> 24. Abnormal heartbeat	5. Asthma/bronchitis	<input checked="" type="checkbox"/> 25. High blood pressure	6. Hayfever /other significant allergy	<input checked="" type="checkbox"/> 26. Stroke	7. Any skin trouble	<input checked="" type="checkbox"/> 27. Serious chest pain	8. Tuberculosis	<input checked="" type="checkbox"/> 28. 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How much tobacco each day? <b>NIL</b>		Average daily alcohol consumption <b>NIL</b>																																																									
Have you ever taken elicited drugs? ( ) PDO test all new/potential employees for elicited/recreational drugs <b>NIL</b>																																																											
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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>10/12/2022</b>		Signature of Applicant: <b>Sudhakar</b>																																																									
Page 79		Specification																																																									
The controlled version of this CMF Document resides online in Livelink®. Printed copies are UNCONTROLLED.																																																											





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 163		WEIGHT kg 66.8.	BMI 25.4	B.P. 126 94	PULSE 78 /mins.	HEARING L R	VISION Uncorrected Corrected	DISTANT R L	NEAR R L	Colour Vision N	Blood Group		
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS				N	A						
/	1. Urinalysis	<i>Biphasic T wave.</i>				/		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:

 FIT ALL AREAS FIT WITH RESTRICTION TEMPORARY UNFIT UNFIT

## REVIEW/CONSULTATION

Date:

Name (Block Capitals): Dr. / Nurse

DR. SHIVA KUMAR

Signature:

DR. SHIVA KUMAR SIDDIAMH  
General Practitioner  
MOH Lic No: 5075  
NMC Speciality: Hospital, Al Hall

Signature:

س.ر.ق. ١٦٦٨١٣٧  
C.R. No: 1668137  
Sultanate of Oman

RECEPTION