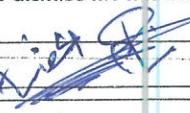
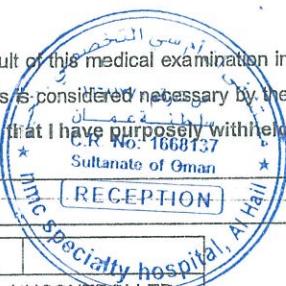




## Appendix 32: EX1 Form (Initial Examination Report)

## INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL.)

 <b>Petroleum Development Oman MEDICAL DEPARTMENT</b> PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS		Surname <b>AL MAAINI</b>																																																																																																																																	
		Forenames <b>NASSER MOHAMMED</b>																																																																																																																																	
Address		Home telephone number <b>97073321</b>																																																																																																																																	
Place of examination <b>NAME HAIL</b>		Date <b>01/02/23</b>																																																																																																																																	
If a dependant enter employee's name here: Surname: <b>AL MAAINI</b> Forenames: <b>NASSER MOHAMMED</b>																																																																																																																																			
Birth date:	Nationality: <b>OMAN</b>	Country of birth: <b>OMAN</b>	Religion: <b>MUSLIM</b>																																																																																																																																
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced	<input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter	Number of children: <b>4</b>																																																																																																																																
Reason for examination	Pre-Employment	Job: <b>DRIVER</b>																																																																																																																																	
	Pre-Overseas	Area:																																																																																																																																	
Name and address of family doctor		List your last 3 jobs																																																																																																																																	
		(1)																																																																																																																																	
		(2)																																																																																																																																	
Are you a Registered Disabled Person? (UK only)		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>Y</th> <th>N</th> <th>Y</th> <th>N</th> <th>Y</th> <th>N</th> </tr> <tr> <td>1. Sinus trouble</td> <td><input checked="" type="checkbox"/></td> <td>21. Cancer</td> <td><input checked="" type="checkbox"/></td> <td>40. Rejected for employment or insurance for medical reasons</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>2. Neck swelling/glands</td> <td><input checked="" type="checkbox"/></td> <td>22. Heart Disease</td> <td><input checked="" type="checkbox"/></td> <td>41. Awarded benefits for industrial injury/illness</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>3. Difficulty in vision</td> <td><input checked="" type="checkbox"/></td> <td>23. Rheumatic fever</td> <td><input checked="" type="checkbox"/></td> <td>42. Treated for a mental condition, e.g. depression</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>4. Any ear discharge</td> <td><input checked="" type="checkbox"/></td> <td>24. Abnormal heartbeat</td> <td><input checked="" type="checkbox"/></td> <td>43. Treated for problem drinking or drug abuse</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>5. Asthma/bronchitis</td> <td><input checked="" type="checkbox"/></td> <td>25. High blood pressure</td> <td><input checked="" type="checkbox"/></td> <td>44. Exposed to toxic substance or noise</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>6. Hayfever /other significant allergy</td> <td><input checked="" type="checkbox"/></td> <td>26. Stroke</td> <td><input checked="" type="checkbox"/></td> <td colspan="2">FOR WOMEN ONLY</td> </tr> <tr> <td>7. Any skin trouble</td> <td><input checked="" type="checkbox"/></td> <td>27. Serious chest pain</td> <td><input checked="" type="checkbox"/></td> <td>45. Have you ever had:-</td> <td></td> </tr> <tr> <td>8. Tuberculosis</td> <td><input checked="" type="checkbox"/></td> <td>28. Any blood disease</td> <td><input checked="" type="checkbox"/></td> <td>46. An abnormal smear</td> <td></td> </tr> <tr> <td>9. Shortness of breath</td> <td><input checked="" type="checkbox"/></td> <td>29. Kidney disease</td> <td><input checked="" type="checkbox"/></td> <td>47. Any gynaecological treatment</td> <td></td> </tr> <tr> <td>10. Coughed/vomited blood</td> <td><input checked="" type="checkbox"/></td> <td>30. Blood in urine</td> <td><input checked="" type="checkbox"/></td> <td>48. Are you pregnant?</td> <td></td> </tr> <tr> <td>11. Severe abdominal pain</td> <td><input checked="" type="checkbox"/></td> <td>31. Diabetes</td> <td><input checked="" type="checkbox"/></td> <td>49. HAVE YOU HAD AN ILLNESS</td> <td></td> </tr> <tr> <td>12. Stomach ulcer</td> <td><input checked="" type="checkbox"/></td> <td>32. Headaches/migraine</td> <td><input checked="" type="checkbox"/></td> <td>50. NOT MENTIONED ABOVE</td> <td></td> </tr> <tr> <td>13. Recurrent indigestion</td> <td><input checked="" type="checkbox"/></td> <td>33. Dizziness/fainting</td> <td><input checked="" type="checkbox"/></td> <td></td> <td></td> </tr> <tr> <td>14. Jaundice or hepatitis</td> <td><input checked="" type="checkbox"/></td> <td>34. Epilepsy</td> <td><input checked="" type="checkbox"/></td> <td></td> <td></td> </tr> <tr> <td>15. Gall Bladder disease</td> <td><input checked="" type="checkbox"/></td> <td>35. Joints/spinal trouble</td> <td><input checked="" type="checkbox"/></td> <td></td> <td></td> </tr> <tr> <td>16. Marked change in bowel habits</td> <td><input checked="" type="checkbox"/></td> <td>36. Surgical operation</td> <td><input checked="" type="checkbox"/></td> <td></td> <td></td> </tr> <tr> <td>17. Blood in stools (motions)</td> <td><input checked="" type="checkbox"/></td> <td>37. Serious accident/fracture</td> <td><input checked="" type="checkbox"/></td> <td></td> <td></td> </tr> <tr> <td>18. 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How much tobacco each day? <b>5-6 day</b>		Average daily alcohol consumption <b>last time consumed</b>		<b>(1) day back</b>																																																																																																																															
Have you ever taken illicit drugs? <input checked="" type="checkbox"/> PDO test all new/potential employees for illicit/recreational drugs																																																																																																																																			
FAMILY HISTORY: Diabetes ( <input checked="" type="checkbox"/> ) Tuberculosis ( <input checked="" type="checkbox"/> ) Epilepsy ( <input checked="" type="checkbox"/> ) Asthma ( <input checked="" type="checkbox"/> ) Eczema ( <input checked="" type="checkbox"/> ) Heart disease ( <input checked="" type="checkbox"/> ) High blood pressure ( <input checked="" type="checkbox"/> ) Stroke ( <input checked="" type="checkbox"/> ) Blood Disease ( <input checked="" type="checkbox"/> ) Cancer ( <input checked="" type="checkbox"/> )																																																																																																																																			
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>01/02/23</b>	Signature of Applicant: 																																																																																																																																		
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. Cardio-vascular System	unremarkable								
/	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	WEIGHT kg	BMI	B.F.	PULSE /mins.	HEARING L R	VISION Uncorrected Corrected	DISTANT R L R	NEAR R L R	Colour Vision	Blood Group
165	81	29.7	134 87	78	L R	N N	6/6 6/6	N/N	N	
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	
Date: 8/2/23 Name (Block Capitals): Dr. / Nurse	
Signature:	
DR. NADIA FAHAD General Practitioner MOH Lic No: 17683 nmc speciality hospital, Al Hail	
Date: 12/2/23 Name (Block Capitals): Dr. / Nurse	
Signature:	
DR. NADIA FAHAD General Practitioner MOH Lic No: 17683 nmc speciality hospital, Al Hail	
Date: 12/2/23 Name (Block Capitals): Dr. / Nurse	
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