

# MEDICAL EVALUATION REPORT FOR OQ CONTRACTORS - SUMMARY



CANDIDATE / EMPLOYEE		T.O.	
Civil ID / Passport #	Company ID #	ARASHPREET SINGH PARMIT SINGH	
131177492		# 0049489 # 21 Y/M BAS-Pw Bill: 00517	
Nationality	Age	Sex	Position
Indian	1/10/2001		Helper
			Location

EXAMINATION TYPE			
Examination	<input type="checkbox"/> Pre-employment	<input type="checkbox"/> Periodic	<input type="checkbox"/> Exit

VITAL SIGNS & BODY MEASURES			
Blood Pressure Category:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Prehypertension	<input type="checkbox"/> Hypertension Stage 1
BMI Category:	<input type="checkbox"/> Underweight	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Overweight
Remarks:	<input type="checkbox"/> Obese <input type="checkbox"/> Morbid Obesity		

VISUAL TEST			
Visual Acuity Test	RT <input checked="" type="checkbox"/> 6/6	LT <input checked="" type="checkbox"/> 6/6	
Colour Vision Test	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Not Required
Pre-existing condition:	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Required		
Remarks:			

RESPIRATORY SYSTEM			
Spirometry Test	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Not Required
Chest X-Ray	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Not Required
Physical Assessment	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	
Remarks:			

ENT SYSTEM			
Audiometry Test	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Not Required
Otoscopy	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Not Required
Physical Assessment	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	(Whisper, Weber & Rinne Tests)
Remarks:			

CARDIOVASCULAR SYSTEM			
ECG Test	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Not Required
Physical Assessment	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	
Remarks:			

NEUROLOGICAL SYSTEM			
Physical Assessment	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	
Remarks:			

MUSCULOSKELETAL SYSTEM			
Physical Assess.	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	
Lumbar X-Ray	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Not Required
Remarks:			

LABORATORY INVESTIGATIONS			
Lab Tests:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	If abnormal, please specify below:
Blood Grouping:	B + R <sup>+</sup>		
Remarks:			

Glucose Level Category	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Pre diabetic	<input type="checkbox"/> Diabetic
Cholesterol Risk Category	<input checked="" type="checkbox"/> Low Risk	<input type="checkbox"/> Moderate Risk	<input type="checkbox"/> High Risk
Routine Urine Analysis	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Not Required
Stool Analysis	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Not Required

QUESTIONNAIRES			
Medical & Surgical History Questionnaire	Remarks		
Respiratory Protection Questionnaire	Remarks		
Hearing Conservation Questionnaire	Remarks		
Screening Questionnaire	Remarks		
Fagerstrom Test - Smoking	<input type="checkbox"/> Non-smoker	<input type="checkbox"/> Low dependence	<input type="checkbox"/> Moderate dependence
CAGE Questionnaire Alcohol Use	<input type="checkbox"/> No use of alcohol	<input type="checkbox"/> Screening negative	<input type="checkbox"/> Clinically significant
SRQ-20 Self-reported Questionnaire	<input type="checkbox"/> No positive answers	<input type="checkbox"/> Positive answers Factor I (1 to 6)	<input type="checkbox"/> Positive answers Factor II (7 to 12)
	<input type="checkbox"/> Positive answers Factor III (13 to 16)	<input type="checkbox"/> Positive answers Factor IV (17 to 20)	

Clinic Doctor Name	License #	Hospital/Polyclinic	Doctor Signature & Clinic Stamp	Issue Date
Dr. SHAH FAISAL				09/07/2023
Form Revised: 02-30/05/2021				



# FITNESS TO WORK CERTIFICATE - OQ CONTRACTORS



## EMPLOYEE IDENTIFICATION

Civil ID / Passport #	Company ID #	ARASHPREET SINGH PARMJIT SINGH # 0043483 # 21 Y/M B A-S-Pw Bill: 00517	Position <i>Helper</i>
Nationality	Age	Sex	Location

## EXAMINATION TYPE

<input checked="" type="checkbox"/> Pre-employment Examination (PRE)	<input type="checkbox"/> Periodic Medical Examination (PME)	<input type="checkbox"/> Post-absence Examination
<input type="checkbox"/> Change of Position Examination	<input type="checkbox"/> Exit Examination	<input type="checkbox"/> Critical Activities Examination
<input type="checkbox"/> Emergency Response Team	<input type="checkbox"/> Travelling Examination	<input type="checkbox"/> Medical Surveillance

## Medical Suitability for Work

Medical Suitability for Work	<input checked="" type="checkbox"/> Fit to work <input type="checkbox"/> Fit with following restrictions <input type="checkbox"/> Pending Fitness <input type="checkbox"/> Not fit to work
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**FIT**

## Restrictions

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

Other, specify

New Position	New Function	New Department
NA	NA	NA

Examination Date <i>6/7/23</i>	Exams Performed
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Medical Review Date <i>09/07/2023</i>	Employee Signature <i>Arashpreet Singh</i>
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Doctor Name <i>SHAH FAISAL</i>	Medical License <i>22368</i>	Hospital <i>PEACE LAND MEDICAL CENTER</i>	Medical Doctor Signature <i>SR</i>
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OQ Occupational Health & Safety  
Medical Practitioner  
Med Lic No. 22368

