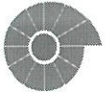
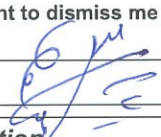




Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

 Petroroleum Development Oman MEDICAL DEPARTMENT		Surname AL SHAIBAN																																																																																																																												
PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS		Forenames MOHAMMED YOUSUF MUBARRAK																																																																																																																												
Place of examination NMC ALHAIL		Address _____																																																																																																																												
Date 18/04/2023		Home telephone number _____																																																																																																																												
If a dependant enter employee's name here: Surname: _____ Forenames: _____																																																																																																																														
Birth date: 31/10/1999		Nationality: OMAN																																																																																																																												
Country of birth: _____		Religion: _____																																																																																																																												
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced																																																																																																																												
Reason for examination <input checked="" type="checkbox"/> Pre-Employment <input type="checkbox"/> Pre-Overseas		Relationship to employee <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter																																																																																																																												
Job: _____		Number of children: _____																																																																																																																												
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.)																																																																																																																														
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FOR WOMEN ONLY		Have you ever had:-																																																																																																																												
45. An abnormal smear		46. Any gynaecological treatment																																																																																																																												
47. Are you pregnant?		48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE																																																																																																																												
How much tobacco each day? _____		Average daily alcohol consumption _____																																																																																																																												
Have you ever taken elicited drugs? (X) PDO test all new/potential employees for elicited/recreational drugs																																																																																																																														
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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: _____		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		
<input checked="" type="checkbox"/>		1 Eyes & Pupils	
<input checked="" type="checkbox"/>		2 E.N.T.	
<input checked="" type="checkbox"/>		3 Teeth & Mouth	
<input checked="" type="checkbox"/>		4 Lungs & Chest	
<input checked="" type="checkbox"/>		5 Cardiovascular System	
<input checked="" type="checkbox"/>		6 Abdo. Viscera	
<input checked="" type="checkbox"/>		7 Hernial Orifices	
<input checked="" type="checkbox"/>		8 Anus & Rectum	
<input checked="" type="checkbox"/>		9 Genito-urinary	
<input checked="" type="checkbox"/>		10. Extremities	
<input checked="" type="checkbox"/>		11. Musculo-skeletal	
<input checked="" type="checkbox"/>		12. Skin & Varicose Vns.	
<input checked="" type="checkbox"/>		13. C.N.S.	
HEIGHT cm	WEIGHT kg	BMI	B.P.
175	58	18.9	120 / 80
PULSE		HEARING	VISION
88 /mins.		L N R N	DISTANT NEAR Uncorrected Corrected
			Colour Vision Blood Group
			Normal
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS	
<input checked="" type="checkbox"/>		1. Urinalysis	
<input checked="" type="checkbox"/>		2. Hb, Bloodcount, ESR	
<input checked="" type="checkbox"/>		3. LFT, RFT, RBS	
<input checked="" type="checkbox"/>		4. Drug Screen	
<input checked="" type="checkbox"/>		5. Lipids (40 years +)	
<input checked="" type="checkbox"/>		6. Sickle Cell test	
<input checked="" type="checkbox"/>		7. Audiogram	
<input checked="" type="checkbox"/>		8. Lung Function	
<input checked="" type="checkbox"/>		9. Chest X-Ray	
<input checked="" type="checkbox"/>		10. ECG	
<input checked="" type="checkbox"/>		11. CVS risk for 40 yrs. & above	
<input checked="" type="checkbox"/>		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:		Name (Block Capitals): Dr. / Nurse	
		Signature:	
REVIEW/CONSULTATION			
Date:		Name (Block Capitals): Dr. / Nurse	
		Signature:	