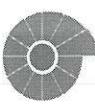
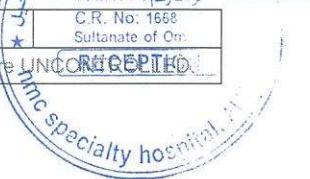




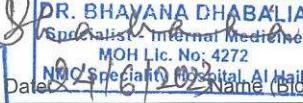
Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

 Petroleum Development Oman MEDICAL DEPARTMENT <small>PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS</small>		Surname AL SULEIMANI																																																																																						
		Forenames ABDULLAH MOHAMMED JUMA																																																																																						
		Address																																																																																						
		Home telephone number 99169878																																																																																						
Place of examination NMC AL HAIR Date 20-06-23																																																																																								
If a dependant enter employee's name here: Surname.		Forenames.																																																																																						
Birth date: 05-12-1970 Nationality: Omani		Country of birth: OMAN Religion: MUSLIM																																																																																						
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		<input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced		Relationship to employee		Number of children: 13																																																																																		
Male		<input checked="" type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter																																																																																						
Reason for examination Pre-Employment <input type="checkbox"/> Job: CLERK		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>Y</td> <td>N</td> </tr> <tr> <td>1. Sinus trouble</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>2. Neck swelling/glands</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>3. Difficulty in vision</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>4. Any ear discharge</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>5. Asthma/bronchitis</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>6. Hayfever /other significant allergy</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>7. Any skin trouble</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>8. Tuberculosis</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>9. Shortness of breath</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>10. Coughed/vomited blood</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>11. Severe abdominal pain</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>12. Stomach ulcer</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>13. Recurrent indigestion</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>14. Jaundice or hepatitis</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>15. Gall Bladder disease</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>16. Marked change in bowel habits</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>17. Blood in stools (motions)</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>18. Marked change in weight</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>19. Varicose veins</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>20. Lump in breast/armpit</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>21. Cancer</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>22. Heart Disease</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>23. Rheumatic fever</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>24. Abnormal heartbeat</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>25. High blood pressure</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>26. Stroke</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>27. Serious chest pain</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>28. Any blood disease</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>29. Kidney disease</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>30. Blood in urine</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>31. Diabetes</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>32. Headaches/migraine</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>33. Dizziness/fainting</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>34. Epilepsy</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>35. Joints/spinal trouble</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>36. Surgical operation</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>37. Serious accident/fracture</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>38. Tropical disease</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>39. Fear of heights</td> <td><input checked="" type="checkbox"/></td> </tr> </table>			Y	N	1. Sinus trouble	<input checked="" type="checkbox"/>	2. Neck swelling/glands	<input checked="" type="checkbox"/>	3. Difficulty in vision	<input checked="" type="checkbox"/>	4. Any ear discharge	<input checked="" type="checkbox"/>	5. Asthma/bronchitis	<input checked="" type="checkbox"/>	6. Hayfever /other significant allergy	<input checked="" type="checkbox"/>	7. Any skin trouble	<input checked="" type="checkbox"/>	8. Tuberculosis	<input checked="" type="checkbox"/>	9. Shortness of breath	<input checked="" type="checkbox"/>	10. Coughed/vomited blood	<input checked="" type="checkbox"/>	11. Severe abdominal pain	<input checked="" type="checkbox"/>	12. Stomach ulcer	<input checked="" type="checkbox"/>	13. Recurrent indigestion	<input checked="" type="checkbox"/>	14. Jaundice or hepatitis	<input checked="" type="checkbox"/>	15. Gall Bladder disease	<input checked="" type="checkbox"/>	16. Marked change in bowel habits	<input checked="" type="checkbox"/>	17. Blood in stools (motions)	<input checked="" type="checkbox"/>	18. Marked change in weight	<input checked="" type="checkbox"/>	19. Varicose veins	<input checked="" type="checkbox"/>	20. Lump in breast/armpit	<input checked="" type="checkbox"/>	21. Cancer	<input checked="" type="checkbox"/>	22. Heart Disease	<input checked="" type="checkbox"/>	23. Rheumatic fever	<input checked="" type="checkbox"/>	24. Abnormal heartbeat	<input checked="" type="checkbox"/>	25. High blood pressure	<input checked="" type="checkbox"/>	26. Stroke	<input checked="" type="checkbox"/>	27. Serious chest pain	<input checked="" type="checkbox"/>	28. Any blood disease	<input checked="" type="checkbox"/>	29. Kidney disease	<input checked="" type="checkbox"/>	30. Blood in urine	<input checked="" type="checkbox"/>	31. Diabetes	<input checked="" type="checkbox"/>	32. Headaches/migraine	<input checked="" type="checkbox"/>	33. Dizziness/fainting	<input checked="" type="checkbox"/>	34. Epilepsy	<input checked="" type="checkbox"/>	35. Joints/spinal trouble	<input checked="" type="checkbox"/>	36. Surgical operation	<input checked="" type="checkbox"/>	37. Serious accident/fracture	<input checked="" type="checkbox"/>	38. Tropical disease	<input checked="" type="checkbox"/>	39. Fear of heights	<input checked="" type="checkbox"/>	HAVE YOU EVER BEEN:- 40. Rejected for employment or insurance for medical reasons 41. Awarded benefits for industrial injury/illness 42. Treated for a mental condition, e.g. depression 43. Treated for problem drinking or drug abuse 44. Exposed to toxic substance or noise		Y	N
Y	N																																																																																							
1. Sinus trouble	<input checked="" type="checkbox"/>																																																																																							
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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? Yes - 1 pack/day		Average daily alcohol consumption NO																																																																																						
Have you ever taken elicited drugs? NO		PDO test all new/potential employees for elicited/recreational drugs																																																																																						
FAMILY HISTORY: Diabetes <input checked="" type="checkbox"/>		Tuberculosis <input type="checkbox"/>		Epilepsy <input type="checkbox"/>		Asthma <input type="checkbox"/>	Eczema <input type="checkbox"/>																																																																																	
Heart disease <input type="checkbox"/>		High blood pressure <input type="checkbox"/>		Stroke <input type="checkbox"/>		Blood Disease <input type="checkbox"/>	Cancer <input 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: 20-06-23		Signature of Applicant: 																																																																																						





FOR	COMPLETION	BY	EXAMINING	DOCTOR	OR	NURSE					
Further details of medical history and recreational activities											
H/o surgery (colon/Bladder) 10 years ago. Road traffic accident - 17 years ago → # facial bone.											
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.									
With in Normal Range.											
HEIGHT cm		WEIGHT kg	BMI	B.P. 107/ 74	PULSE 92/mins.	HEARING L - N R - N	VISION Uncorrected Corrected	DISTANT R L 6/6P	NEAR R L N6 N6 6/6P	Colour Vision Normal	Blood Group DR. KAVITA VERRAPPA Specialist: Ophthalmologist MOH Lic. No: 311 NMC Speciality Hospital, Al Hall
180		91	28.09								
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.)											
None. DR. FREAN GHODJANI Specialist: Cardiology MOH Lic. No: 21459 nmc speciality hospital, Al Ghoura 25/06/2023											
ASSESSMENT:											
<input checked="" type="checkbox"/> FIT ALL AREAS		<input type="checkbox"/> FIT WITH RESTRICTION		<input type="checkbox"/> TEMPORARY UNFIT		<input type="checkbox"/> UNFIT					
 DR. BHAVNA DHABALIA Specialist: Internal Medicine MOH Lic. No: 4272 NMC Speciality Hospital, Al Hall		25/6/23									
Date: 25/6/23 Name (Block Capitals): Dr. / Nurse											
Signature:											
REVIEW/CONSULTATION											
Ophthalmologist, Infectologist & Cardiology.											
Signature:											
Date: 25/6/23 Name (Block Capitals): Dr. / Nurse											
Signature:											
 RECEPTION NMC Speciality Hospital, Al Hall											

Ophthalmologist, Infectologist and Cardiologist.

Date: 12/12/12 Name (Block Capitals): Dr. / Nurse

Signature:



20/6/2023.