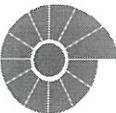


1.1 Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

 Petroleum Development Oman MEDICAL DEPARTMENT		Surname AL BALUSHI Forenames MOHAMMED ABDULLAH SAID Address Home telephone number Employment No #																																																																																																																																													
Place of examination NML AL-HAIL Date:- 24/08/2021 PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS																																																																																																																																															
If a dependant enter employee's name here: Surname: 26/08/1965 Nationality: OMANI		Forenames: 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 <table border="1" style="float: right; border-collapse: collapse;"> <tr> <td><input type="checkbox"/> Wife</td> <td><input type="checkbox"/> Son</td> <td><input type="checkbox"/> Daughter</td> </tr> </table>		<input type="checkbox"/> Wife	<input type="checkbox"/> Son	<input type="checkbox"/> Daughter																																																																																																																																									
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Reason for examination Pre-Employment <input 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" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">Y</th> <th style="text-align: center;">N</th> <th></th> <th style="text-align: center;">Y</th> <th style="text-align: center;">N</th> <th></th> </tr> </thead> <tbody> <tr> <td>1. Sinus trouble</td> <td style="text-align: center;"><input checked="" type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>21. Cancer</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>HAVE YOU EVER BEEN:-</td> </tr> <tr> <td>2. Neck swelling/glands</td> <td style="text-align: center;"><input checked="" type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>22. Heart Disease</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>40. 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Asthma/bronchitis</td> <td style="text-align: center;"><input checked="" type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>25. High blood pressure</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>43. Treated for problem drinking or drug abuse</td> </tr> <tr> <td>6. Hayfever /other significant allergy</td> <td style="text-align: center;"><input checked="" type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>26. Stroke</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>44. Exposed to toxic substance or noise</td> </tr> <tr> <td>7. Any skin trouble</td> <td style="text-align: center;"><input checked="" type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>27. 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Coughed/vomited blood</td> <td style="text-align: center;"><input checked="" type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>30. Blood in urine</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>46. Any gynaecological treatment</td> </tr> <tr> <td>11. Severe abdominal pain</td> <td style="text-align: center;"><input checked="" type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>31. Diabetes</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>47. Are you pregnant?</td> </tr> <tr> <td>12. Stomach ulcer</td> <td style="text-align: center;"><input checked="" type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>32. 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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: 24/08/2021		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												
✓		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		WEIGHT kg	BM I	B.P. 150 92.4.9 100	PULSE 88 mins.	HEARING L R	VISION DISTANT R L				NEAR R L	Colour Vision	Blood Group
170		72					Uncorrected	✓	✓			✓	
							Corrected						
N	A				LABORATORY AND OTHER SPECIAL INVESTIGATIONS			N	A				
✓		1. Urinalysis			mild ↑ in Cholesterol for follow up.			✓		7. Audiogram			
✓		2. Hb, Blood count, 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 SPECIFIC RESTRICTION												
<input type="checkbox"/>	TEMPORARY UNFIT												
<input type="checkbox"/>	AWAITING SPECIALIST ASSESSMENT												
REVIEW/CONSULTATION													
DATE: 28/8/2021		DOCTOR NAME: Dr. Christine					DR. CHRISTINE MAMDOUH LOTFY ABDALLA General Practitioner MOH Lic. No. 17978 nmc speciality hospital, Al-Hail		SIGNATURE:				