

Part one: Declaration

Completing this assessment will assist in determining if reasonable accommodation is necessary for you to perform the proposed job.

BP Privacy Notice

BP International Limited (BP), registered at Chertsey Road, Sunbury on Thames, Middlesex, TW16 7BP company number [ ], will use the information which is contained on this form and additional information collected during your medical assessments ("your information") for the purpose of assessing your fitness to work and/or to assess your suitability to go on an international assignment (if relevant).

Your information will be processed by BP health team staff in the appropriate BP offices and other medical service providers who supply services to BP, who are under a duty of confidentiality. All records are kept in line with BP's Records Retention Schedule.

Since BP operates globally, BP may need to transfer your information to other countries, including countries outside the European Economic Area (EEA). However, we always seek to ensure that your information receives the same level of protection as it would within the EEA. Should you have any questions about the use of Your information, please contact your BP Health Team.

Declaration

I certify that the information I have provided on this Form is to the best of my knowledge correct and complete. I confirm that I have read and agree to the use of my information as outlined in the BP Privacy Notice above.

I confirm that I understand an opinion will be made on my fitness to work and/or suitability to go on an international assignment (if relevant). I will contact BP health team for advice if there is any change to my health which may affect my fitness to work and/or suitability to go on an international assignment (if relevant).

Signature

[Handwritten signature]

Date

15/8/24  
(dd/mm/yyyy)

Name (please print)

[Empty box for name]



### Fitness to Work Certificate for drivers

Employee Data		Date 15/8/24	
Name FIOA HUSSAIN		Department/Company	
I.D No. 79727149	Age 36 Y	Occupation DRIVER	
Type of Medical Evaluation		Mark those applying ✓	
A5- HVD- Crane or forklift driving & all heavy vehicles		A7- Professional driving-light vehicles	
<p>Health Advisor Statement: The above named person has been examined according to the statements laid down in "Protocols and Guidance Notes on the Medical Evaluation of Fitness to Work". At this time his/her fitness to work status for the above tasks is as follows.</p>			
Fit with no restrictions			
Fit with following restriction(s)			
<i>The employee is fit for above work but should avoid the following task(s)</i>	<i>Temporary restriction</i>		
Work near moving machinery or sharp edges			
Operate Heavy motor vehicles, forklifts or heavy machinery			
Other (Specify)			
Temporary Unfit until			
Permanently Unfit			
Name of health advisor		Signature	Date





Appendix 20: (Form SQ5): Epworth Screening Quest. For Sleep Apnoea

Employee Data	Date: 15/8/24
Name: FIDA HUSSAIN	Department/Company:
I. D No. 79727149	Tel #
	Occupation :

This questionnaire will help identify if you have any health condition which may need a more detailed medical assessment as part of your fitness to work determination. If you have any queries please contact your local Health Services staff. All information provided on this form and during consultations remains strictly confidential. When further clinical evaluation is required following completion of a screening questionnaire, the details should be recorded on Q1 and E1 forms.

How likely are you to fall asleep in the following situations? (use 0 to 3 score as shown below)

- 0 Would never doze
  - 1 Slight chance of dozing
  - 2 Moderate chance of dozing
  - 3 High chance of dozing
- \_\_\_\_\_ 0 sitting and reading
- \_\_\_\_\_ 0 watching TV
- \_\_\_\_\_ 0 sitting inactive in a public place (e.g. theatre or meeting)
- \_\_\_\_\_ 0 as a passenger in the car for an hour without a break
- \_\_\_\_\_ 1 Lying down to rest in the afternoon when circumstances permit
- \_\_\_\_\_ 1 Sitting a talking with someone
- \_\_\_\_\_ 1 Sitting quietly after lunch without alcohol
- \_\_\_\_\_ 0 In a car, while stopped for a few minutes in traffic
- \_\_\_\_\_ 0
- Total 2

If you score a total of 15 or more you should seek advice from medical personnel on site before continuing to drive or operate machinery in the workplace.

Declaration: I, \_\_\_\_\_ (Print Name) certify that to the best of my knowledge the above information supplied by me is true and correct.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



Part one: Declaration

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Signature

[Handwritten signature in Arabic]

Date

15/8/16  
(dd/mm/yyyy)

Name (please print)

[Empty box for name]



**Part Two: Basic Details**

**Personal Details**

Surname	<input type="text" value="HUSSAIN"/>	Maiden Name	<input type="text"/>
First Name(s)	<input type="text" value="FIDA"/>	Date of Birth	<input type="text" value="23-11-1987"/>
Gender	<input type="text" value="Male"/>	Current location	<input type="text"/>
Home Address	<input type="text"/>		
Postcode / zip	<input type="text"/>	Preferred Contact number	<input type="text"/>
Email	<input type="text"/>	Mobile number / Cell phone	<input type="text"/>
BP staff	<input checked="" type="checkbox"/> Yes	(if not please state your Employer) <input type="text"/>	
Employee ID	<input type="text"/>		
Proposed Work Country	<input type="text"/>	Proposed Work Site	<input type="text"/>
Segment / Division / Function	<input type="text"/>		
Business unit	<input type="text"/>		
New job Title	<input type="text"/>	New Line Manager	<input type="text"/>

**Reason for Health Assessment**

Pre-employment	<input type="checkbox"/> Yes
Pre-placement / transfer	<input type="checkbox"/> No
Post absence	<input type="checkbox"/> No
For cause	<input type="checkbox"/> No
Periodic	<input type="checkbox"/> No

**List of Tasks / Roles**

Aircraft Refuelier	<input type="checkbox"/> No
Confined Space Worker	<input type="checkbox"/> No
Crane Operator	<input type="checkbox"/> No
Professional Driver	<input type="checkbox"/> No
Expatriation / Rotation Work	<input type="checkbox"/> No
Fire and Emergency Crew	<input type="checkbox"/> No
Offshore Worker	<input type="checkbox"/> No
Remote Worker	<input type="checkbox"/> No
SCBA /Respirator User	<input type="checkbox"/> No
Work at Height / Depth / Embarkation	<input type="checkbox"/> No
Work in Extreme Cold	<input type="checkbox"/> No
Work in Extreme Heat	<input type="checkbox"/> No



**Part Three: General Health**

To be completed during appointment with Health Practitioner.

Name **FIDA HUSSAIN**

Date of Birth **23-11-1987**

Please Provide Details

Do you have any concern about your health that you would like to discuss confidentially with an occupational health professional?  No

Please answer these questions

Are you able to perform all the tasks required for this job?  Yes

Do you require any adjustments to enable you to perform all the tasks as above?  No

Are you currently having or awaiting investigations or treatment for physical or psychological health conditions?  No

Are you taking any medication(s)?  No

Do you have any allergies?  No

Please Provide Details

Please complete this section if you have ticked any of the tasks / roles.

Recent surgery (within 6-8 weeks)  No

Heart disease or angina?  No

Diabetes?  No  
If yes, please specify type-

Chest problems, breathing difficulties, wheezing, recurrent bronchitis or pneumothorax in the last year?  No

Asthma?  No

Sinusitis / Persistent ear problems?  No

Transient ischaemic attacks (TIA) or stroke (CVA) or brain haemorrhage?  No

Epilepsy?  No

Balance problems or vertigo?  No

Please Provide Details



To be completed during appointment with Health Practitioner.

Part Three: General Health

Name **FIDA HUSSAIN**

Date of Birth **23-11-1987**

Please answer these questions for ALL tasks / roles.

Do you suffer from or have you had any of the following?

Please provide details

Any infectious disease, malaria, tuberculosis, travellers' diarrhoea or other specific infectious illness?  No

Are you pregnant at the moment? If so, please specify when the baby is due.  No

A sleep disorder, sleep apnoea or narcolepsy?  No

Cancer, immunosuppression, or any other significant health condition not mentioned previously?  No


Please answer these additional questions for the following tasks / roles ONLY: Expatriation / Rotation work, Offshore Worker, Remote Worker, Work in Extreme Cold, Work in Extreme Heat.

Do you suffer from or have you had any of the following?

Please provide details

Removal of your spleen?  No

Thrombosis (eg blood clot, deep vein thrombosis, pulmonary embolism)?  No

Kidney or bladder stones?  No




Part Four: Clinical Examination

To be completed by examining Health Practitioner.

Name **FIDA HUSSAIN**

Date of Birth **23-11-1987**

Please indicate units of measure as applicable			Please provide details			
Baseline Assessment	Height		180			
			cm	ft	ins	
	Weight		50			
			kg	st	lbs	
	Body Mass Index (BMI)	wt(kg)/ht(m) <sup>2</sup>	15.4			
	Radial pulse	per minute	48			
	Blood Pressure		Systolic		Diastolic	
			Final Reading Only		Final Reading Only	
	* blood pressure to be taken after 5 minutes rest.	105		62		
Urine Test	Normal	Yes				
Comments						

Right			Comments			Loft			Comments		
Visual Assessment	Light reflexes	Normal	Yes			Normal	Yes				
	Accommodation	Normal	Yes			Normal	Yes				
	Nystagmus	Normal	Yes			Normal	Yes				
	Eye movements	Normal	Yes			Normal	Yes				
	Peripheral Vision	Normal	Yes			Normal	Yes				
	Fundoscopy	Normal	Yes			Normal	Yes				
	Visual Acuity	Right Corrected	Right Uncorrected			Left Corrected	Left Uncorrected	Both Corrected	Both Uncorrected		
Distance Vision 7/6 7/20	6/6				6/6						6/6
Intermediate Vision											
Near Vision	Normal				Normal						
Colour Vision - Ishihara	Normal	Colour recognition if abnormal									
Select appropriate	Yes										



Part Four: Clinical Examination

To be completed by examining Health Practitioner.

Name **FIDA HUSSAIN**

Date of Birth **23-11-1987**

		Right	Comments	Left	Comments
Hearing Assessment	Auditory meatus	Normal <input checked="" type="checkbox"/>		Normal <input checked="" type="checkbox"/>	
	Tympanic membrane	Normal <input checked="" type="checkbox"/>		Normal <input checked="" type="checkbox"/>	
	Hearing (whispered voice)	Normal <input checked="" type="checkbox"/>		Normal <input checked="" type="checkbox"/>	
	Rinne (if indicated)	Normal		Normal <input checked="" type="checkbox"/>	
	Weber (if indicated)	Normal		Normal <input checked="" type="checkbox"/>	
		Not applicable			
		Normal	Comments		
General	Head and Neck	<input checked="" type="checkbox"/>	NORMAL		
	Teeth / gums / oral hygiene	<input checked="" type="checkbox"/>			
	Tongue / Fauces	<input checked="" type="checkbox"/>			
	Thyroid	<input checked="" type="checkbox"/>			
	Lymph glands	<input checked="" type="checkbox"/>			
	Axillae	<input checked="" type="checkbox"/>			
		Normal			
Cardio-Vascular	Heart murmurs	<input checked="" type="checkbox"/>	NORMAL		
	Heart sounds	<input checked="" type="checkbox"/>			
	Peripheral pulses	<input checked="" type="checkbox"/>			
	Peripheral veins	<input checked="" type="checkbox"/>			
		Normal	Comments		
Respiratory	Nasal Airways	<input checked="" type="checkbox"/>	NORMAL		
	Trachea	<input checked="" type="checkbox"/>			
	Chest shape / movement	<input checked="" type="checkbox"/>			
	Percussion	<input checked="" type="checkbox"/>			
	Breath sounds	<input checked="" type="checkbox"/>			




**Part Four: Clinical Examination**

To be completed by examining Health Practitioner.

Name **FIDA HUSSAIN**

Date of Birth **23-11-1987**

	Normal	Comments
Gastro-intestinal / Abdomen	Abdomen <input type="checkbox"/> Yes	NORMAL
	Liver <input type="checkbox"/> Yes	
	Spleen <input type="checkbox"/> Yes	
	Kidneys <input type="checkbox"/> Yes	
	Hernial orifices <input type="checkbox"/> Yes	

Gastrointestinal System: Abdomen:	Comments
	NORMAL

	Normal	Comments
Musculoskeletal	Hands / feet <input type="checkbox"/> Yes	NORMAL
	Limbs <input type="checkbox"/> Yes	
	Back and neck <input type="checkbox"/> Yes	
	Joints <input type="checkbox"/> Yes	
	Injuries, Any residual disability <input type="checkbox"/> Yes	



**Part Four: Clinical Examination**

To be completed by examining Health Practitioner.

Name **FIDA HUSSAIN**

Date of Birth **23-11-1987**

<b>Nervous</b>			Normal			Comments		
	Balance					Yes		
	Power					Yes		
	Tone					Yes		
	Co-ordination					Yes		
		BIC	TRI	SUP	KNE	ANK	PLA	Comments
Reflexes	Right				Yes	Yes	Yes	
Present	Left				Yes	Yes	Yes	

<b>Other</b>			Normal			Comments		
	Skin					Yes		
	Mental state					Yes		
	Audiometry assessment		Yes					
	Spirometry assessment		Not Examined					

NORMAL

<b>Skin</b>	<b>Description</b>
	NORMAL

<b>Additional Notes</b>

**Summary** (summarise information relevant to the task)

Low BMI, Left Exotropia and Sinus Bradycardia.



**Part Five: Immunisation History**

To be completed by examining Health Practitioner.

Name **FIDA HUSSAIN**

Date of Birth **23-11-1987**

Please update and give immunisations as appropriate

Vaccine	Primary Course Completed	Date of Last dose or Date given (dd/mm/yyyy)
BCG / TB Status		
Diphtheria		
Hepatitis A		
Hepatitis B		
Influenza		
Japanese Encephalitis		
Meningitis ACWY		
Polio		
Rabies		
Tetanus		
Tickborne Encephalitis		
Typhoid		
Yellow Fever		
Measles/Mumps/Rubella		
Varicella		

Children: please specify last dose of childhood immunisations and when next dose due.

Additional Comments



Part Six: Travel Health Advice

CHECKLIST TO BE COMPLETED BY HEALTH CARE PROVIDERS FOR BUSINESS TRAVELLER, EXPATRIATE OR ROTATOR.

Name	FIDA HUSSAIN	Date of Birth	23-11-1987
Travel Health Advice Checklist		Completed	
Travel immunisation information			No
Food & water precautions			No
Importance of reporting illness			No
Pregnancy			No
Prevention of travel related Deep Vein Thrombosis			No
Sexual health advice			No
Malaria / malaria tablets discussed and provided for destination			No
Bite avoidance measures			No
Travel Kit			No
Needle & syringe kit			No

Additional Comments

[Empty box for additional comments]



**Part Seven: Investigations**

APPLIES ONLY IF CLINICALLY INDICATED FOLLOWING HEALTH ASSESSMENT OR FOR EXPATRIATES OR ROTATORS AS PART OF THE HEALTH ASSESSMENT FOR HIGHER RISK COUNTRIES OR FOR VISA OR WORK PERMIT PURPOSES

Name  Date of Birth

Test	Results	Date	Health Professional
<b>BLOOD TESTS</b>			
Full blood count and film	<input type="text" value="Normal"/>	<input type="text" value="15/8/24"/>	<input type="text" value="[Signature]"/>
Fasting blood sugar	<input type="text" value="Normal"/>	<input type="text" value="✓"/>	<input type="text" value="[Signature]"/>
Liver Function	<input type="text" value="Normal"/>	<input type="text" value="✓"/>	<input type="text" value="[Signature]"/>
Blood grouping	<input type="text" value="O+ve"/>	<input type="text" value="✓"/>	<input type="text" value="[Signature]"/>
QuantiFERON	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other blood tests	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Chest X-Ray	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Other tests based on location specific risks eg hep B serology	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
(Please specify)	<input type="text"/>		

**FIT**

**Additional Comments**



Part Eight: Fitness for Task Health Assessment Outcome

Name **FIDA HUSSAIN**

Date of Birth **23-11-1987**

Medical Suitability for Work

attended a fitness for task health assessment on:

for the following:

Aircraft Refueller

Confined Space Worker

Crane Operator

Driver

Expatriation / Rotation Work

Fire and Emergency Crew

Offshore Worker

Remote Worker

SCBA / Respirator User

Work at Height / Depth / Embarkation

Work in Extreme Cold

Work in Extreme Heat

For expatriation this person was considered to be:

For the assigned role / tasks this person was considered to be:

Medically suitable?

Medically suitable?

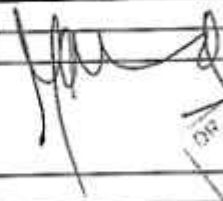

Please detail restrictions below:

Please detail restrictions below:

Medically unsuitable

Medically unsuitable

Name  
Designation  
Date (dd/mm/yyyy)  
Name and Address of Clinic  
  
Telephone Number

DR MASOOD SIDDIQUE
GENERAL PRACTITIONER
15-08-2024
NMC SPECIALTY HOSPITAL


2426-9222/2426-9200

DEPARTMENT OF LABORATORY MEDICINE

<b>File No:</b> 50124091	<b>Report No:</b> 0128446
<b>Name:</b> FIDA HUSSAIN	<b>Sample Date:</b> 15/08/2024 <b>Time:</b> 10:22
<b>Address:</b>	<b>Received By:</b>
<b>Gender:</b> M <b>Age:</b> 36 Y <b>Nationality:</b> PAKISTANI	<b>Received Date:</b> <b>Time:</b>
<b>GSM No.:</b> 79132025 <b>ID Card No.:</b> 79727149	<b>Report Date:</b> 15/08/2024 <b>Time:</b> 12:33
<b>Ref. By:</b> DR MASOOD SIDDIQUE	<b>Bill No:</b> 0318916 <b>Bill Date:</b> 15/08/2024
	<b>Report Status:</b> Final

INVESTIGATION	RESULT	REFERENCE RANGE
<b>BP FIT TO WORK - PACKAGE</b>		
<b>COMPLETE BLOOD COUNT</b>		
TOTAL WBC COUNT	6.02 x 10 <sup>3</sup> / μL	4.00-11.00 x 10 <sup>3</sup> / μL
<b>DIFFERENTIAL COUNT</b>		
NEUTROPHIL (%)	35.92 %	40-75%
LYMPHOCYTE (%)	42.76 %	20-45%
MONOCYTE (%)	6.78 %	2-8%
EOSINOPHIL (%)	12.81 %	1-6%
BASOPHIL (%)	1.73 %	0-1%
HAEMOGLOBIN	13.86 gm/dl	Male : 13 -18 gm/dl Female:11-15 gm /dl childrens upto 1year-11.0 - 13.0 gm /dl upto12years-11.5 - 14.5 gm /dl cord blood:13 -19.5 gm /dl
RBC COUNT	4.80 million/cu	Male :4.5-6.5 million/cu Female:3.9-5.5 million/cu
PLATELET COUNT	236.70 x 10 <sup>3</sup> / μL	150 - 400 x 10 <sup>3</sup> / μL
HEMATOCRIT	43.42 %	Male :42 - 52% Female:37- 47%
MCV	90.37 fl	76 - 96 fl
MCH	28.84 pg	27 - 33 pg
MCHC	31.91 gm/dl	32 - 36 gm/dl
FASTING BLOOD SUGAR	4.07 mmol/L	4.11 - 6.05 mmol/L
<b>LIVER FUNCTION TEST</b>		
TOTAL BILIRUBIN	10 10 μ mol/l	Adults- up to 21 μ mol/l , Children >1 month- up to 17 μ mol/L, Neonates : 1.7 - 180 μmol/L
DIRECT BILIRUBIN	3.10 μ mol/L	Adults :- 0 - 5.0 μ mol/L, Neonates:- 0-10 μ mol/L,

Verified By:



10589

Lab Technologist

MOH License No: 17976  
Electronically signed at: 8/15/2024 12:34:00

Approved By:



DR ROSE MARY

Specialist Pathologist

MOH License No: 18178  
Electronically signed at: 15/08/2024 12:37:00



DEPARTMENT OF LABORATORY MEDICINE

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<b>Ref. By:</b> DR MASOOD SIDDIQUE	<b>Bill No:</b> 0318916 <b>Bill Date:</b> 15/08/2024
	<b>Report Status:</b> Final

INVESTIGATION	RESULT	REFERENCE RANGE
TOTAL PROTIEN	75.20 g/L	Adults : 66 - 87 g/L
ALBUMIN	44.50 g/L	39.7 - 49.4 g/L
Globulin	30.7 g/L	23-35g/L
SGOT (AST)	35.70 U/L	MALE : up to 40 U/L, FEMALE : up to 32 U/L.
SGPT (ALT)	46.20 U/L	MALE : up to 41 U/L, FEMALE : up to 33 U/L.
ALKPO4 (ALP)	49.00 U/L	Adults: MALES: 40 - 129 U/L, FEMALES: 35 - 104 U/L.
Gamma GT (GGT)	36.00 U/L	MALE- 8 - 61 U/L,  FEMALE- 5 - 36 U/L
ALCOHOL CHECK		
ETHANOL	NOT DETECTED g/L	< 0.1 g/L
URINE ROUTINE		
URINE BIOCHEMISTRY		
URINE GLUCOSE	NEGATIVE	NEGATIVE
URINE PROTEIN	NEGATIVE	NEGATIVE
URINE KETONE	NEGATIVE	NEGATIVE
URINE BILIRUBIN	NEGATIVE	NEGATIVE
NITRITE	NEGATIVE	NEGATIVE
URINE PH	6.5	4.6-8.0
SPECIFIC GRAVITY	1.020	1.010-1.030
BLOOD	NEGATIVE	NEGATIVE
UROBILINOGEN	NORMAL	NORMAL
URINE MACROSCOPY		
COLOUR	YELLOW	
APPEARANCE	CLEAR	

Verified By:



10589

Lab Technologist

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Approved By:



DR ROSE MARY

Specialist Pathologist

MOH License No: 18178

Electronically signed at: 15/08/2024 12:37:00



nmc Healthcare LLC

C.R. No: 101137

Suitcase of Quito

Phone No: 794 4000 716

DEPARTMENT OF LABORATORY MEDICINE

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<b>Ref. By:</b> DR MASOOD SIDDIQUE	<b>Bill No:</b> 0318916 <b>Bill Date:</b> 15/08/2024
	<b>Report Status:</b> Final

INVESTIGATION	RESULT	REFERENCE RANGE
<b>URINE MICROSCOPY</b>		
RBC	NIL /hpf	0-3
PUSCELLS	2-3 /hpf	0-5
EPITHELIAL CELLS	0-1 /hpf	NIL
CRYSTAL	NIL /hpf	NIL
CASI	NIL /hpf	NIL
BACTERIA	NIL	NIL
MUCOUS THREAD	NIL	NIL
<b>DRUG SCREENING TEST 5 PANEL</b>		
AMPHETAMINE	NEGATIVE	NEGATIVE
BARBITURATES	NEGATIVE	NEGATIVE
COCAINE	NEGATIVE	NEGATIVE
MARIJUANA	NEGATIVE	NEGATIVE
MORPHINE	NEGATIVE	NEGATIVE
<b>BLOOD GROUP &amp; RH TYPING</b>	<b>"O" Rh POSITIVE</b>	

Confirmation of the Newborn's blood group is indicated when the "A" and "B" antigen expression and the isoagglutinins are fully developed (2-4 years).

Verified By:



10589

Lab Technologist

MOH License No: 17976

Electronically signed at: 8/15/2024 12:34:00

Approved By:



DR ROSE MARY

Specialist Pathologist

MOH License No: 18178

Electronically signed at: 15/08/2024 12:37:00



nmc HealthCare LLC

C.R. No: 140177

Ministry of Health, Saudi Arabia

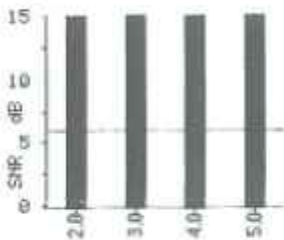
PO Box 204, Jeddah 21581

# AUDIOMETRY REPORT

U107.05  
 15-AUG-24 12:17  
 DP 4s 4 sec avg  
 SN: G11005649 G12010484

NAME: \_\_\_\_\_

Left: Pass



F2	L1	L2	DP	NF	SNR	P
2.0	64	55	4	-20	24	P
3.0	65	54	3	-16	18	P
4.0	63	52	4	-20	24	P
5.0	62	55	1	-20	21	P

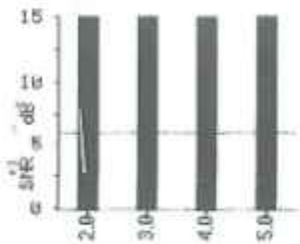
nt Fida Hussain

Sex M MRN 5012409 Date of Test 15/08/24

U107.05  
 15-AUG-24 12:23  
 DP 4s 4 sec avg  
 SN: G11005649 G12010484

NAME: \_\_\_\_\_

Right: Pass



F2	L1	L2	DP	NF	SNR	P
2.0	65	55	4	-14	18	P
3.0	65	55	4	-16	20	P
4.0	64	53	8	-14	22	P
5.0	63	53	4	-13	17	P



*[Handwritten Signature]*  
 Signature of the Technician





## BP Medical (FTW)

Ahmed Al Marzouqi <ahmed@truckomangroup.com>

Wed 8/14/2024 11:07 AM

To: NMC Hail [NMC Oman] <nmc.hail@nmcoman.com>; Customercare Hail [NMC Oman] <customercare.hail@nmcoman.com>  
Cc: Sabri Al Mandhari <sabri@truckomangroup.com>; Basemanager <basemanagerblock61@khazzanlogistics.com>;  
tinashe.mwerenga@bp.com <tinashe.mwerenga@bp.com>; klhadmin <klhadmin@khazzanlogistics.com>

📎 1 attachments (367 KB)

Passport - Fida Hussain.pdf;

\*\*\*This email was sent from a source outside of NMC\*\*\*

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Dear NMC Team,

Please arrange BP (FTW) Medical today, for our new employee.

1. Fida Hussain - 9601.



Khazzan Warehouse  
Management Services

Ahmed Al Marzouqi | HRA

KWMS, Truckoman Oil & Gas Services S.A.O.C

A: P.O Box: 367, P.C. 116, Mina Al Fahal, Sultanate of Oman

P: +968 22308851 M: +968 95665607

W: [www.khazzanlogistics.com](http://www.khazzanlogistics.com) E: [ahmed@truckomangroup.com](mailto:ahmed@truckomangroup.com)



