

1.1 Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL - CONFIDENTIAL)

 Petroleum Development Oman MEDICAL DEPARTMENT		Surname <u>AL SULEIMAN</u> Forenames <u>HARIB RABIA HARIB</u> Address <u>TRACK OMAN</u> Home telephone number <u></u>																																																																																																																												
Place of examination	Date:-	Employment No # <u></u>																																																																																																																												
PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS Place of examination <u>NML Ghoubab</u> Date:- <u>15-11-2021</u>		Birth date: <u>01/01/1968</u> Nationality: <u>Oman</u> Country of birth: <u>Oman</u> Religion: <u>Muslim</u>																																																																																																																												
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		<input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced																																																																																																																												
Reason for examination Pre-Employment <input type="checkbox"/> Job <input type="checkbox"/> Pre-Overseas <input type="checkbox"/> Area <input type="checkbox"/>		Relationship to employee <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter																																																																																																																												
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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How much tobacco each day?		Average daily alcohol consumption																																																																																																																												
Have you ever taken elicited drugs? () 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: <u></u>		Signature of Applicant: <u></u>																																																																																																																												

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	Normal								
		2. E.N.T.	G								
		3. Teeth & Mouth	H								
		4. Lungs & Chest	J								
		5. Cardiovascular System	K								
		6. Abdo. Viscera	L								
		7. Hernial Orifices	M								
		8. Anus & Rectum	N								
		9. Genito-urinary	O								
		10. Extremities	P								
		11. Musculo-skeletal	Q								
		12. Skin & Varicose Vns.	R								
		13. C.N.S.	S								
HEIGHT cm	WEIGHT kg	BM	B.P. 140 90	PULSE 86/mins.	HEARING L ✓ R ✓	VISION DISTANT R L R L				Colour Vision	Blood Group
179	77				Uncorrected Corrected	+	+				
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS				N	A				
✓		1. Urinalysis				✓		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:

- FIT ALL AREAS
- FIT WITH SPECIFIC RESTRICTION
- TEMPORARY UNFIT
- AWAITING SPECIALIST ASSESSMENT

REVIEW/CONSULTATION

DATE:

DOCTOR NAME:

DR. SUMANT PAJANKER
Specialist - Respiratory Medicine
MBBS, MD (Respiratory Medicine)
MOH Lic No. 15494
nmc specialty hospital, Al-Ghoudra

SIGNATURE: