11.15 Appendix 15: Fitness to Work Certificate

Employee Data			Date 25/09/22
Name HAMOOD HAMED HAMOOD AL ZAHLI			Department/Company TRUCKOMAN.
I.D No. 2272412	Age 29yr		Occupation FOREMAN.

Type of Medical Evaluation			Mark those applying √
A1 Aircraft refuelling		A6 Fire / Emergency response team work	
A2 Breathing apparatus		A7 Professional driving	
A3 Business traveller		A8 Remote location work	
A4 Catering and food preparation		A9 Transfers – group A country	
A5 Crane or forklift driving & all heavy vehicles		A10 Transfers – group B country	

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.

Fit with no restrictions			✓
Fit with following restriction(s)			
The employee is fit for above work but should avoid the following task(s)	***Temporary restriction***	***Permanent restriction***	
Work near moving machinery or sharp edges			
Working at height			
Puling, pushing, or carrying weight over ____ Kg			
Ascend/descend ladders or stairs			
Operate motor vehicles, forklifts or heavy machinery			
Use of a respirator			
Repetitive twisting of valves or wrenches			
Flying			
Other (Specifiy)			
Temporary Unfit until			
Permanently Unfit			**Date**

Name of health advisor DR. LIPON KANTI BARUA GENERAL PRACTITIONER RUSAYL HEALTH CENTRE MOH 1657 **Signature** **Date** 25/09/22

C.R. No.: 1/25995/4 P.O. Box : 18 P.C. 124 Rusayl Sultanate of Oman

مركز الرسيل الصحي
RUSAYL HEALTH CENTRE
ISO 9001- 2015 Certified Co.

No. B 17843

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)

RUSAYL HEALTH CENTRE
ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Surname/ Forenames	HAMOOD HAMED HAMOOD AL ZAWLI
Nationality	OMANI
Mobile No. 93816809	Home/Leave Address:
Company Number: 8138	Reference Indicator:

Personal Details

A ☑ Male ☐ Female ☑ Married ☐ Single ☐ Separated /Divorced /Widow(er)

Home/Leave Address:

Relationship to employee ☐ Wife ☐ Son ☐ Daughter No of Children:

Reason for Examination (tick as appropriate)

Periodic Medical Examination ☐ Final / Retirement ☐ Other Reason: ☐

Employee only

B Present Job and Location:

Next Job and Location:

Are you a registered person with special needs? ☐

Do you belong to any Medical Insurance Scheme? ☐

Previous Medical History: All important medical events should be listed and dated at every medical examination. To be completed together with the interviewing Nurses or Doctor who will be able to help by referring to your notes.

Please answer the following questions and tick 'N' (no) or 'Y' (yes) in the column. If 'Y' Please describe

		N	Y	Description
	Have you, since your last medical been treated by your family doctor or specialist for significant (major) ailments?	✓		
1	Ear, nose, eye or throat problems	✓		
2	Chest problems like asthma, bronchitis, other bad cough	✓		
3	Heart abnormality, chest pains	✓		
4	Abdominal pains, abnormal bowel motions	✓		
5	Urogenital problems (kidney disease, menstrual disorder)	✓		
6	Skin trouble or allergies	✓		
7	Epileptic fits, dizzy spells or migraine	✓		
8	History of mental illness, depression anxiety	✓		
9	Diabetes, thyroid disease	✓		
10	Blood disorder e.g. anaemia, blood cancer e.g. leukaemia	✓		
11	Any history of accidents or fractures	✓		
12	**Have you had any serious allergies**	✓		
13	Do any dependants have a significant ongoing illness?	✓		
14	Any family history of cancers	✓		
	Do you take any regular medicines, or have your taken in the past?	✓		
	Do you smoke? If yes, what and how much each day?	✓		
	Do you drink alcohol? If yes, what is your average weekly intake?	✓		
	Have you ever taken elicited/recreational drugs?	✓		
	Are you doing regular sports or physical activities?	✓		

STATEMENT: I have read the above questions and the above answers are correct and no information concerning my present or past state of health has been withheld. . I understand and agree that this form will be held as a confidential record by PDO Medical Department, and may be copied (by paper or secure electronic transmission)) to the Occupational Health Services for the purpose of Health Surveillance and other Occupational Health review .

Date: 25/09/22

Signature of Applicant: 25.9.2022

C.R. No.: 1/25995/4
P.O. Box : 18
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Sultanate of Oman
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FOR COMPLETION BY EXAMINING DOCTOR OR NURSE

Further details of medical history and recreational activities

N	A	N = Normal A = Abnormal (please describe)	PHYSICAL EXAMINATION
✓		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	BMI	B.P.	PULSE	HEARING
176	127.5	41.2	140/80	78/mins.	L R

VISION

	DISTANT R	DISTANT L	NEAR R	NEAR L
Uncorrected				
Corrected				

R 6/5
L 6/9

N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A	
✓		1. Urinalysis	M Triglycerides		7. Audiogram
✓		2. Hb, Bloodcount, ESR	↑ for Tab LOPID (600.)		8. Lung Function
✓		3. LFT, RFT, RBS	Ofo 41 — 6/12		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.)

Pt's FBS 179, HbA1C ~~6.9~~ 6.6. Borderline Xtendy Dx DM.
Diet & life style Modification Suggested

ASSESSMENT AND RECOMMENDATIONS:

☑ FIT ALL AREAS ☐ FIT WITH RESTRICTION ☐ TEMPORARY UNFIT ☐ UNFIT

DR. LIPON KANTI BARUA
GENERAL PRACTITIONER
RUSAYL HEALTH CENTRE
MOH LIC NO. 14857

Date: 25/09/22 Name (Block Capitals): Dr. / Nurse Signature:

مركز الرسيل الصحي
س.ت: ١/٢٥٩٩٥/٤
C.R. No.: 1/25995/4
P.O. Box: 18
P.C.: 124, Rusayl
Sultanate of Oman
RUSAYL HEALTH CENTRE

REVIEW/CONSULTATION

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