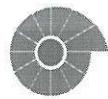
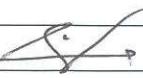


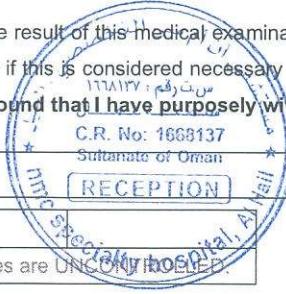


Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

Petroleum Development Oman
MEDICAL DEPARTMENTPLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Place of examination NMC HAIL		Date 3/6/2023	Surname AL HINAI																																																																																																																											
If a dependant enter employee's name here:		Forenames KHALFAN MASOUD SAID																																																																																																																												
Surname AL HINAI		Forenames KHALFAN MASOUD SAID		Address																																																																																																																										
Birth date: 01/01/1972		Nationality: OMANI		Country of birth: OMAN																																																																																																																										
<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 <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter																																																																																																																										
Reason for examination		Pre-Employment		Job: Supervisor																																																																																																																										
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"> <thead> <tr> <th></th> <th>Y</th> <th>N</th> </tr> </thead> <tbody> <tr><td>1. Sinus trouble</td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>2. Neck swelling/glands</td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>3. Difficulty in vision</td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>4. Any ear discharge</td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>5. Asthma/bronchitis</td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>6. Hayfever /other significant allergy</td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>7. Any skin trouble</td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>8. Tuberculosis</td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>9. Shortness of breath</td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>10. Coughed/vomited blood</td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>11. Severe abdominal pain</td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>12. Stomach ulcer</td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>13. Recurrent indigestion</td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>14. Jaundice or hepatitis</td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>15. Gall Bladder disease</td><td><input checked="" type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>16. 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		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																																																																																																																												
		FOR WOMEN ONLY 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? <input checked="" type="checkbox"/>		Average daily alcohol consumption <input checked="" type="checkbox"/>																																																																																																																												
Have you ever taken elicited drugs? <input checked="" type="checkbox"/> PDO test all new/potential employees for elicited/recreational drugs																																																																																																																														
FAMILY HISTORY: Diabetes (<input checked="" type="checkbox"/>) Tuberculosis (<input checked="" type="checkbox"/>) Epilepsy (<input checked="" type="checkbox"/>) Asthma (<input checked="" type="checkbox"/>) Eczema (<input checked="" type="checkbox"/>) Heart disease (<input checked="" type="checkbox"/>) High blood pressure (<input checked="" type="checkbox"/>) Stroke (<input checked="" type="checkbox"/>) Blood Disease (<input checked="" type="checkbox"/>) Cancer (<input checked="" 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: 03-06-2023		Signature of Applicant: 																																																																																																																												
Page 79		Specification																																																																																																																												
The controlled version of this CMF Document resides online in Livelink®, Printed copies are UNCONTROLLED.																																																																																																																														





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											
<input checked="" type="checkbox"/>	1. Eyes & Pupils	BP 160/100. Unconstrained										
<input checked="" type="checkbox"/>	2. E.N.T.	NAD										
<input checked="" type="checkbox"/>	3. Teeth & Mouth	NAD										
<input checked="" type="checkbox"/>	4. Lungs & Chest	BP chest is clear.										
<input checked="" type="checkbox"/>	5. Cardiovascular System	S + S + 0.										
<input checked="" type="checkbox"/>	6. Abdo. Viscera	NAD										
<input checked="" type="checkbox"/>	7. Hernial Orifices	NAD										
<input checked="" type="checkbox"/>	8. Anus & Rectum	NAD										
<input checked="" type="checkbox"/>	9. Genito-urinary	NAD										
<input checked="" type="checkbox"/>	10. Extremities	NAD										
<input checked="" type="checkbox"/>	11. Musculo-skeletal	NAD										
<input checked="" type="checkbox"/>	12. Skin & Varicose Vns.	No - 0										
<input checked="" type="checkbox"/>	13. C.N.S.	Normal										
HEIGHT cm	WEIGHT kg	BMI	B.P.	PULSE 60 /mins.	HEARING L N R N	VISION Uncorrected Corrected	DISTANT R L R L	NEAR R L	Colour Vision	Blood Group		
164	86	31.9	130 /90						NAD	—		

N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS				N	A				
<input checked="" type="checkbox"/>		1. Urinalysis				<input checked="" type="checkbox"/>		7. Audiogram			
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	2. Hb, Bloodcount, ESR				<input checked="" type="checkbox"/>		8. Lung Function			
.	<input checked="" type="checkbox"/>	3. LFT, RFT (RBS)				<input checked="" type="checkbox"/>		9. Chest X-Ray			
		4. Drug Screen				<input checked="" type="checkbox"/>		10. ECG			
<input checked="" type="checkbox"/>		5. Lipids (40 years +)				<input checked="" type="checkbox"/>		11. CVS risk for 40 yrs. & above			
<input checked="" type="checkbox"/>		6. Sickle Cell test				<input checked="" type="checkbox"/>		12. HIV, Hepatitis screening			

↑ FBS - 9.39.

OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)

FIT

ASSESSMENT:

FIT ALL AREAS FIT WITH RESTRICTION TEMPORARY UNFIT UNFIT

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

Signature:

REVIEW/CONSULTATION

Recheck FBS, HbA1c - if elevated glucose level found
admit in inpatient consultation for Diabetic control

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

Signature:

C.R. No: 1668137

Sultanate of Oman