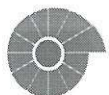




## Appendix 32: EX1 Form (Initial Examination Report)

## INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

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

Surname <u>AL SUWAKI</u>		Forenames <u>Muhammad Said Mohammed</u>		Address <u></u>	
Place of examination <u>NMC AL HAIL</u>		Date <u>06-07-23</u>		Home telephone number <u></u>	
If a dependant enter employee's name here:					
Surname:		Forenames:			
Birth date: <u>20/10/68</u>		Nationality: <u>Omani</u>		Country of birth: <u>Oman</u>	
Religion: <u>Islam</u>					
<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 <input type="checkbox"/> Job: Pre-Overseas <input type="checkbox"/> Area:		Number of children: <u>6</u>			
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.)					
Y		N		Y N	
1. Sinus trouble		<input checked="" type="checkbox"/>		21. Cancer	
2. Neck swelling/glands		<input checked="" type="checkbox"/>		22. Heart Disease	
3. Difficulty in vision		<input checked="" type="checkbox"/>		23. Rheumatic fever	
4. Any ear discharge		<input checked="" type="checkbox"/>		24. Abnormal heartbeat	
5. Asthma/bronchitis		<input checked="" type="checkbox"/>		25. High blood pressure	
6. Hayfever /other significant allergy		<input checked="" type="checkbox"/>		26. Stroke	
7. Any skin trouble		<input checked="" type="checkbox"/>		27. Serious chest pain	
8. Tuberculosis		<input checked="" type="checkbox"/>		28. Any blood disease	
9. Shortness of breath		<input checked="" type="checkbox"/>		29. Kidney disease	
10. Coughed/vomited blood		<input checked="" type="checkbox"/>		30. Blood in urine	
11. Severe abdominal pain		<input checked="" type="checkbox"/>		31. Diabetes	
12. Stomach ulcer		<input checked="" type="checkbox"/>		32. Headaches/migraine	
13. Recurrent indigestion		<input checked="" type="checkbox"/>		33. Dizziness/fainting	
14. Jaundice or hepatitis		<input checked="" type="checkbox"/>		34. Epilepsy	
15. Gall Bladder disease		<input checked="" type="checkbox"/>		35. Joints/spinal trouble	
16. Marked change in bowel habits		<input checked="" type="checkbox"/>		36. Surgical operation	
17. Blood in stools (motions)		<input checked="" type="checkbox"/>		37. Serious accident/fracture	
18. Marked change in weight		<input checked="" type="checkbox"/>		38. Tropical disease	
19. Varicose veins		<input checked="" type="checkbox"/>		39. Fear of heights	
20. Lump in breast/armpit		<input checked="" type="checkbox"/>			
How much tobacco each day? <u>NO</u>		Average daily alcohol consumption <u>NO</u>			
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: <u>06-07-23</u>		Signature of Applicant: <u>[Signature]</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											
		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	VISION		Colour Vision		Blood Group	
179		84		26	126/90	70/min.	L 6 R 7	DISTANT R L Uncorrected 6/6 6/6 Corrected		NEAR R L 6/6 6/6		32	
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS					N	A					
✓		1. Urinalysis					✓		7. Audiogram				
✓		2. Hb, Bloodcount, 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. Sickie Cell test							12. HIV, Hepatitis screening				
OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)													
<div style="border: 2px solid blue; padding: 10px; display: inline-block;">FIT</div>													
ASSESSMENT:													
<input checked="" type="checkbox"/> FIT ALL AREAS <input type="checkbox"/> FIT WITH RESTRICTION <input type="checkbox"/> TEMPORARY UNFIT <input type="checkbox"/> UNFIT													
Date: 06/07/2023 Name (Block Capitals): Dr. / Nurse DR. Shiva Kumar													
REVIEW/CONSULTATION													
Date: Name (Block Capitals): Dr. / Nurse Signature:													