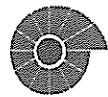




Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

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

Place of examination NMC AL HAIL Date 24-07-23

Surname AL BALUSHI)	
Forenames IBRAHIM NAJBAKH CHAR SHAMBER	
Address	
Home telephone number 98810155	

If a dependant enter employee's name here:				
Surname: Forenames:				
Birth date: 01-01-1970	Nationality: OMAN)	Country of birth: OMAN	Religion: MUSLIM	
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced	<input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter	Relationship to employee	Number of children:

Reason for examination		Pre-Employment <input type="checkbox"/> Job:
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.)

	Y	N		Y	N		Y	N
1. Sinus trouble	<input checked="" type="checkbox"/>	<input type="checkbox"/>	21. Cancer	<input checked="" type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER BEEN:-		
2. Neck swelling/glands	<input checked="" type="checkbox"/>	<input type="checkbox"/>	22. Heart Disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>	40. Rejected for employment or insurance for medical reasons	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Difficulty in vision	<input checked="" type="checkbox"/>	<input type="checkbox"/>	23. Rheumatic fever	<input checked="" type="checkbox"/>	<input type="checkbox"/>	41. Awarded benefits for industrial injury/illness	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Any ear discharge	<input checked="" type="checkbox"/>	<input type="checkbox"/>	24. Abnormal heartbeat	<input checked="" type="checkbox"/>	<input type="checkbox"/>	42. Treated for a mental condition, e.g. depression	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Asthma/bronchitis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	25. High blood pressure	<input checked="" type="checkbox"/>	<input type="checkbox"/>	43. Treated for problem drinking or drug abuse	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Hayfever /other significant allergy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	26. Stroke	<input checked="" type="checkbox"/>	<input type="checkbox"/>	44. Exposed to toxic substance or noise	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Any skin trouble	<input checked="" type="checkbox"/>	<input type="checkbox"/>	27. Serious chest pain	<input checked="" type="checkbox"/>	<input type="checkbox"/>	FOR WOMEN ONLY		
8. Tuberculosis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	28. Any blood disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Have you ever had:-		
9. Shortness of breath	<input checked="" type="checkbox"/>	<input type="checkbox"/>	29. Kidney disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>	45. An abnormal smear	<input checked="" type="checkbox"/>	<input type="checkbox"/>
10. Coughed/vomited blood	<input checked="" type="checkbox"/>	<input type="checkbox"/>	30. Blood in urine	<input checked="" type="checkbox"/>	<input type="checkbox"/>	46. Any gynaecological treatment	<input checked="" type="checkbox"/>	<input type="checkbox"/>
11. Severe abdominal pain	<input checked="" type="checkbox"/>	<input type="checkbox"/>	31. Diabetes	<input checked="" type="checkbox"/>	<input type="checkbox"/>	47. Are you pregnant?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
12. Stomach ulcer	<input checked="" type="checkbox"/>	<input type="checkbox"/>	32. Headaches/migraine	<input checked="" type="checkbox"/>	<input type="checkbox"/>	48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE	<input checked="" type="checkbox"/>	<input type="checkbox"/>
13. Recurrent indigestion	<input checked="" type="checkbox"/>	<input type="checkbox"/>	33. Dizziness/fainting	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
14. Jaundice or hepatitis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	34. Epilepsy	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
15. Gall Bladder disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>	35. Joints/spinal trouble	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
16. Marked change in bowel habits	<input checked="" type="checkbox"/>	<input type="checkbox"/>	36. Surgical operation	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
17. Blood in stools (motions)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	37. Serious accident/fracture	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
18. Marked change in weight	<input checked="" type="checkbox"/>	<input type="checkbox"/>	38. Tropical disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
19. Varicose veins	<input checked="" type="checkbox"/>	<input type="checkbox"/>	39. Fear of heights	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
20. Lump in breast/armpit	<input checked="" type="checkbox"/>	<input type="checkbox"/>						

How much tobacco each day? NN	Average daily alcohol consumption NO.
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Have you ever taken elicited drugs? (X) PDO test all new/potential employees for elicited/recreational drugs

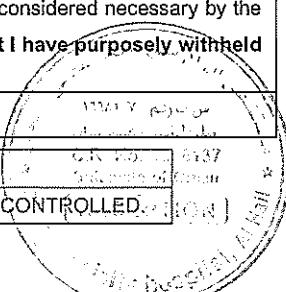
FAMILY HISTORY: Diabetes (X)	Tuberculosis (X)	Epilepsy (X)	Asthma (X)	Eczema (X)
Heart disease (X)	High blood pressure (X)	Stroke (X)	Blood Disease (X)	Cancer (X)

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: 24-07-23

Signature of Applicant: 2231





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		<p>3/1 vitium b 6g, thinnest at ~ NAD</p> <p>3/1 chest is clear Ses to. soft, abd.</p> <p>NAD</p>								
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 68/mins.	HEARING L R	VISION Uncorrected Corrected	DISTANT R L	NEAR R L	Colour Vision	Blood Group	
180	67kg	20.68	130/90		(N) (N)				Normal		

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

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

Note. cholesterol value is deangle, requires internal
medicine consultation for management.

ASSESSMENT:

FIT ALL AREAS FIT WITH RESTRICTION TEMPORARY UNFIT UNFIT



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

Signature:

REVIEW/CONSULTATION

25/07/2023

Dr. Muhammad Kamran

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

Signature:

