



8079

	Petroleum Development Oman LLC	Revision: 4.0 Effective: October 2016
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11.15 Appendix 15: Fitness to Work Certificate

Employee Data		Date <u>26/11/22</u>	
Name <u>SAEEM FAEL HAMED</u>		Department/Company <u>Pd Oman</u>	
I.D No. <u>11876012</u>		Age <u>38</u>	Occupation <u>Helper</u>
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		<input checked="" type="checkbox"/>	
Fit with following restriction(s)			
<i>The employee is fit for above work but should avoid the following task(s)</i>	<i>Temporary restriction</i>	<i>Permanent restriction</i>	
Work near moving machinery or sharp edges			
Working at height			
Pulling, 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 (Specify)			
Temporary Unfit until			
Permanently Unfit		Date <u>26/11/2022</u>	
Name of health advisor <u>DR. CHIEMEKA NDUKA EKEGHE</u>		 DR. CHIEMEKA NDUKA EKEGHE GENERAL PRACTITIONER RUWADI HEALTH CENTRE MOH LIC NO. 19798	



مركز الرسيل الصحي RUSAYL HEALTH CENTRE

ISO 9001- 2015 Certified Co.

No. B **11140**

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE
ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Surname/
Forenames

SALTEM FAEL HAMED SALTEM

Nationality

OMANI

Company Number:

Reference Indicator:

CIVIL ID - 118/0012

Mobile No. **95888390**

Home/Leave Address:

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:

Helper

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?			occasionally
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:

Signature of Applicant:

DR. CHEMKA NDIKA EKEGHE
GENERAL PRACTITIONER
RUSAYL HEALTH CENTRE
LIC NO. 19798



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	poor oral hygiene
✓		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
165		89.1	32.7
		B.P.	
		120	70
		PULSE /mins.	97
		HEARING	
		L WS	
		R WS	
		VISION	
		DISTANT	NEAR
		Uncorrected	Corrected
		6/6	6/6
		R WS	L WS
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS	
✓		1. Urinalysis	
✓		2. Hb, Bloodcount, ESR	
✓		3. LFT, RFT, RBS	
✓		4. Drug Screen	
✓		5. Lipids (40 years +)	
✓		6. Sick Cell test	
N	A	7. Audiogram	
N	A	8. Lung Function	
N	A	9. Chest X-Ray	
N	A	10. ECG	
N	A	11. CVS risk for 40 yrs. & above	
N	A	12. HIV, Hepatitis screening	
OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)			
Obesity with hypertension mildly elevated SGOT			
ASSESSMENT AND RECOMMENDATIONS:			
<input checked="" type="checkbox"/> FIT ALL AREAS <input type="checkbox"/> FIT WITH RESTRICTION <input type="checkbox"/> TEMPORARY UNFIT <input type="checkbox"/> UNFIT			
Date: 26/1/12 Name (Block Capitals): Dr. / Nurse CH. MEKEKA NDUKA EKEGHE Signature: [Signature]			
REVIEW/CONSULTATION			
regular exercise low fat low oil diet repeat FPP, LFT in 6 months			
Date: 26/1/12 Name (Block Capitals): Dr. / Nurse CH. MEKEKA NDUKA EKEGHE Signature: [Signature]			