



MEDICAL FITNESS CERTIFICATE FOR TRUCKOMAN

NAME

PARAKKANDY MADHUSOODANAN

AGE/D.O.B

48 Y ,08.03.1972

DATE

26.01.2021

PASS/ID NO:

72797459

GENDER

MALE

VISION-RT-EYE

6/6 WITHOUT GLASSES

HEIGHT

175 CM

LT-EYE

6/6 WITHOUT GLASSES

WEIGHT

83 KG

HEART

NORMAL

BP

118/76 mmHg

LUNGS

NORMAL

PULSE

70/ Min

ABDOMEN

NORMAL

CNS

NORMAL

SKIN

NORMAL

ENT

NORMAL

INVESTIGATIONS

FBS

NORMAL

BLOOD GROUP

O POSITIVE

HAEMOGRAM

NORMAL

LFT

NORMAL

RFT

NORMAL

LIPID PROFILE

Slightly elevated Triglycerides

SICKLING TEST

NEGATIVE

URINE ROUTINE

NORMAL

ECG

NORMAL

AUDIOGRAM

Normal hearing threshold with mild SHNL at 2000Hz & 4000Hz B/L

FRAMINGHAM SCORE

Probability of developing
cardiovascular disease in next 10
years is 5%

COMMENTS

*

To use adequate ear protection in high noise environment

*

Slightly elevated Triglycerides-

Advised lifestyle modification

CONCLUSION

MEDICALLY FIT

Signature:

Dr.B.VENKATESH KUMAR
 CARDIOLOGIST
 MOH NO#14581

FIT



Headquarters:

CR. No. 1693808, P.B No. 443, P.C. 112,

Ruwi, Sultanate of Oman, Tel: +968 24799760, Fax: 24799765

Al Khuwair : 24488322 | Sohar : 26846660 | Al Khoud : 24546099 | Salalah : 23291830

Barka : 26884910 | Sur : 25546112 | Nizwa : 25447777 | Falaj : 26754131

Email: info@badroman.com

المقر الرئيسي :

س. ت. : ١٩٣٨٠٨، ص. ب. : ٤٤٣، الرمز البريدي : ١١٢

روي سلطنة عمان. هاتف : ٢٤٧٩٩٧٦٠، فاكس : ٢٤٧٩٩٧٦٥

الخوير : ٢٤٤٨٨٣٢٢ | صحار : ٢٤٨٤٦٦٠٠ | الخوض : ٢٤٥٤٦٠٩٩ | صلالة : ٢٣٢٩١٨٣٠

بركاء : ٢٦٨٨٤٩١٠ | صور : ٢٥٥٤٦١١٢ | نزوى : ٢٥٤٤٧٧٧٧ | فلج : ٢٦٧٥٤١٣١

البريد الإلكتروني : info@badroman.com

Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)



**Petroleum Development Oman
MEDICAL DEPARTMENT**

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Place of examination BADR AL SAMAA Date 26/1/24		Surname PARA Kanny MADHU SUBRAMAN	
		Forenames :	
Address		Home telephone number	
If a dependant enter employee's name here:			
Surname:		Forenames:	
Birth date:	Nationality:	Country of birth:	Religion:
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input 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: <input type="checkbox"/>		Number of children:	
Pre-Overseas Area: <input type="checkbox"/>			
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"/>	21. Cancer	<input checked="" type="checkbox"/>
2. Neck swelling/glands	<input checked="" type="checkbox"/>	22. Heart Disease	<input checked="" type="checkbox"/>
3. Difficulty in vision	<input checked="" type="checkbox"/>	23. Rheumatic fever	<input checked="" type="checkbox"/>
4. Any ear discharge	<input checked="" type="checkbox"/>	24. Abnormal heartbeat	<input checked="" type="checkbox"/>
5. Asthma/bronchitis	<input checked="" type="checkbox"/>	25. High blood pressure	<input checked="" type="checkbox"/>
6. Hayfever/other significant allergy	<input checked="" type="checkbox"/>	26. Stroke	<input checked="" type="checkbox"/>
7. Any skin trouble	<input checked="" type="checkbox"/>	27. Serious chest pain	<input checked="" type="checkbox"/>
8. Tuberculosis	<input checked="" type="checkbox"/>	28. Any blood disease	<input checked="" type="checkbox"/>
9. Shortness of breath	<input checked="" type="checkbox"/>	29. Kidney disease	<input checked="" type="checkbox"/>
10. Coughed/vomited blood	<input checked="" type="checkbox"/>	30. Blood in urine	<input checked="" type="checkbox"/>
11. Severe abdominal pain	<input checked="" type="checkbox"/>	31. Diabetes	<input checked="" type="checkbox"/>
12. Stomach ulcer	<input checked="" type="checkbox"/>	32. Headaches/migraine	<input checked="" type="checkbox"/>
13. Recurrent indigestion	<input checked="" type="checkbox"/>	33. Dizziness/fainting	<input checked="" type="checkbox"/>
14. Jaundice or hepatitis	<input checked="" type="checkbox"/>	34. Epilepsy	<input checked="" type="checkbox"/>
15. Gall Bladder disease	<input checked="" type="checkbox"/>	35. Joints/spinal trouble	<input checked="" type="checkbox"/>
16. Marked change in bowel habits	<input checked="" type="checkbox"/>	36. Surgical operation	<input checked="" type="checkbox"/>
17. Blood in stools (motions)	<input checked="" type="checkbox"/>	37. Serious accident/fracture	<input checked="" type="checkbox"/>
18. Marked change in weight	<input checked="" type="checkbox"/>	38. Tropical disease	<input checked="" type="checkbox"/>
19. Varicose veins	<input checked="" type="checkbox"/>	39. Fear of heights	<input checked="" type="checkbox"/>
20. Lump in breast/armpit	<input checked="" type="checkbox"/>		
How much tobacco each day?		Average daily alcohol consumption	
Have you ever taken elicited drugs? () PDO test all new/potential employees for elicited/recreational drugs			
FAMILY HISTORY: Diabetes () Tuberculosis () Epilepsy () Asthma () Eczema ()			
Heart disease () High blood pressure () Stroke () Blood Disease () Cancer ()			
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: 26/1/24		Signature of Applicant:	
FOR COMPLETION BY EXAMINING DOCTOR OR NURSE			
Further details of medical history and recreational activities			

Dr. B. VENKATESH KUMAR
CARDIOLOGIST
MOH NO#14581



Take ear protection
in noisy environment.

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