



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

COMMENTS * To use adequate ear protection in high noise environment
 * Slightly elevated Triglycerides. Advised lifestyle modification

CONCLUSION

MEDICALLY FIT

Signature:

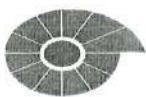
Dr. B. VENKATESH KUMAR
 CARDIOLOGIST
 MOH NO#14581

FIT



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 26/1/21	Surname PRAKASH <i>MADHU SINGH</i>		
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If a dependant enter employee's name here:		Forenames:		
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Surname:		Forenames:		
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Birth date:	Nationality:	Country of birth:	Religion:	
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<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	Number of children:	
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Reason for examination		Pre-Employment	Job: <input type="checkbox"/>
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Pre-Overseas Area: <input type="checkbox"/>	
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Name and address of family doctor	List your last 3 jobs		
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		(1)	
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		(2)	
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Are you a Registered Disabled Person? (UK only) <input type="checkbox"/>	Do you belong to any Medical Insurance Scheme? <input type="checkbox"/>		
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DO YOU HAVE OR HAVE YOU HAD:- (Tick "Yes" or "No" column or put a (?) if uncertain exclude minor ailments.)			
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	Y	N		Y	N		Y	N
1. Sinus trouble	<input checked="" type="checkbox"/>		21. Cancer	<input checked="" type="checkbox"/>		HAVE YOU EVER BEEN:-		
2. Neck swelling/glands	<input checked="" type="checkbox"/>		22. Heart Disease	<input checked="" type="checkbox"/>		40. Rejected for employment or insurance for medical reasons	<input checked="" type="checkbox"/>	
3. Difficulty in vision	<input checked="" type="checkbox"/>		23. Rheumatic fever	<input checked="" type="checkbox"/>		41. Awarded benefits for industrial injury/illness	<input checked="" type="checkbox"/>	
4. Any ear discharge	<input checked="" type="checkbox"/>		24. Abnormal heartbeat	<input checked="" type="checkbox"/>		42. Treated for a mental condition, e.g. depression	<input checked="" type="checkbox"/>	
5. Asthma/bronchitis	<input checked="" type="checkbox"/>		25. High blood pressure	<input checked="" type="checkbox"/>		43. Treated for problem drinking or drug abuse	<input checked="" type="checkbox"/>	
6. Hayfever/other significant allergy	<input checked="" type="checkbox"/>		26. Stroke	<input checked="" type="checkbox"/>		44. Exposed to toxic substance or noise	<input checked="" type="checkbox"/>	
7. Any skin trouble	<input checked="" type="checkbox"/>		27. Serious chest pain	<input checked="" type="checkbox"/>		FOR WOMEN ONLY		
8. Tuberculosis	<input checked="" type="checkbox"/>		28. Any blood disease	<input checked="" type="checkbox"/>		45. An abnormal smear	<input checked="" type="checkbox"/>	
9. Shortness of breath	<input checked="" type="checkbox"/>		29. Kidney disease	<input checked="" type="checkbox"/>		46. Any gynaecological treatment	<input checked="" type="checkbox"/>	
10. Coughed/vomited blood	<input checked="" type="checkbox"/>		30. Blood in urine	<input checked="" type="checkbox"/>		47. Are you pregnant?	<input checked="" type="checkbox"/>	
11. Severe abdominal pain	<input checked="" type="checkbox"/>		31. Diabetes	<input checked="" type="checkbox"/>		48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE	<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		
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Have you ever taken elicited drugs? <input checked="" type="checkbox"/>	PDO test all new/potential employees for elicited/recreational drugs		
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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: **26/1/21** Signature of Applicant:

FOR COMPLETION BY EXAMINING DOCTOR OR NURSE
Further details of medical history and recreational activities


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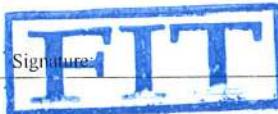


N = Normal A = Abnormal (please describe)			PHYSICAL EXAMINATION							
N	A		<p>Normal & Routine</p> <p>1. Eyes & Pupils</p> <p>2. E.N.T.</p> <p>3. Teeth & Mouth } normal</p> <p>4. Lungs & Chest</p> <p>5. Cardiovascular System</p> <p>6. Abdo. Viscera</p> <p>7. Hernial Orifices</p> <p>8. Anus & Rectum</p> <p>9. Genito-urinary</p> <p>10. Extremities</p> <p>11. Musculo-skeletal</p> <p>12. Skin & Varicose Vns.</p> <p>13. C.N.S.</p>							
HEIGHT cm	WEIGHT kg	BMI	B.P.	PULSE /mins.	HEARING L R	DISTANT	VISION NEAR	Colour Vision	Blood Group	
175	83.5	27.03	118/76	70	R Uncorrected Corrected	L R Uncorrected Corrected	R L R L b/b b/b N/A N/A	(O)	O+ve	
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS				N	A			
✓	1. Urinalysis						7. Audiogram	Bilateral hearing sensitivity normal		
✓	2. Hb, Bloodcount, ESR						8. Lung Function	with mild asthma		
✓	3. LFT, RFT, RBS						9. Chest X-Ray	24Kg?		
✓	4. Drug Screen						10. ECG			
✓	5. Lipids (40 years +)						11. CVS risk for 40 yrs. & above			
✓	6. Sickle Cell test						12. HIV, Hepatitis screening			

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

ASSESSMENT:

FIT ALL AREAS FIT WITH RESTRICTION TEMPORARY UNFIT UNFIT



Date: 26/1/19 Name (Block Capitals): Dr. / Nurse Signature:

REVIEW/CONSULTATION

Date: 26/1/19 Name (Block Capitals): Dr. / Nurse Signature:

Take ear protection
in noisy environment.

Signature

Dr. SAJILA P.P.
MBBS., DNB (ENT), DLO.
Specialist Ent Surgeon
MOH Lic No.: 18387

Dr. B. VENKATESH KUMAR
CARDIOLOGIST
MOH NO#14581

