

MEDICAL FITNESS CERTIFICATE FOR (P.D.O)

NAME **MANJIT SINGH**

AGE/D.O.B	40 Y,14.09.1981	DATE	07.09.2021
PASS/ID NO:	72261426	GENDER	MALE
VISION-RT-EYE	6/6 WITHOUT GLASSES	HEIGHT	168 CM
LT-EYE	6/6 WITHOUT GLASSES	WEIGHT	79 KG
HEART	NORMAL	BP	130/82 mmHg
LUNGS	NORMAL	PULSE	76/Min
ABDOMEN	NORMAL	CNS	NORMAL
SKIN	NORMAL	ENT	NORMAL

INVESTIGATIONS

FBS	ELEVATED
GHb	8.80%
BLOOD GROUP	AB POSITIVE
HAEMOGRAM	NORMAL
LIPID PROFILE	Hypertriglyceridemia
RFT	NORMAL
LFT	NASH
SICKLING TEST	NEGATIVE
URE	SUGAR (++)
AUDIOGRAM	NORMAL AUDIOMETRIC THRESHOLD

COMMENTS K/C/O T2DM & SHT on Oral medication
FBS -elevated- Advised to do HbA1c
NASH - Advised treatment
HBA1c -8.8% Diabetic drug modified
Hypertriglyceridemia - Started on medication To repeat lipidprofile after 3 mnts

CONCLUSION MEDICALLY FIT

 Dr. B. VENKATESH KUMAR
CARDIOLOGIST
MOH NO#14581



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شیوه ایجاد این کتاب

١٤٦٣ هـ / ١٩٤٤ مـ / ٢٠١٢ مـ

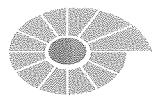
الخوير: ٢٤٤٨٨٣٢٢ | صهار: ٢٤٥٦٧٩٩ | الخوض: ٢٤٥٦٧٩٩ | ط

برکاء: ۷۰۴۱۳| صور: ۷۰۴۷۰| نزوى: ۷۰۵۴۳| فلح: ۷۰۸۸۹|

البريد الإلكتروني: info@badroman.com

Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)



**Petroleum Development Oman
MEDICAL DEPARTMENT**

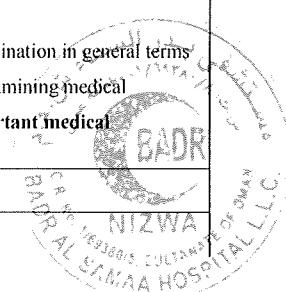
PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

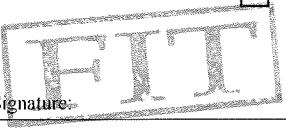
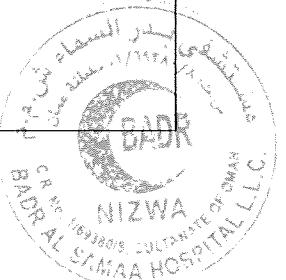
Place of examination BADR AL SAMAA		Date 01/09/19		Surname KAMALI JIMAH							
				Forenames :							
				Address							
				Home telephone number							
If a dependant enter employee's name here:											
Surname:				Forenames:							
Birth date:		Nationality:		Country of birth:							
<input checked="" 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							
Number of children:											
Reason for examination		Pre-Employment Job: <input type="checkbox"/>									
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"/>		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"/>		Have you ever had:-			
9. Shortness of breath		<input checked="" type="checkbox"/>		29. Kidney disease		<input checked="" type="checkbox"/>		45. An abnormal smear		<input checked="" type="checkbox"/>	
10. Coughed/vomited blood		<input checked="" type="checkbox"/>		30. Blood in urine		<input checked="" type="checkbox"/>		46. Any gynaecological treatment		<input checked="" type="checkbox"/>	
11. Severe abdominal pain		<input checked="" type="checkbox"/>		31. Diabetes		<input checked="" type="checkbox"/>		47. Are you pregnant?		<input checked="" type="checkbox"/>	
12. Stomach ulcer		<input checked="" type="checkbox"/>		32. Headaches/migraine		<input checked="" type="checkbox"/>		48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE		<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? None				Average daily alcohol consumption (None)							
Have you ever taken elicited drugs? (None) PDO test all new/potential employees for elicited/recreational drugs											
FAMILY HISTORY: Diabetes <input checked="" type="checkbox"/> Tuberculosis <input type="checkbox"/> Epilepsy <input type="checkbox"/> Asthma <input type="checkbox"/> Eczema <input type="checkbox"/> Heart disease <input type="checkbox"/> High blood pressure <input checked="" type="checkbox"/> Stroke <input type="checkbox"/> Blood Disease <input type="checkbox"/> Cancer <input 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: 01/09/19										Signature of Applicant: (Signature)	
FOR COMPLETION BY EXAMINING DOCTOR OR NURSE Further details of medical history and recreational activities											

*Father - 54yrs
Mother - 54yrs 172cm
Brother - 54yrs
Sister - 54yrs*

(Signature) 54yrs /mm

*Dr. B. VENKATESH KUMAR
CARDIOLOGIST
MOH NO#14581*



N = Normal A = Abnormal (please describe)			PHYSICAL EXAMINATION							
N	A		1. Eyes & Pupils: Normal & Reactive 2. E.N.T.: Ear-Nose-Throat normal, mild DNS & throat normal 3. Teeth & Mouth: mm 4. Lungs & Chest: S.H.P. No mmw 5. Cardiovascular System: Left. m(P) mmw 6. Abdo. Viscera: mm 7. Hernial Orifices: mm 8. Anus & Rectum: mm 9. Genito-urinary: mm 10. Extremities: mm 11. Musculo-skeletal: mm 12. Skin & Varicose Vns.: mm 13. C.N.S.: mm							
HEIGHT cm	WEIGHT kg	BMI	B.P.	PULSE b/mins.	HEARING L R	DISTANT Uncorrected Corrected	VISION R L R L b6 b6 N6 N6	Colour Vision	Blood Group	
168	79.6	28.6	130/82	76				(N)	AB +ve	
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS				N	A			
<input checked="" type="checkbox"/>	1. Urinalysis							7. Audiogram 131 lateral hearing		
<input checked="" type="checkbox"/>	2. Hb, Bloodcount, ESR							8. Lung Function normal		
<input checked="" type="checkbox"/>	3. LFT, RFT, RBS							9. Chest X-Ray normal		
	4. Drug Screen							10. ECG		
<input checked="" type="checkbox"/>	5. Lipids (40 years +)							11. CVS risk for 40 yrs. & above		
<input checked="" type="checkbox"/>	6. Sickle Cell test							12. HIV, Hepatitis screening		
OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.) Keto T2 DM & SHF on oral medication Nash - Advised treatment, Diabetic drug modified.										
ASSESSMENT:										
FIT ALL AREAS <input checked="" type="checkbox"/>		FIT WITH RESTRICTION <input type="checkbox"/>		TEMPORARY UNFIT <input type="checkbox"/>		UNFIT <input type="checkbox"/>				
Date: 04/09/13		Name (Block Capitals): Dr. / Nurse		Signature:						
REVIEW/CONSULTATION										
Date: 04/09/13		Name (Block Capitals): Dr. / Nurse		Signature:						

DR. VENKATESH KUMAR
CARDIOLOGIST
MOH NO#14581