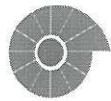




Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

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

Place of examination NMC SPECIALITY AL HOU		Date 7 11 24	Surname AL HINAI																																																													
			Forenames ABDULLAH SAIF YUMA																																																													
			Address																																																													
			Home telephone number																																																													
If a dependant enter employee's name here: Surname: _____ Forenames: _____																																																																
Birth date:	Nationality:	Country of birth:	Religion:																																																													
<input 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:																																																													
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.)																																																																
<table border="1"> <tr> <th>Y</th> <th>N</th> </tr> <tr> <td><input checked="" type="checkbox"/> 1. Sinus trouble</td> <td><input checked="" type="checkbox"/> 21. Cancer</td> </tr> <tr> <td><input checked="" type="checkbox"/> 2. Neck swelling/glands</td> <td><input checked="" type="checkbox"/> 22. Heart Disease</td> </tr> <tr> <td><input checked="" type="checkbox"/> 3. Difficulty in vision</td> <td><input checked="" type="checkbox"/> 23. Rheumatic fever</td> </tr> <tr> <td><input checked="" type="checkbox"/> 4. Any ear discharge</td> <td><input checked="" type="checkbox"/> 24. Abnormal heartbeat</td> </tr> <tr> <td><input checked="" type="checkbox"/> 5. Asthma/bronchitis</td> <td><input checked="" type="checkbox"/> 25. High blood pressure</td> </tr> <tr> <td><input checked="" type="checkbox"/> 6. Hayfever /other significant allergy</td> <td><input checked="" type="checkbox"/> 26. Stroke</td> </tr> <tr> <td><input checked="" type="checkbox"/> 7. 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Dizziness/fainting</td> </tr> <tr> <td><input checked="" type="checkbox"/> 14. Jaundice or hepatitis</td> <td><input checked="" type="checkbox"/> 34. Epilepsy</td> </tr> <tr> <td><input checked="" type="checkbox"/> 15. Gall Bladder disease</td> <td><input checked="" type="checkbox"/> 35. Joints/spinal trouble</td> </tr> <tr> <td><input checked="" type="checkbox"/> 16. Marked change in bowel habits</td> <td><input checked="" type="checkbox"/> 36. Surgical operation</td> </tr> <tr> <td><input checked="" type="checkbox"/> 17. Blood in stools (motions)</td> <td><input checked="" type="checkbox"/> 37. Serious accident/fracture</td> </tr> <tr> <td><input checked="" type="checkbox"/> 18. Marked change in weight</td> <td><input checked="" type="checkbox"/> 38. Tropical disease</td> </tr> <tr> <td><input checked="" type="checkbox"/> 19. Varicose veins</td> <td><input checked="" type="checkbox"/> 39. Fear of heights</td> </tr> <tr> <td><input checked="" type="checkbox"/> 20. 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Exposed to toxic substance or noise</td> <td><input checked="" type="checkbox"/> 45. An abnormal smear</td> </tr> <tr> <td colspan="2">FOR WOMEN ONLY</td> </tr> <tr> <td colspan="2"><input checked="" type="checkbox"/> Have you ever had:-</td> </tr> <tr> <td colspan="2"><input checked="" type="checkbox"/> 46. Any gynaecological treatment</td> </tr> <tr> <td colspan="2"><input checked="" type="checkbox"/> 47. Are you pregnant?</td> </tr> <tr> <td colspan="2"><input checked="" type="checkbox"/> 48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE</td> </tr> </table>		Y	N	<input checked="" type="checkbox"/> 40. Rejected for employment or insurance for medical reasons	<input checked="" type="checkbox"/> 41. Awarded benefits for industrial injury/illness	<input checked="" type="checkbox"/> 42. Treated for a mental condition, e.g. depression	<input checked="" type="checkbox"/> 43. Treated for problem drinking or drug abuse	<input checked="" type="checkbox"/> 44. 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How much tobacco each day? NO.		Average daily alcohol consumption NO.																																																														
Have you ever taken elicited drugs? <input checked="" type="checkbox"/> PDO test all new/potential employees for elicited/recreational drugs																																																																
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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: _____	Signature of Applicant: _____																																																															



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.			R.P. Corrected. vision is 6/6.								
✓		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. 123 67	PULSE 78/mins.	HEARING L N R N	VISION Uncorrected Corrected	DISTANT R L		NEAR R L		Colour Vision	Blood Group
162		109	41.5					G	G	N	N	Normal	
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS				N	A						
✓		1. Urinalysis						7. Audiogram					
✓		2. Hb, Bloodcount, ESR						8. Lung Function					
✓		3. LFT, RFT, RBS						9. Chest X Ray					
✓		4. Drug Screen						10. ECG					
✓		5. Lipids (40 years +)						11. CVS risk for 40 yrs. & above					
✓		6. Sickle Cell test						12. HIV, Hepatitis screening					
9-47- Fasting blood sugar.													

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

• Morbidity Obesity.



ASSESSMENT:

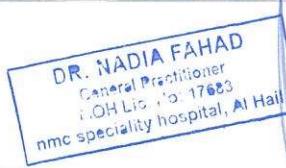
FIT ALL AREAS FIT WITH RESTRICTION TEMPORARY UNFIT UNFIT

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

Signature:

REVIEW/CONSULTATION

8/11/23



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

Signature: