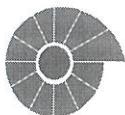


## 1.1 Appendix 32: EX1 Form (Initial Examination Report)

### INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)



Petroleum Development Oman  
MEDICAL DEPARTMENT

PLEASE COMPLETE YOUR PERSONAL  
DETAILS IN BLOCK CAPITALS

Place of examination <b>NMC - AL - HAIR</b>		Date:- <b>08/01/2028</b>	Surname <b>Al Hinai</b> Forenames <b>Abdullah Al Hinai</b> Address																																																																																																																															
			Home telephone number																																																																																																																															
			Employment No #																																																																																																																															
If a dependant enter employee's name here: Surname: _____ Forenames: _____ Birth date: <b>08/01/1968</b> Nationality: <b>OMANI</b> 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	<input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter	Relationship to employee 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.)																																																																																																																																		
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Any blood disease</td> <td><input checked="" type="checkbox"/></td> <td colspan="2" style="text-align: center;">45. An abnormal smear</td> </tr> <tr> <td>9. Shortness of breath</td> <td><input checked="" type="checkbox"/></td> <td>29. Kidney disease</td> <td><input checked="" type="checkbox"/></td> <td colspan="2" style="text-align: center;">46. Any gynaecological treatment</td> </tr> <tr> <td>10. Coughed/vomited blood</td> <td><input checked="" type="checkbox"/></td> <td>30. Blood in urine</td> <td><input checked="" type="checkbox"/></td> <td colspan="2" style="text-align: center;">47. Are you pregnant?</td> </tr> <tr> <td>11. Severe abdominal pain</td> <td><input checked="" type="checkbox"/></td> <td>31. Diabetes</td> <td><input checked="" type="checkbox"/></td> <td colspan="2" style="text-align: center;">48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE</td> </tr> <tr> <td>12. Stomach ulcer</td> <td><input checked="" type="checkbox"/></td> <td>32. 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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																																																																																																																																		
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<b>PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT</b> 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:																																																																																																																																	



RECEPTION

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	WNL										
		2. E.N.T.	WNL										
		3. Teeth & Mouth	WNL										
		4. Lungs & Chest	WNL										
		5. Cardiovascular System	WNL										
		6. Abdo. Viscera	WNL										
		7. Hernial Orifices	Normal										
		8. Anus & Rectum											
		9. Genito-urinary											
		10. Extremities	WNL.										
		11. Musculo-skeletal											
		12. Skin & Varicose Vns.											
		13. C.N.S.											
HEIGHT cm		WEIGHT kg	BM I	B.P. 100 70	PULSE 70/mins.	HEARING L R WNL	VISION DISTANT R L Uncorrected Corrected				NEAR R L	Colour Vision Normal	Blood Group
165	112.6	46.3											
N	A				LABORATORY AND OTHER SPECIAL INVESTIGATIONS				N	A			
		1. Urinalysis			ECHO (N)				✓		7. Audiogram		
		2. Hb, Blood count, 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		
OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)													
ASSESSMENT:													
<input checked="" type="checkbox"/> FIT ALL AREAS <input type="checkbox"/> FIT WITH SPECIFIC RESTRICTION <input type="checkbox"/> TEMPORARY UNFIT <input type="checkbox"/> AWAITING SPECIALIST ASSESSMENT													
													
REVIEW/CONSULTATION													
DATE:	DOCTOR NAME:			Mohamed Ahmed Monstra									
SIGNATURE: Mohamed Ahmed Monstra 3-11-2021													