



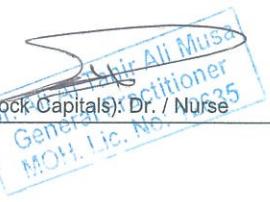
## Appendix 32: EX1 Form (Initial Examination Report)

## INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

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

Place of examination <b>NMC A THAIL</b>		Date	Surname																																																																																															
			Forenames																																																																																															
			Address <b>(U95) EMP NO.</b>																																																																																															
			Home telephone number <b>97135688</b>																																																																																															
If a dependant enter employee's name here: Surname: <b>NAIR</b>		Forenames: <b>UNNIKRISHNAN</b>																																																																																																
Birth date: <b>10/03/1963</b>	Nationality: <b>INDIAN</b>	Country of birth: <b>INDIA</b>	Religion: <b>HINDU</b>																																																																																															
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced	<input checked="" type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter	Relationship to employee																																																																																															
Reason for examination	Pre-Employment	<input checked="" type="checkbox"/> Job: <b>WORKSHOP FOREMAN</b>	Number of children: <b>2</b>																																																																																															
	Pre-Overseas	<input type="checkbox"/> Area: <b>NIMR</b>																																																																																																
Name and address of family doctor		List your last 3 jobs <b>(1) WORKSHOP FOREMAN (2) WORKSHOP FOREMAN</b>																																																																																																
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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How much tobacco each day?		Average daily alcohol consumption <input type="checkbox"/>																																																																																																
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<b>PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT:-</b> <p>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.</p>																																																																																																		
Date:	Signature of Applicant: <b>Ugnavit</b>																																																																																																	



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				
<input checked="" type="checkbox"/>	1. Eyes & Pupils				
<input checked="" type="checkbox"/>	2. E.N.T.				
<input checked="" type="checkbox"/>	3. Teeth & Mouth	2 molars extraction (old)			
<input checked="" type="checkbox"/>	4. Lungs & Chest				
<input checked="" type="checkbox"/>	5. Cardiovascular System				
<input checked="" type="checkbox"/>	6. Abdo. Viscera				
<input checked="" type="checkbox"/>	7. Hernial Orifices				
<input type="checkbox"/>	8. Anus & Rectum				
<input checked="" type="checkbox"/>	9. Genito-urinary				
<input checked="" type="checkbox"/>	10. Extremities				
<input checked="" type="checkbox"/>	11. Musculo-skeletal				
<input checked="" type="checkbox"/>	12. Skin & Varicose Vns.				
<input checked="" type="checkbox"/>	13. C.N.S.				
HEIGHT cm	WEIGHT kg	BMI	B.P.		
172	71.95	26.35	150 / 80		
PULSE 60 /mins.	HEARING L R	VISION Uncorrected Corrected	DISTANT R L NEAR R L		
Colour Vision	Blood Group				
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS			
<input checked="" type="checkbox"/>	1. Urinalysis				
<input checked="" type="checkbox"/>	2. Hb, Bloodcount, ESR				
<input checked="" type="checkbox"/>	3. LFT, RFT, RBS				
<input type="checkbox"/>	4. Drug Screen				
<input checked="" type="checkbox"/>	5. Lipids (40 years +)				
<input checked="" type="checkbox"/>	6. Sickle Cell test				
<input checked="" type="checkbox"/>	7. Audiogram				
<input checked="" type="checkbox"/>	8. Lung Function				
<input type="checkbox"/>	9. Chest X-Ray				
<input checked="" type="checkbox"/>	10. ECG				
<input type="checkbox"/>	11. CVS risk for 40 yrs. & above				
<input checked="" type="checkbox"/>	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 RESTRICTION <input type="checkbox"/> TEMPORARY UNFIT <input type="checkbox"/> UNFIT					
Date: 11/01/2022			Name (Block Capitals): Dr. / Nurse		
			Signature:		
REVIEW/CONSULTATION					
Date: Name (Block Capitals): Dr. / Nurse Signature:					



ست رقم: ١٦٦٨١٣٧  
C.R. No: 1668137  
Sultanate of Oman  
RECEPTION