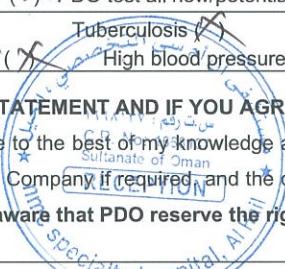




## Appendix 32: EX1 Form (Initial Examination Report)

## INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

 <b>Petroleum Development Oman MEDICAL DEPARTMENT</b>  <b>PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS</b>		<b>Surname</b> THOMAS <b>Forenames</b> BENNY MUNUVGLIL <b>Address</b>  <b>Home telephone number</b>																																																																																																																												
<b>Place of examination</b> NMC ALHAJIL <b>Date</b> 26/04/2023																																																																																																																														
<b>If a dependant enter employee's name here:</b> <b>Surname:</b> <b>Birth date:</b> 08/05/1970 <b>Nationality:</b> INDIAN		<b>Forenames:</b> <b>Country of birth:</b> INDIA <b>Religion:</b>																																																																																																																												
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced	<b>Relationship to employee</b> <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter	<b>Number of children:</b> 2																																																																																																																											
<b>Reason for examination</b> Pre-Employment		<b>Job:</b> OPERATOR																																																																																																																												
Pre-Overseas		<b>Area:</b>																																																																																																																												
<b>Name and address of family doctor</b>		<b>List your last 3 jobs</b> (1) (2)																																																																																																																												
<b>Are you a Registered Disabled Person? (UK only)</b>		<b>Do you belong to any Medical Insurance Scheme?</b>																																																																																																																												
<b>DO YOU HAVE OR HAVE YOU HAD:-</b> (Tick "Yes" or "No" column or put a (?) if uncertain exclude minor ailments)																																																																																																																														
<table border="1"> <tr> <th></th> <th>Y</th> <th>N</th> </tr> <tr> <td>1. Sinus trouble</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>2. Neck swelling/glances</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>3. Difficulty in vision</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>4. Any ear discharge</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>5. Asthma/bronchitis</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>6. Hayfever /other significant allergy</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>7. Any skin trouble</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>8. 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<b>Have you ever taken elicited drugs?</b> <input checked="" type="checkbox"/> PDO test all new/potential employees for elicited/recreational drugs		<b>HAVE YOU EVER BEEN:-</b>  <b>FOR WOMEN ONLY</b>  <b>Have you ever had -</b>  <b>NOT MENTIONED ABOVE</b>																																																																																																																												
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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.																																																																																																																														
<b>Date:</b> 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											
<input checked="" type="checkbox"/>	1. Eyes & Pupils											
<input checked="" type="checkbox"/>	2. E.N.T.											
<input checked="" type="checkbox"/>	3. Teeth & Mouth											
<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 checked="" 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 159	WEIGHT kg 86	BMI 34.02	B.P. 142 99	PULSE 67/mins.	HEARING L (N) R (N)	VISION Uncorrected Corrected	DISTANT R L 6/6 6/6	NEAR R L (N) (N)	Colour Vision	Blood Group		
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS					N	A				
<input checked="" type="checkbox"/>	1. Urinalysis						<input checked="" type="checkbox"/>	7. Audiogram				
<input checked="" type="checkbox"/>	2. Hb, Bloodcount, ESR						<input checked="" type="checkbox"/>	8. Lung Function				
<input checked="" type="checkbox"/>	3. LFT, RFT, RBS						<input checked="" type="checkbox"/>	9. Chest X-Ray				
<input checked="" type="checkbox"/>	4. Drug Screen						<input checked="" type="checkbox"/>	10. ECG				
<input checked="" type="checkbox"/>	5. Lipids (40 years +)						<input checked="" type="checkbox"/>	11. CVS risk for 40 yrs. & above				
<input checked="" type="checkbox"/>	6. Sickle Cell test						<input checked="" type="checkbox"/>	12. HIV, Hepatitis screening				

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

**FIT**

ASSESSMENT		<input type="checkbox"/> FIT ALL AREAS		<input type="checkbox"/> FIT WITH RESTRICTION		<input type="checkbox"/> TEMPORARY UNFIT		<input type="checkbox"/> UNFIT	
Date:	Name (Block Capitals): Dr. / Nurse	Signature:							
REVIEW/CONSULTATION									
Date:	Name (Block Capitals): Dr. / Nurse	Signature:							