



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

## INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

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

Surname <b>ROIT AIT</b>																																																																							
Forenames <b>VENKATESAN</b>																																																																							
Address <b>9437859</b>																																																																							
Home telephone number																																																																							
Place of examination <b>HMC AL HAID</b> Date <b>30-08-2022</b>																																																																							
If a dependant enter employee's name here:																																																																							
Surname: <b> </b> Forenames: <b> </b>																																																																							
Birth date: <b>22-12-1968</b>	Nationality: <b>INDIAN</b>	Country of birth: <b>India</b>	Religion: <b> </b>																																																																				
<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"/> Relationship to employee <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter	Number of children: <b> </b>																																																																				
Reason for examination	Pre-Employment <input type="checkbox"/> Job: <b> </b>																																																																						
	Pre-Overseas <input type="checkbox"/> Area: <b> </b>																																																																						
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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How much tobacco each day? <b>NO</b>	Average daily alcohol consumption <b>NO</b>																																																																						
Have you ever taken elicited drugs? <b>NO</b> PDO test all new/potential employees for elicited/recreational drugs																																																																							
FAMILY HISTORY: Diabetes <input checked="" type="checkbox"/> Tuberculosis ( ) Epilepsy ( ) Asthma ( ) Eczema ( ) Heart disease ( ) High blood pressure ( ) Stroke ( ) Blood Disease ( ) Cancer ( )																																																																							
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: <b>30-08-2022</b>	Signature of Applicant: <b>R. Venkatesan</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			PULSE	HEARING	VISION	DISTANT		NEAR		Colour Vision	Blood Group
				/mins.	L — R —	Uncorrected Corrected	R	L	R	L		
✓		1. Eyes & Pupils										
✓		2. E.N.T.										
✓		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	75/—	—	DISTANT R L	NEAR R L				
166cm	60kg	25.04	81				66	66	at N			
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				

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

Referred to ENT - impaired Audiometry.

Referred to Internist — See x-ray of chest

## ASSESSMENT:

FIT ALL AREAS  FIT WITH RESTRICTION  TEMPORARY UNFIT  UNFIT

Date: 30/08/2021 Name (Block Capitals): Dr. / Nurse

DR. SHANT KUMAR

Signature:

DR. SHANT KUMAR SUDIAH  
General Practitioner  
MOH Lic. No: 1608137  
nmc speciality hospital, Al-Hail

**FIT**

## REVIEW/CONSULTATION

Reviewed the patient. - DM on treatment  
- No Hb any breathing difficulty / wheezing episodes  
- Clinically no sign of airway obstruction. Spirometry done. Improper technique

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

— Fit with no restriction from Internal medicine

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Specification

The controlled version of this CMF Document resides online in Livelink®. Printed copies are UNCONTROLLED.

— Fit with no restriction

Signature: MOH Lic. No: 1608137  
nmc speciality hospital, Al-Hail  
RECEPTION

DR. RONISANTH KALLINKEEL  
Specialist - Internal Medicine  
MOH Lic. No: 16847  
nmc speciality hospital, Al-Hail

DR. ALTAF HUSSAIN  
Specialist- ENT  
MOH Lic. No: 18133  
nmc speciality hospital, Al-Hail