

MEDICAL FITNESS CERTIFICATE FOR P.D.O

NAME **JAGWANT SINGH**

AGE/D.O.B	45 Y, 15.03.1976	DATE	17.08.2021
PASS/ID NO:	70268013	GENDER	MALE
VISION-RT-EYE	6/6 WITHOUT GLASSES	HEIGHT	175 KG
LT-EYE	6/6 WITHOUT GLASSES	WEIGHT	79 KG
HEART	NORMAL	BP	130/85 mmHg
LUNGS	NORMAL	PULSE	74/Min
ABDOMEN	NORMAL	CNS	NORMAL
SKIN	NORMAL	ENT	NORMAL

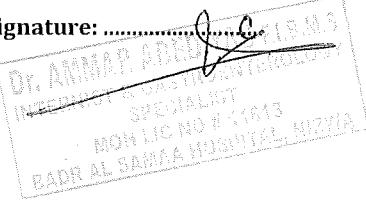
INVESTIGATIONS

FBS	NORMAL
BLOOD GROUP	B POSITIVE
HAEMOGRAM	NORMAL
LIPID PROFILE	DLP
RFT	NORMAL
LFT	NORMAL
SICKLING TEST	NEGATIVE
URE	NORMAL
ECG	NORMAL
AUDIOGRAM	Normal hearing threshold with mild dip at 4000Hz B/L
FRAMINGHAM SCORE	Probability of developing cardiovascular disease in next 10 years is 4.6%

COMMENTS **To use adequate ear protection in high noise environment**
DLP- Advised lifestyle modification

CONCLUSION

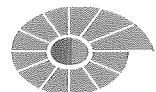
MEDICALLY FIT

Signature:



Appendix 32: EX1 Form (Initial Examination Report)

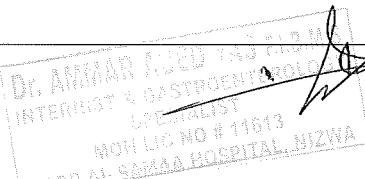
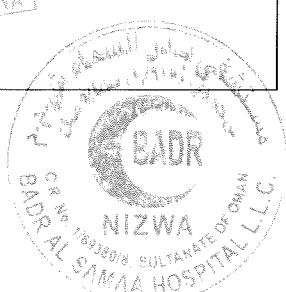
INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)



**Petroleum Development Oman
MEDICAL DEPARTMENT**

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Surname					
Forenames : <i>Jaswant Singh</i>					
Address					
Home telephone number					
Place of examination BADR AL SAMAA		Date <i>17.08.2021</i>			
If a dependant enter employee's name here:					
Surname:		Forenames:			
Birth date: <i>K.03/09/94</i>		Nationality:			
Relationship to employee		Country of birth:			
<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		Number of children:			
Reason for examination Pre-Employment Job: <input type="checkbox"/>					
Pre-Overseas Area: <input type="checkbox"/>					
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.)					
Y	N	Y	N	Y	N
1. Sinus trouble		21. Cancer		HAVE YOU EVER BEEN:-	
2. Neck swelling/glands		22. Heart Disease		40. Rejected for employment or insurance for medical reasons	
3. Difficulty in vision		23. Rheumatic fever		41. Awarded benefits for industrial injury/illness	
4. Any ear discharge		24. Abnormal heartbeat		42. Treated for a mental condition, e.g. depression	
5. Asthma/bronchitis		25. High blood pressure		43. Treated for problem drinking or drug abuse	
6. Hayfever/other significant allergy		26. Stroke		44. Exposed to toxic substance or noise	
7. Any skin trouble		27. Serious chest pain		FOR WOMEN ONLY	
8. Tuberculosis		28. Any blood disease		Have you ever had:-	
9. Shortness of breath		29. Kidney disease		45. An abnormal smear	
10. Coughed/vomited blood		30. Blood in urine		46. Any gynaecological treatment	
11. Severe abdominal pain		31. Diabetes		47. Are you pregnant?	
12. Stomach ulcer		32. Headaches/migraine		48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE	
13. Recurrent indigestion		33. Dizziness/fainting			
14. Jaundice or hepatitis		34. Epilepsy			
15. Gall Bladder disease		35. Joints/spinal trouble			
16. Marked change in bowel habits		36. Surgical operation			
17. Blood in stools (motions)		37. Serious accident/fracture			
18. Marked change in weight		38. Tropical disease			
19. Varicose veins		39. Fear of heights			
20. Lump in breast/armpit					
How much tobacco each day?		Average daily alcohol consumption			
Have you ever taken elicited drugs? <input checked="" type="checkbox"/> PDO test all new/potential employees for elicited/recreational drugs					
FAMILY HISTORY: Diabetes <input checked="" type="checkbox"/> Tuberculosis <input checked="" type="checkbox"/> Epilepsy <input checked="" type="checkbox"/> Asthma <input checked="" type="checkbox"/> Eczema <input checked="" type="checkbox"/> Heart disease <input checked="" type="checkbox"/> High blood pressure <input checked="" type="checkbox"/> Stroke <input checked="" type="checkbox"/> Blood Disease <input checked="" type="checkbox"/> Cancer <input checked="" type="checkbox"/>					
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: <i>17.08.2021</i>		Signature of Applicant: <i>J.S.</i>			
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	N —												
✓		2. E.N.T.	N —												
✓		3. Teeth & Mouth	N —												
✓		4. Lungs & Chest	N —												
✓		5. Cardiovascular System	N —												
✓		6. Abdo. Viscera	N —												
✓		7. Hernial Orifices	N —												
✓		8. Anus & Rectum	N —												
✓		9. Genito-urinary	N —												
✓		10. Extremities	N —												
✓		11. Musculo-skeletal	N —												
✓		12. Skin & Varicose Vns.	N —												
✓		13. C.N.S.	N —												
HEIGHT cm		WEIGHT kg	BMI	B.P. 130 85	PULSE /mins.	HEARING L R	DISTANT Uncorrected Corrected	VISION R L R L 6/6 6/6 4/4 4/4				Colour Vision	Blood Group		
175	79	25.8													
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.)															
OUP - Advised Lifestyle modification															
ASSESSMENT:															
FIT ALL AREAS		<input checked="" type="checkbox"/>	FIT WITH RESTRICTION		<input type="checkbox"/>	TEMPORARY UNFIT		<input type="checkbox"/>	UNFIT		<input type="checkbox"/>				
Date:	Name (Block Capitals): Dr. / Nurse		Signature:		 DR. AMMAR AL SAADI INTEREST & GASTROENTEROLOGY GASTROLOGIST MOH LIC NO # 11613 BADR AL SAMAA HOSPITAL, NIZWA										
REVIEW/CONSULTATION															
Date:	Name (Block Capitals): Dr. / Nurse		Signature:		 BADR AL SAMAA HOSPITAL, NIZWA SULTANATE OF OMAN										