



TRUCKONAN

Appendix 33: EX2 Form (Routine/Periodic Medical Examination)  
ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL - CONFIDENTIAL)

Client Ref. No.	19850	Reg. Dt.	09/08/2023	Department	Leum Development Oman MEDICAL DEPARTMENT	Surname/ Forenames	Gopal Ramal Ingam		
ame	GOPAL RAMAL INGAM			Nationality	INDIAN	Nationality	INDIAN # D.O.B # 02-02-1973		
nder	Male	ASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS							
Mobile No.	96714745		Address:	64731423		Company Number:	1405	Reference Indicator:	
<b>Personal Details</b>									
A <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		<input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced /Widow(er)							
Home/Leave Address:			Relationship to employee		<input type="checkbox"/> Wife	<input type="checkbox"/> Son	<input type="checkbox"/> Daughter	No of Children: 2	
Reason for Examination (tick as appropriate)									
Periodic Medical Examination <input checked="" type="checkbox"/>		Final / Retirement <input type="checkbox"/>		Other Reason: <input type="checkbox"/>					
<b>Employee only</b>									
B Present Job and Location: ADMIN - HAINA		Next Job and Location:							
Are you a registered person with special needs? <input type="checkbox"/>				Do you belong to any Medical Insurance Scheme? <input type="checkbox"/>					
Previous Medical History: All important medical events should be listed and dated at every medical examination. To be completed together with the interviewing Nurses or Doctor who will be able to help by referring to your notes.									
Please answer the following questions and tick 'N' (no) or 'Y' (yes) in the column. If 'Y' please describe.									
		N	Y	Description					
Have you since your last medical been treated by your family doctor or specialist for significant (major) ailments?		<input checked="" type="checkbox"/>							
1	Ear, nose, eye or throat problems	<input checked="" type="checkbox"/>							
2	Chest problems like asthma, bronchitis, another bad cough	<input checked="" type="checkbox"/>							
3	Heart abnormality, chest pains	<input checked="" type="checkbox"/>							
4	Abdominal pains, abnormal bowel motions	<input checked="" type="checkbox"/>							
5	Urogenital problems (kidney disease, menstrual disorder)	<input checked="" type="checkbox"/>							
6	Skin trouble or allergies	<input checked="" type="checkbox"/>							
7	Epileptic fits, dizzy spells or migraine	<input checked="" type="checkbox"/>							
8	History of mental illness, depression anxiety	<input checked="" type="checkbox"/>							
9	Diabetes, thyroid disease, history of Hypertension	<input checked="" type="checkbox"/>							
10	Blood disorder e.g. anaemia, blood cancer e.g. leukaemia	<input checked="" type="checkbox"/>							
11	Any history of accidents or fractures	<input checked="" type="checkbox"/>							
12	Have you had any serious allergies	<input checked="" type="checkbox"/>							
13	Do any dependants have a significant ongoing illness?	<input checked="" type="checkbox"/>							
14	Any family history of cancers	<input checked="" type="checkbox"/>							
Do you take any regular medicines, or have you taken in the past?		<input checked="" type="checkbox"/>						TATOCGR E - o - o - 1	
Do you smoke? If yes, what and how much each day?		<input checked="" type="checkbox"/>							
Do you drink alcohol? If yes, what is your average weekly intake?		<input checked="" type="checkbox"/>							
Have you ever taken elicited/recreational drugs?		<input checked="" type="checkbox"/>							
Are you doing regular sports or physical activities?		<input checked="" type="checkbox"/>							
STATEMENT: I have read the above questions and the above answers are correct and no information concerning my present or past state of health has been withheld. I understand and agree that this form will be held as a confidential record by PDO Medical Department and may be copied (by paper or secure electronic transmission) to the Occupational Health Services for the purpose of Health Surveillance and other Occupational Health review									
Date: 09-08-2023			Signature of Applicant: Gopal Ramal Ingam 09-08-23						



Appendix 33: EX2 Form (Routine/Periodic Medical Examination)  
**ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL - CONFIDENTIAL)**

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								
✓	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 169	WEIGHT kg 67	BMI 23.5	B.P. 110/70 mmhg	PULSE 74/mins.	HEARING L N R N	VISION DISTANT R L Uncorrected 6/6 Corrected 6/6	NEAR R L	Color Vision ✓ Normal 2. Abnormal	
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS				N	A		
✓	1. Urinalysis					✓		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.)

1. Lsm (Diet & Exercise)

ASSESSMENT AND RECOMMENDATIONS:

FIT ALL AREAS  FIT WITH RESTRICTION

Date: 28/8/23 Name (Block Capitals): Dr. / Nurse



REVIEW/CONSULTATION

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

Signature:



### Peace Land Medical Center

P.O.Box 1403, Postal Code: 133, Al Azaiba Al Sahwa Tower  
 Sultanate of Oman  
 Tel: 24617117/24617148/24617149

Name: GOPAL RAMALINGAM File No: 19850  
 Age: 50 Y Nationality : INDIAN Bill No: 25504  
 Gender: MALE Date: 8/9/2023  
 Ref.By: DR : SHIMA Time:  
 GSM No.: 79321673

Test	Result	Nomal Range
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#### PDO MEDICAL CHECKUP :

#### URINE ROUTINE ANALYSIS

##### PHYSICAL

Quantity	5 ml	5 ml
Colour	Yellow	Yellow
Sp. Gravity	1.010	
pH	Acidic	
Appearance	Clear	

##### CHEMICAL

Nitrite	Negative	Negative
Protein	Negative	Negative
Glucose	Negative	Negative
Ketones	Negative	Negative
Urobilinogen	Normal	Normal
Bilirubin	NIL	Negative
Blood	Negative	Negative

##### MICROSCOPIC

PUS CELLS	1-2	2-4/ hpf
EPITHELIAL CELLS	1-2	2-4/ hpf
RBC'S	1-2	0-4/ hpf
CRYSTALS	NIL	
BACTERIA	NIL	
OTHERS	NIL	

#### COMPLETE BLOOD COUNT

RBC	4.7	Male 4.38 - 4.98 10 12/l Female 4.5 - 5.5 10 12/l
HAEMOGLOBIN	13.2	Male 13 -16 gm % Female 11 - 14 gm %
HCT	39.00%	Male 39.30 -44.10 % Female 37-47 %
MCV	81	84-94 ft



MCH	27	26.3-31.9 pg
<u>Medical Technologist</u>		
MCHC	33	29.6-35.6g/dl
WBC COUNT	6.7	( 4.0-11.0) 10 9/l
DIFFERENTIAL COUNT		
NEUTROPHIL	41%	53-69.7 %
LYMPHOCYTE	42%	23.9-37.9 %
EOSINOPHIL	5%	1-6 %
MONOCYTE	12%	2-10 %
BASOPHIL	0%	0-1%
PLATELET	290	156-342 10 9/l
FASTING BLOOD SUGAR	93 mg/dl	80-110 mg/dl
<b>LIVER FUNCTION TEST</b>		
ALKALINE PHOSPHATE	77 U/L	44-147U/L
S. BILIRUBIN TOTAL	0.6 mg/dl	0.0-2.0 mg/dl
GGT	33 mg/dl	0.0-55.0 mg/dl
S.G.O.T	20 U/L	0.0-45.0 U/L
S.G.P.T	19 U/L	10-45 U/L
ALBUMIN	4.4 mg/dl	3.50-5.20 mg/dl
TOTAL PROTEIN	8.0 mg/dl	6-8.0 mg/dl
SERUM BILIRUBIN DIRECT	0.2 mg/dl	0.0-0.40 mg/dl
<b>RENAL FUNCTION TEST</b>		
UREA	30 mg/dl	18.0-55.0 mg/dl
S. CREATININE	0.9 mg/dl	0.70-1.30mg/dl
URIC ACID	5.2 mg/dl	3.4-7.2 mg/dl
<b>LIPID PROFILE(CH, TG, HDL,LDL)</b>		
Total Cholestral	173 mg/dl	Normal < 200 mg/dl Borderline 200- 239 mg/dl High > 240 mg/dl
TG	118 mg/dl	Normal < 200 mg/dl Borderline 200- 250 mg/dl High > 250 mg/dl
HDL-CHOL	52 mg/dl	35.3-79 mg/dl Low Risk > 50 mg/dl Nomal Risk 35-50 mg/dl High Risk < 35 mg/dl
LDL-CHOL	109 mg/dl	<130 mg/dl
VLDL	24 mg/dl	5-40 mg/dl



Medical Technologist



2023-08-09 09:28:30

6 channel + 1 Rhythm Report

Hospital: Prescribed by:

Heart Rate: 75 bpm ## Analysis Result ## (To be finally confirmed by cardiologist)

PR Int.: 182 ms

Normal Sinus Rhythm

QRS Dur.: 92 ms

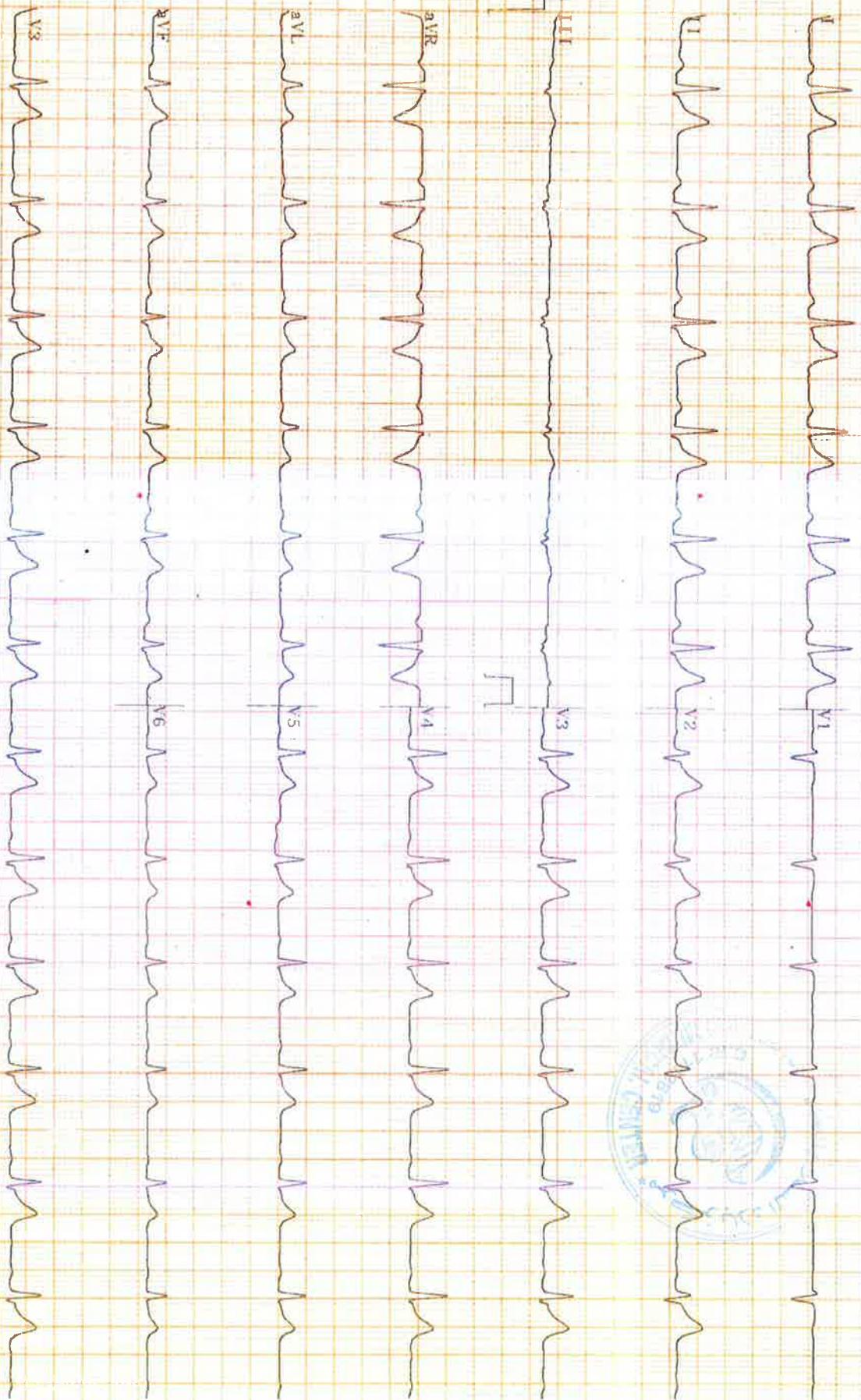
Normal Axis

QT/QTc: 360/403 ms

[ Normal ECG ]

P-R-T axes:

41 25 34





بلاد السلام للخدمات الطبية ش.م.م.  
Peace Land Medical Services L.L.C

PATIENT ID: 19850

Estimated 10-year Global CVD Risk

4.70%

Risk Category

Low Risk

Estimated Vascular Age

42 Years

Treatment Guidelines

ATP-III (2004)

LDL <160 mg/dL (<4.14 mmol/L)  
Non-HDL <190 mg/dL (<4.93 mmol/L)

CCS (2009)

LDL >5 mmol/L (>193 mg/dL)  
TChol/HDL-C >6 mmol/L (>231 mg/dL)

≥50 % decrease in LDL-C

ESC (2007, see Info for more)

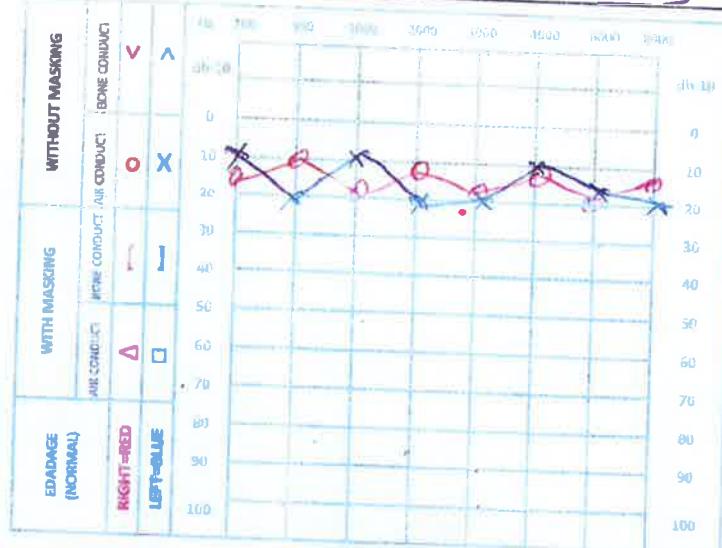
LDL <3 mmol/L (<120 mg/dL)  
TChol <5 mmol/L (<194 mg/dL)





## **AUDIOLOGY TEST REPORT**

NAME: <u>GIOPAL RAMALINGAM</u>	COMPANY: <u>TRUCKMAN</u>	
AGE: <u>02/02/1973</u>	GENDER: <u>M/F</u>	OCCUPATION: <u>ADMIN</u>
REF. BY:	DATE: <u>29/10/2023</u>	



**INTERPRETATION**

*Sibelmed*

RESULT  
 NORMAL  
 HEARING LOSS  
 RIGHT  
 LEFT





# Peace Land Medical Center

## Fitness for work certificate

Employee Data		Date 09/08/2023
Name (TOPAL RAMALINHAN)	I.D No. 64731423	Department/Company TRUCK OMAN Occupation ADMIN
Type of Medical Evaluation Mark those applying ✓		
A1 Aircraft refuelling	A6 Fire / Emergency response team work	
A2 Breathing apparatus	A7 Professional driving	
A3 Business traveller	A8 Remote location work	
A4 Catering and food preparation	A9 Transfers – group A country	
A5 Crane or forklift driving & all heavy vehicles	A10 Transfers – group B country	
<p><b>Health Advisor Statement :</b> The above named person has been examined according to the statements laid down in "Protocols and Guidance Notes on the Medical Evaluation of Fitness to Work". At this time his/her fitness to work status for the above tasks is as follows.</p>		
Fit with no restrictions		
Fit with following restriction(s)		
The employee is fit for above work but should avoid the following task(s)	Temporary restriction	Permanent restriction
Work near moving machinery or sharp edges		
Working at height		
Pulling, pushing, or carrying weight over _____ Kg		
Ascend/descend ladders or stairs		
Operate motor vehicles, forklifts or heavy machinery		
Use of a respirator		
Repetitive twisting of valves or wrenches		
Flying		
Other (Specify)		
Temporary Unfit until		
Permanently Unfit		
Name of health advisor Signature		



Date

28/8/23



Dr. Sajna Seyedabddollah Jafar  
Cardiologist Specialist  
MOH Lic. No. 21962



## nmc specialty hospital, al ghoubra

P.O BOX : 613, Postal Code : 133  
AL-GHOUBRA  
24504000

### Fitness Certificate

Empno:

Ref No : 0000169/FIT/NMC/2023

Date of issue : 26/08/2023

This is to certify that Mr. / Mrs. **GOPAL RAMAL** with file no **14414674** was *Treated* at *nmc specialty hospital, al ghoubra* on **26/08/2023** and will be **FIT TO WORK** from the medical point of view starting from **26/08/2023**

#### DIAGNOSIS

**TMT IS NEGATIVE FOR ISCHEMIA**

#### Remarks

**DR MUHAMMAD SIDDIQUI**

Place: *nmc specialty hospital, al ghoubra*

(Hospital Seal)

Signature

