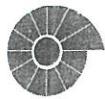




Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

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

Place of examination NMC AI HAIL		Date 12/09/2022	Surname MD																																																																																																											
			Forenames DABLU HOWLADER																																																																																																											
			Address																																																																																																											
			Home telephone number 95418231																																																																																																											
If a dependant enter employee's name here: Surname: MD		Forenames: DABLU HOWLADER																																																																																																												
Birth date: 10/02/1971		Nationality: BANGLADESH	Country of birth: BANGLADESH	Religion: MUSLIM																																																																																																										
<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	Relationship to employee Number of children: 2																																																																																																										
Reason for examination Pre-Employment		<input type="checkbox"/> Job:																																																																																																												
Pre-Overseas		<input checked="" type="checkbox"/> Area:																																																																																																												
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?		Average daily alcohol consumption																																																																																																												
Have you ever taken elicited drugs? () PDO test all new/potential employees for elicited/recreational drugs																																																																																																														
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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: 12/09/2022		Signature of Applicant: DABLU																																																																																																												





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	Unremarkable									
	7. Hernial Orifices										
	8. Anus & Rectum										
	9. Genito-urinary										
	10. Extremities										
	11. Musculo skeletal										
	12. Skin & Varicose Vns										
	13. C.N.S.										
HEIGHT cm 168	WEIGHT kg 28	BMI 27.6	B.P. 143 93	PULSE 80/mins.	HEARING L R	VISION Uncorrected Corrected	DISTANT R L	NEAR R L	Colour Vision	Blood Group	

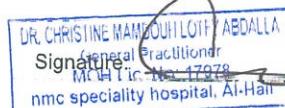
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS			N	A		
	1. Urinalysis	ALT ↑ for further evaluation → high Cholesterol LDL for follow up				7. Audiogram		
	2. Hb, Bloodcount, ESR							8. Lung Function
	3. LFT, RFT, RBS							9. Chest X-Ray
	4. Drug Screen							10. ECG
	5. Lipids (40 years +)							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.)

ASSESSMENT:

FIT ALL AREAS FIT WITH RESTRICTION TEMPORARY UNFIT UNFIT

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



REVIEW/CONSULTATION

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

Signature:

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

RECEPTION

