



#1407



## MEDICAL CERTIFICATE FOR PDO

**NAME** **JARNAIL SINGH**

AGE/D.O.B	51 Y,26.05.1970	DATE	28.10.2021
PASS/ID NO:	87934222	GENDER	MALE
VISION-RT-EYE	6/6 WITHOUT GLASSES	HEIGHT	169 CM
LT-EYE	6/6 WITHOUT GLASSES	WEIGHT	72 KG
HEART	NORMAL	BP	136/90 mmHg
LUNGS	NORMAL	PULSE	82/Min
ABDOMEN	NORMAL	CNS	NORMAL
SKIN	NORMAL	ENT	NORMAL

### INVESTIGATIONS

FBS	IFG
BLOOD GROUP	AB POSITIVE
HAEMOGRAM	NORMAL
LFT	Slightly elevated SGPT
RFT	NORMAL
LIPID PROFILE	DLP
SICKLING TEST	NEGATIVE
URE	NORMAL
AUDIOGRAM	Normal hearing threshold with sloping SNHL at HF B/L
ECG	T inversion L1, AVL, V6 Normal sinus Rhythm
TMT	NEGATIVE STRESS INDUCED ISCHEAMIA
FRAMINGHAM SCORE	Probability of developing cardiovascular disease in next 10 years is 9.9%

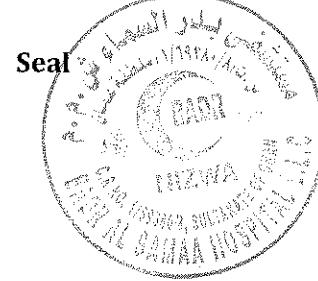
**COMMENTS** \* K/C/O SHT x 4 yr on regular medication advised for only moderate alcohol  
 \* To use adequate ear protection in high noise environment

**CONCLUSION :** **MDICALLY FIT**

Signature: .....

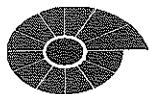
Dr.B.VENKATESH KUMAR  
 CARDIOLOGIST  
 MOH NO#14581

FIT



**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

Place of examination <b>BADR AL SAMAA</b>		Date: <i>28/10/12</i>		Surname <i>JARNVIL SINGH</i>			
				Forenames :			
				Address			
				Home telephone number			
If a dependant enter employee's name here:							
Surname:		Forenames:					
Birth date:	Nationality:	Country of birth:		Religion:			
<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-Overscas 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	
1. Sinus trouble		<input checked="" type="checkbox"/>		21. Cancer		<input checked="" type="checkbox"/>	
2. Neck swelling/glands		<input checked="" type="checkbox"/>		22. Heart Disease		<input checked="" type="checkbox"/>	
3. Difficulty in vision		<input checked="" type="checkbox"/>		23. Rheumatic fever		<input checked="" type="checkbox"/>	
4. Any ear discharge		<input checked="" type="checkbox"/>		24. Abnormal heartbeat		<input checked="" type="checkbox"/>	
5. Asthma/bronchitis		<input checked="" type="checkbox"/>		25. High blood pressure		<input checked="" type="checkbox"/>	
6. Hayfever/other significant allergy		<input checked="" type="checkbox"/>		26. Stroke		<input checked="" type="checkbox"/>	
7. Any skin trouble		<input checked="" type="checkbox"/>		27. Serious chest pain		<input checked="" type="checkbox"/>	
8. Tuberculosis		<input checked="" type="checkbox"/>		28. Any blood disease		<input checked="" type="checkbox"/>	
9. Shortness of breath		<input checked="" type="checkbox"/>		29. Kidney disease		<input checked="" type="checkbox"/>	
10. Coughed/vomited blood		<input checked="" type="checkbox"/>		30. Blood in urine		<input checked="" type="checkbox"/>	
11. Severe abdominal pain		<input checked="" type="checkbox"/>		31. Diabetes		<input checked="" type="checkbox"/>	
12. Stomach ulcer		<input checked="" type="checkbox"/>		32. Headaches/migraine		<input checked="" type="checkbox"/>	
13. Recurrent indigestion		<input checked="" type="checkbox"/>		33. Dizziness/fainting		<input checked="" type="checkbox"/>	
14. Jaundice or hepatitis		<input checked="" type="checkbox"/>		34. Epilepsy		<input checked="" type="checkbox"/>	
15. Gall Bladder disease		<input checked="" type="checkbox"/>		35. Joints/spinal trouble		<input checked="" type="checkbox"/>	
16. Marked change in bowel habits		<input checked="" type="checkbox"/>		36. Surgical operation		<input checked="" type="checkbox"/>	
17. Blood in stools (motions)		<input checked="" type="checkbox"/>		37. Serious accident/fracture		<input checked="" type="checkbox"/>	
18. Marked change in weight		<input checked="" type="checkbox"/>		38. Tropical disease		<input checked="" type="checkbox"/>	
19. Varicose veins		<input checked="" type="checkbox"/>		39. Fear of heights		<input checked="" type="checkbox"/>	
20. Lump in breast/armpit		<input checked="" type="checkbox"/>					
How much tobacco each day?		<i>Nil</i>		Average daily alcohol consumption		<i>Nil (60 ml/day)</i>	
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>28/10/12</i>				Signature of Applicant:			
FOR COMPLETION BY EXAMINING DOCTOR OR NURSE Further details of medical history and recreational activities							

*SHR x Lups*

*B. VENKATESH KUMAR*  
CARDIOLOGIST  
MOH NO#14581

N = Normal A = Abnormal (please describe)			PHYSICAL EXAMINATION							
N	A									
		1. Eyes & Pupils	Normal & Reactive							
		2. E.N.T.	B/L TM normal, voice throat -> normal							
		3. Teeth & Mouth								
		4. Lungs & Chest	Normal							
		5. Cardiovascular System	S.H. (A) No murmur							
		6. Abdo. Viscera	LFT M(+) Normal							
		7. Hernial Orifices	Normal							
		8. Anus & Rectum	Normal							
		9. Genito-urinary	Normal							
		10. Extremities	Normal							
		11. Musculo-skeletal	Normal							
		12. Skin & Varicose Vns.	Normal							
		13. C.N.S.	Normal							
HEIGHT cm	WEIGHT kg	BMI	B.P. 136/90	PULSE 82/mins.	HEARING L R	DISTANT Uncorrected Corrected	VISION NEAR R L R L 6/6 6/6 N/6 N/6	Colour Vision (N)	Blood Group AB+	
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS				N	A			
		1. Urinalysis	Tm - Negative						7. Audiogram	B/L hearing sensitivity normal with
		2. Hb, Bloodcount, ESR	Hb - Normal						8. Lung Function	Normal / little
		3. LFT, RFT, RBS	LFT - Normal						9. Chest X-Ray	Normal
		4. Drug Screen	Normal						10. ECG	T & ST abn at high freq
		5. Lipids (40 years +)	Normal						11. CVS risk for 40 yrs. & above	
		6. Sickle Cell test	Normal						12. HIV, Hepatitis screening	
OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)										
SHT x 4yr on regular med/sym										
ASSESSMENT:										
<input checked="" type="checkbox"/> FIT ALL AREAS <input type="checkbox"/> FIT WITH RESTRICTION <input type="checkbox"/> TEMPORARY UNFIT <input type="checkbox"/> UNFIT <input type="checkbox"/>										
Date: 28/10/18 Name (Block Capitals): Dr. / Nurse Signature:										
REVIEW/CONSULTATION										
Date: 28/10/18 Name (Block Capitals): Dr. / Nurse Signature:										

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