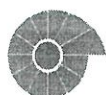


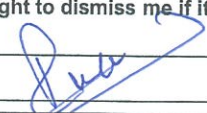
Appendix 32: EX1 Form (Initial Examination Report)

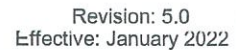
INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)



**Petroroleum Development Oman
MEDICAL DEPARTMENT**

PLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Surname PAULOSE		Forenames EDATHICHIRA VARKEY	
Address		Home telephone number	
Place of examination NMC ALHAIL		Date 12/03/2023	
If a dependant enter employee's name here.			
Surname:		Forenames:	
Birth date: 10/04/1988	Nationality: INDIAN	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	Relationship to employee <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter	Number of children:
Reason for examination Pre-Employment <input type="checkbox"/> Job: Pre-Overseas <input 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 checked="" type="checkbox"/>		Do you belong to any Medical Insurance Scheme? <input checked="" 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/arnpit	<input checked="" type="checkbox"/>		
HAVE YOU EVER BEEN:-			
		40. Rejected for employment or insurance for medical reasons	<input checked="" type="checkbox"/>
		41. Awarded benefits for industrial injury/illness	<input checked="" type="checkbox"/>
		42. Treated for a mental condition, e.g. depression	<input checked="" type="checkbox"/>
		43. Treated for problem drinking or drug abuse	<input checked="" type="checkbox"/>
		44. Exposed to toxic substance or noise	
FOR WOMEN ONLY			
		45. An abnormal smear	
		46. Any gynaecological treatment	
		47. Are you pregnant?	
		48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE	
How much tobacco each day? 1 Pack/day → 20 gents Average daily alcohol consumption 2 times/week			
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:		Signature of Applicant: 	



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