

ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



RUSAYL HEALTH CENTRE

ISO 9001- 2015 Certified Co.

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Surname/
Forenames

MANIKANDAN UTHRAPATHY

Nationality INDIAN

Mobile No. 95950718

Home/Leave Address:

Company Number: 8140

Reference Indicator:

Personal Details Age: 37 yrs

CIVIC ID: 96187491 TRUUCOMAN

A Male Female

Married Single Separated /Divorced /Widow(er)

Home/Leave Address:

Relationship to employee

Wife

Son

Daughter

No of Children:

Reason for Examination (tick as appropriate)

Periodic Medical Examination

Final / Retirement

Other Reason:

Employee only

B Present Job and Location:

HELPER IN ARMEN

Next Job and Location:

Are you a registered person with special needs?

Do you belong to any Medical Insurance Scheme?

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?			
1 Ear, nose, eye or throat problems	<input checked="" type="checkbox"/>		
2 Chest problems like asthma, bronchitis, other 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	<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 your taken in the past?	<input checked="" type="checkbox"/>		
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.

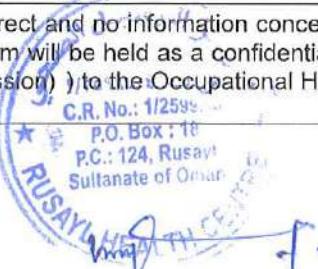
C.R. No.: 1/259

P.O. Box : 18

P.C.: 124, Rusayl

Sultanate of Oman

Date: 17th September, 2020 Signature of Applicant:



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	WEIGHT kg	BMI	B.P. 130 80	PULSE 72/mins.	HEARING L N R N	VISION	
						DISTANT	NEAR
166	65	24.0			Uncorrected Corrected	6/6 6/6	N/N

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.)

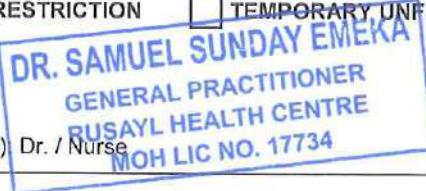
Normal findings

ASSESSMENT AND RECOMMENDATIONS:

FIT ALL AREAS FIT WITH RESTRICTION TEMPORARY UNFIT UNFIT

Date: 17/08/20

Name (Block Capitals) Dr. / Nurse



S. E. E.

Signature:

REVIEW/CONSULTATION

Date:

Name (Block Capitals) Dr. / Nurse

Signature:





11.15 Appendix 15: Fitness to Work Certificate

Employee Data		Date <i>17/09/2020</i>
Name <i>MANIKANDAN UTIRAPATHY</i>		Department/Company <i>Truckman</i>
I.D No. <i>96187491</i>	Age <i>37 yrs</i>	Occupation <i>HELPER</i>
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
Health Advisor Statement : 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.		
Fit with no restrictions		✓
Fit with following restriction(s)		
<i>The employee is fit for above work but should avoid the following task(s)</i>	Temporary restriction	Permanent restriction
Work near moving machinery or sharp edges		
Working at height		
Puling, 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		
<i>Permanently Unfit</i> DR. SAMUEL SUNDAY EMEKA GENERAL PRACTITIONER NEW AYI HEALTH CENTRE Name of health advisor MOH LIC NO. 17734		Date <i>17/09/2020</i>
Signature <i>S. EMEKA</i>		Date <i>17/09/2020</i>
C.R. No.: 1/259954 P.O. Box: 10 P.C.: 124, Rusayl Sultanate of Oman		
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