



مجموعة مستشفيات ومستوصفات بدر الساماء

BADR AL SAMAA

GROUP OF HOSPITALS & POLYCLINICS

More Than Healthcare... Human Care

#1413



Organization Accredited
by Joint Commission International
BADR Al Samaa Hospital, Ruwi & Al Khoud

MEDICAL FITNESS CERTIFICATE FOR (P.D.O)

NAME **BALJINDER SINGH**

AGE/D.O.B	38 Y,15.03.1983	DATE	16.08.2021
PASS/ID NO:	72767118	GENDER	MALE
VISION-RT-EYE	6/6 WITHOUT GLASSES	HEIGHT	168 CM
LT-EYE	6/6 WITHOUT GLASSES	WEIGHT	73 KG
HEART	NORMAL	BP	120/70 mmHg
LUNGS	NORMAL	PULSE	72/Min
ABDOMEN	NORMAL	CNS	NORMAL
SKIN	NORMAL	ENT	NORMAL

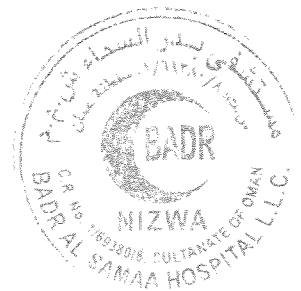
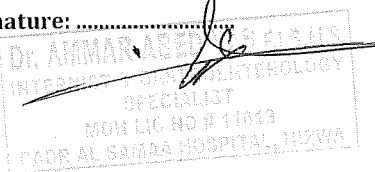
INVESTIGATIONS

FBS	NORMAL
BLOOD GROUP	O POSITIVE
HAEMOGRAM	NORMAL
LIPIDPROFILE	DLP
RFT	NORMAL
LFT	NORMAL
SICKLING TEST	NEGATIVE
URE	NORMAL
AUDIOGRAM	NORMAL AUDIOMETRIC THRESHOLD

COMMENTS **DLP- Advised lifestyle modification**

CONCLUSION **MEDICALLY FIT**

Signature:



Headquarters:

CR. No. 1693808, P.B No. 443, P.C. 112,

Ruwi, Sultanate of Oman, Tel: +968 24799760, Fax: 24799765

Al Khuwair : 24488322 | Sohar : 26846660 | Al Khoud : 24546099 | Salalah : 23291830

Barka : 26884910 | Sur : 25546112 | Nizwa : 25447777 | Falaj : 26754131

Email: info@badroman.com

المقر الرئيسي :

س. ت. : ١٩٣٨٠٨، ص. ب. : ٤٤٣، الرمز البريدي : ١١٢

روي سلطنة عمان. هاتف : ٢٤٧٩٩٧٦٠، فاكس : ٢٤٧٩٩٧٦٥

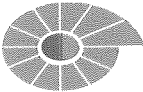

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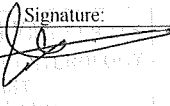
بركاء : ٢٦٨٨٤٩١٠ | صور : ٢٥٥٤١١٢ | لزوي : ٢٥٤٤٧٧٧ | فلج : ٢٦٧٥٤١٣١

البريد الإلكتروني : info@badroman.com

Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

 <p>Petroleum Development Oman MEDICAL DEPARTMENT</p> <p>PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS</p>	Surname	
	Forenames : <u>Baljinder Singh</u>	
	Address	
	Home telephone number	
Place of examination BADR AL SAMAA	Date <u>16/8/2021</u>	
If a dependant enter employee's name here:		
Surname:		Forenames:
Birth date: <u>15/3/1985</u>	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	Relationship to employee <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter
Reason for examination Pre-EmploymentJob: <input type="checkbox"/>		Number of children:
Pre-OverseasArea: <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
Y	N	Y
1. Sinus trouble		21. Cancer
2. Neck swelling/glands		22. Heart Disease
3. Difficulty in vision		23. Rheumatic fever
4. Any ear discharge		24. Abnormal heartbeat
5. Asthma/bronchitis		25. High blood pressure
6. Hayfever/other significant allergy		26. Stroke
7. Any skin trouble		27. Serious chest pain
8. Tuberculosis		28. Any blood disease
9. Shortness of breath		29. Kidney disease
10. Coughed/vomited blood		30. Blood in urine
11. Severe abdominal pain		31. Diabetes
12. Stomach ulcer		32. Headaches/migraine
13. Recurrent indigestion		33. Dizziness/fainting
14. Jaundice or hepatitis		34. Epilepsy
15. Gall Bladder disease		35. Joints/spinal trouble
16. Marked change in bowel habits		36. Surgical operation
17. Blood in stools (motions)		37. Serious accident/fracture
18. Marked change in weight		38. Tropical disease
19. Varicose veins		39. Fear of heights
20. Lump in breast/armpit		
How much tobacco each day?		Average daily alcohol consumption
Have you ever taken elicited drugs? (X) PDO test all new/potential employees for elicited/recreational drugs		
FAMILY HISTORY: Diabetes (X) Tuberculosis (X) Epilepsy (X) Asthma (X) Eczema (X)		
Heart disease (X) High blood pressure (X) Stroke (X) Blood Disease (X) Cancer (X)		
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: <u>16/8/2021</u>	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		Normal				
✓		2. E.N.T.		Normal				
✓		3. Teeth & Mouth		Normal				
✓		4. Lungs & Chest		Normal				
✓		5. Cardiovascular System		Normal				
✓		6. Abdo. Viscera		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.	PULSE /mins.	HEARING L R	VISION DISTANT NEAR Uncorrected Corrected	Colour Vision	Blood Group
168	73	25.9	120 70			R L R L 6/6 6/6 N/6 N/6 Corrected	N	O+
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. Sick Cell test						12. HIV, Hepatitis screening
OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)								
DLP - Advised lifestyle modification								
ASSESSMENT:								
FIT ALL AREAS <input checked="" type="checkbox"/> FIT WITH RESTRICTION <input type="checkbox"/> TEMPORARY UNFIT <input type="checkbox"/> UNFIT <input type="checkbox"/>								
<div style="border: 2px solid black; padding: 10px; display: inline-block; font-size: 2em; font-weight: bold;">FIT</div>								
Date:		Name (Block Capitals): Dr. / Nurse			Signature: 			
REVIEW/CONSULTATION								
Date:		Name (Block Capitals): Dr. / Nurse			Signature: 