



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

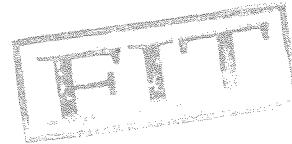
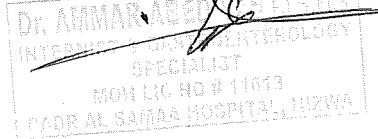
FBS	NORMAL
BLOOD GROUP	O POSITIVE
HAEMOGRAM	NORMAL
LIPID PROFILE	DLP
RFT	NORMAL
LFT	NORMAL
SICKLING TEST	NEGATIVE
URE	NORMAL
AUDIOGRAM	NORMAL AUDIOMETRIC THRESHOLD

COMMENTS **DLP- Advised lifestyle modification**

CONCLUSION

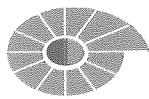
MEDICALLY FIT

Signature:



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

Surname							
Forenames : <i>Baljinder Singh</i>							
Address							
Home telephone number							
Place of examination BADR AL SAMAA		Date <i>16/8/2021</i>					
If a dependant enter employee's name here:							
Surname:		Forenames:					
Birth date: <i>15/3/1980</i>		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-Overseas 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.)							
<table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="text-align: center; padding: 2px;">Y</td> <td style="text-align: center; padding: 2px;">N</td> </tr> </table>		Y	N	<table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="text-align: center; padding: 2px;">Y</td> <td style="text-align: center; padding: 2px;">N</td> </tr> </table>		Y	N
Y	N						
Y	N						
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? <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 type="checkbox"/> Eczema <input checked="" type="checkbox"/> Heart disease <input checked="" type="checkbox"/> High blood pressure <input type="checkbox"/> Stroke <input 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>16/8/2021</i>		Signature of Applicant: <i>B. Baljinder Singh</i>					
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		N —								
/		2. E.N.T.		N —								
/		3. Teeth & Mouth		N —								
/		4. Lungs & Chest		N —								
/		5. Cardiovascular System		N —								
/		6. Abdo. Viscera		N —								
/		7. Hernial Orifices		N —								
/		8. Anus & Rectum		N —								
/		9. Genito-urinary		N —								
/		10. Extremities		N —								
/		11. Musculo-skeletal		N —								
/		12. Skin & Varicose Vns.		N —								
/		13. C.N.S.		N —								
HEIGHT cm		WEIGHT kg	BMI	B.P. 120 70	PULSE /mins.	HEARING L R	DISTANT Uncorrected Corrected	VISION NEAR R L R L 6/6 6/6 6/6 6/6			Colour Vision	Blood Group
168	73	25.9								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. Sickle 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"/>	
Date:		Name (Block Capitals): Dr. / Nurse		Signature:		FIT						
REVIEW/CONSULTATION												
Date:		Name (Block Capitals): Dr. / Nurse		Signature:								
