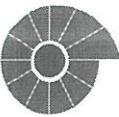
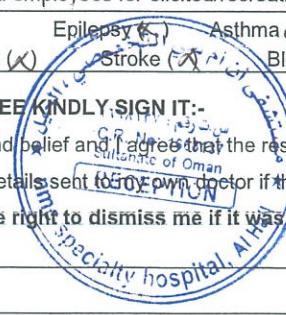


1.1 Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

 <p>Petroleum Development Oman MEDICAL DEPARTMENT</p> <p>PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS</p>		<p>Surname</p> <p>Forenames RAJIV SINGH</p> <p>Address</p> <p>Home telephone number</p> <p>Employment No #</p>																																																																																																																																																																																														
Place of examination NML AL HAIL	Date:- 31/10/2022																																																																																																																																																																																															
<p>If a dependant enter employee's name here:</p> <p>Surname: _____ Forenames: _____</p> <p>Birth date: 22/05/1972 Nationality: INDIAN Country of birth: _____ Religion: _____</p>																																																																																																																																																																																																
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced	<input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter	Relationship to employee Number of children:																																																																																																																																																																																													
Reason for examination	Pre-Employment <input checked="" type="checkbox"/> Job: _____																																																																																																																																																																																															
	Pre-Overseas <input type="checkbox"/> Area: _____																																																																																																																																																																																															
Name and address of family doctor	<p>List your last 3 jobs</p> <p>(1) _____</p> <p>(2) _____</p>																																																																																																																																																																																															
Are you a Registered Disabled Person? (UK only) <input type="checkbox"/>	Do you belong to any Medical Insurance Scheme? <input type="checkbox"/>																																																																																																																																																																																															
<p>DO YOU HAVE OR HAVE YOU HAD:- (Tick "Yes" or "No" column or put a (?) if uncertain exclude minor ailments.)</p> <table border="1"> <thead> <tr> <th></th> <th>Y</th> <th>N</th> <th></th> <th>Y</th> <th>N</th> <th></th> <th>Y</th> <th>N</th> </tr> </thead> <tbody> <tr> <td>1. Sinus trouble</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td>21. Cancer</td> <td><input type="checkbox"/></td> <td><input checked="" type="checkbox"/></td> <td>HAVE YOU EVER BEEN:-</td> <td></td> <td></td> </tr> <tr> <td>2. Neck swelling/glands</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td>22. Heart Disease</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td>40. Rejected for employment or insurance for medical reasons</td> <td></td> <td></td> </tr> <tr> <td>3. Difficulty in vision</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td>23. Rheumatic fever</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td>41. Awarded benefits for industrial injury/illness</td> <td></td> <td></td> </tr> <tr> <td>4. Any ear discharge</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td>24. Abnormal heartbeat</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td>42. Treated for a mental condition, e.g. depression</td> <td></td> <td></td> </tr> <tr> <td>5. Asthma/bronchitis</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td>25. High blood pressure</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td>43. Treated for problem drinking or drug abuse</td> <td></td> <td></td> </tr> <tr> <td>6. Hayfever /other significant allergy</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td>26. Stroke</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td>44. Exposed to toxic substance or noise</td> <td></td> <td></td> </tr> <tr> <td>7. Any skin trouble</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td>27. Serious chest pain</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td></td> <td></td> </tr> <tr> <td>8. Tuberculosis</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td>28. Any blood disease</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td></td> <td></td> </tr> <tr> <td>9. Shortness of breath</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td>29. Kidney disease</td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td></td> <td></td> </tr> <tr> <td>10. 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Have you ever taken elicited drugs? <input checked="" type="checkbox"/> PDO test all new/potential employees for elicited/recreational drugs																																																																																																																																																																																																
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<p>PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT:-</p> <p>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.</p>																																																																																																																																																																																																
Date:	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	BM	B.P.	PULSE 86/mins	HEARING L R	VISION DISTANT R L Uncorrected 6 6 Corrected 6 0		NEAR R L	Colour Vision	Blood Group
175	93		151	86						✓	
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS					N	A			
✓		1. Urinalysis					✓		7. Audiogram		
✓		2. Hb, Blood count, 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.)

ASSESSMENT:

- FIT ALL AREAS
- FIT WITH SPECIFIC RESTRICTION
- TEMPORARY UNFIT
- AWAITING SPECIALIST ASSESSMENT



REVIEW/CONSULTATION

DATE: 6/11/2022

DOCTOR NAME:

Dr. Christine

SIGNATURE: *[Signature]*
Dr. CHRISTINE AYADALLA
General Practitioner
MOH Lic. No. 100000000000000000
nmc specialty hospital, Al Hail