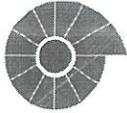




1.1 Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

 Petroleum Development Oman MEDICAL DEPARTMENT		Surname SINGH Forenames SURINDER Address Home telephone number Employment No #																																																																																																									
Place of examination NML AL HAIL Date: 06/10/2022		PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS																																																																																																									
If a dependant enter employee's name here: Surname: _____ Forenames: _____ Birth date: 16/14/1972 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 <input type="checkbox"/> 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 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"> <thead> <tr> <th>Y</th> <th>N</th> </tr> </thead> <tbody> <tr><td><input checked="" type="checkbox"/></td><td>1. Sinus trouble</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>2. Neck swelling/glands</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>3. Difficulty in vision</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>4. Any ear discharge</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>5. Asthma/bronchitis</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>6. Hayfever /other significant allergy</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>7. Any skin trouble</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>8. Tuberculosis</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>9. Shortness of breath</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>10. Coughed/vomited blood</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>11. Severe abdominal pain</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>12. Stomach ulcer</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>13. Recurrent indigestion</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>14. Jaundice or hepatitis</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>15. Gall Bladder disease</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>16. Marked change in bowel habits</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>17. Blood in stools (motions)</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>18. Marked change in weight</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>19. Varicose veins</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>20. Lump in breast/armpit</td></tr> <tr><td><input type="checkbox"/></td><td>21. Cancer</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>22. Heart Disease</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>23. Rheumatic fever</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>24. Abnormal heartbeat</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>25. High blood pressure</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>26. Stroke</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>27. Serious chest pain</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>28. Any blood disease</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>29. Kidney disease</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>30. Blood in urine</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>31. Diabetes</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>32. Headaches/migraine</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>33. Dizziness/fainting</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>34. Epilepsy</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>35. Joints/spinal trouble</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>36. Surgical operation</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>37. Serious accident/fracture</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>38. Tropical disease</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>39. Fear of heights</td></tr> </tbody> </table>		Y	N	<input checked="" type="checkbox"/>	1. Sinus trouble	<input checked="" type="checkbox"/>	2. Neck swelling/glands	<input checked="" type="checkbox"/>	3. Difficulty in vision	<input checked="" type="checkbox"/>	4. Any ear discharge	<input checked="" type="checkbox"/>	5. Asthma/bronchitis	<input checked="" type="checkbox"/>	6. Hayfever /other significant allergy	<input checked="" type="checkbox"/>	7. Any skin trouble	<input checked="" type="checkbox"/>	8. Tuberculosis	<input checked="" type="checkbox"/>	9. Shortness of breath	<input checked="" type="checkbox"/>	10. Coughed/vomited blood	<input checked="" type="checkbox"/>	11. Severe abdominal pain	<input checked="" type="checkbox"/>	12. Stomach ulcer	<input checked="" type="checkbox"/>	13. Recurrent indigestion	<input checked="" type="checkbox"/>	14. Jaundice or hepatitis	<input checked="" type="checkbox"/>	15. Gall Bladder disease	<input checked="" type="checkbox"/>	16. Marked change in bowel habits	<input checked="" type="checkbox"/>	17. Blood in stools (motions)	<input checked="" type="checkbox"/>	18. Marked change in weight	<input checked="" type="checkbox"/>	19. Varicose veins	<input checked="" type="checkbox"/>	20. Lump in breast/armpit	<input type="checkbox"/>	21. Cancer	<input checked="" type="checkbox"/>	22. Heart Disease	<input checked="" type="checkbox"/>	23. Rheumatic fever	<input checked="" type="checkbox"/>	24. Abnormal heartbeat	<input checked="" type="checkbox"/>	25. High blood pressure	<input checked="" type="checkbox"/>	26. Stroke	<input checked="" type="checkbox"/>	27. Serious chest pain	<input checked="" type="checkbox"/>	28. Any blood disease	<input checked="" type="checkbox"/>	29. Kidney disease	<input checked="" type="checkbox"/>	30. Blood in urine	<input checked="" type="checkbox"/>	31. Diabetes	<input checked="" type="checkbox"/>	32. Headaches/migraine	<input checked="" type="checkbox"/>	33. Dizziness/fainting	<input checked="" type="checkbox"/>	34. Epilepsy	<input checked="" type="checkbox"/>	35. Joints/spinal trouble	<input checked="" type="checkbox"/>	36. Surgical operation	<input checked="" type="checkbox"/>	37. Serious accident/fracture	<input checked="" type="checkbox"/>	38. Tropical disease	<input checked="" type="checkbox"/>	39. Fear of heights	<table border="1"> <thead> <tr> <th>Y</th> <th>N</th> </tr> </thead> <tbody> <tr><td><input checked="" type="checkbox"/></td><td>40. Rejected for employment or insurance for medical reasons</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>41. Awarded benefits for industrial injury/illness</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>42. Treated for a mental condition, e.g. depression</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>43. Treated for problem drinking or drug abuse</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>44. Exposed to toxic substance or noise</td></tr> <tr><td><input type="checkbox"/></td><td>HAVE YOU EVER BEEN:-</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>45. An abnormal smear</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>46. Any gynaecological treatment</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>47. Are you pregnant?</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>FOR WOMEN ONLY</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE</td></tr> </tbody> </table>		Y	N	<input checked="" type="checkbox"/>	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	<input type="checkbox"/>	HAVE YOU EVER BEEN:-	<input checked="" type="checkbox"/>	45. An abnormal smear	<input checked="" type="checkbox"/>	46. Any gynaecological treatment	<input checked="" type="checkbox"/>	47. Are you pregnant?	<input checked="" type="checkbox"/>	FOR WOMEN ONLY	<input checked="" type="checkbox"/>	48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE
Y	N																																																																																																										
<input checked="" type="checkbox"/>	1. Sinus trouble																																																																																																										
<input checked="" type="checkbox"/>	2. Neck swelling/glands																																																																																																										
<input checked="" type="checkbox"/>	3. Difficulty in vision																																																																																																										
<input checked="" type="checkbox"/>	4. Any ear discharge																																																																																																										
<input checked="" type="checkbox"/>	5. Asthma/bronchitis																																																																																																										
<input checked="" type="checkbox"/>	6. Hayfever /other significant allergy																																																																																																										
<input checked="" type="checkbox"/>	7. Any skin trouble																																																																																																										
<input checked="" type="checkbox"/>	8. Tuberculosis																																																																																																										
<input checked="" type="checkbox"/>	9. Shortness of breath																																																																																																										
<input checked="" type="checkbox"/>	10. Coughed/vomited blood																																																																																																										
<input checked="" type="checkbox"/>	11. Severe abdominal pain																																																																																																										
<input checked="" type="checkbox"/>	12. Stomach ulcer																																																																																																										
<input checked="" type="checkbox"/>	13. Recurrent indigestion																																																																																																										
<input checked="" type="checkbox"/>	14. Jaundice or hepatitis																																																																																																										
<input checked="" type="checkbox"/>	15. Gall Bladder disease																																																																																																										
<input checked="" type="checkbox"/>	16. Marked change in bowel habits																																																																																																										
<input checked="" type="checkbox"/>	17. Blood in stools (motions)																																																																																																										
<input checked="" type="checkbox"/>	18. Marked change in weight																																																																																																										
<input checked="" type="checkbox"/>	19. Varicose veins																																																																																																										
<input checked="" type="checkbox"/>	20. Lump in breast/armpit																																																																																																										
<input type="checkbox"/>	21. Cancer																																																																																																										
<input checked="" type="checkbox"/>	22. Heart Disease																																																																																																										
<input checked="" type="checkbox"/>	23. Rheumatic fever																																																																																																										
<input checked="" type="checkbox"/>	24. Abnormal heartbeat																																																																																																										
<input checked="" type="checkbox"/>	25. High blood pressure																																																																																																										
<input checked="" type="checkbox"/>	26. Stroke																																																																																																										
<input checked="" type="checkbox"/>	27. Serious chest pain																																																																																																										
<input checked="" type="checkbox"/>	28. Any blood disease																																																																																																										
<input checked="" type="checkbox"/>	29. Kidney disease																																																																																																										
<input checked="" type="checkbox"/>	30. Blood in urine																																																																																																										
<input checked="" type="checkbox"/>	31. Diabetes																																																																																																										
<input checked="" type="checkbox"/>	32. Headaches/migraine																																																																																																										
<input checked="" type="checkbox"/>	33. Dizziness/fainting																																																																																																										
<input checked="" type="checkbox"/>	34. Epilepsy																																																																																																										
<input checked="" type="checkbox"/>	35. Joints/spinal trouble																																																																																																										
<input checked="" type="checkbox"/>	36. Surgical operation																																																																																																										
<input checked="" type="checkbox"/>	37. Serious accident/fracture																																																																																																										
<input checked="" type="checkbox"/>	38. Tropical disease																																																																																																										
<input checked="" type="checkbox"/>	39. Fear of heights																																																																																																										
Y	N																																																																																																										
<input checked="" type="checkbox"/>	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																																																																																																										
<input type="checkbox"/>	HAVE YOU EVER BEEN:-																																																																																																										
<input checked="" type="checkbox"/>	45. An abnormal smear																																																																																																										
<input checked="" type="checkbox"/>	46. Any gynaecological treatment																																																																																																										
<input checked="" type="checkbox"/>	47. Are you pregnant?																																																																																																										
<input checked="" type="checkbox"/>	FOR WOMEN ONLY																																																																																																										
<input checked="" type="checkbox"/>	48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE																																																																																																										
How much tobacco each day? 100		Average daily alcohol consumption Occasionally																																																																																																									
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: 06/10/2022		Signature of Applicant: Surinder Singh																																																																																																									

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	HEARING	VISION				Colour Vision	Blood Group
172	113	1	158 112	125/mins.	L (N) R (N)	Uncorrected Corrected	DISTANT R L	NEAR R L			
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.)											
<p>Stable blood sugar high mood good fit for work</p> <p>DR. MUHAMMAD KAMRAN General Practitioner MOH Lic. No. 7638 nmc speciality hospital, Al-Hail</p> <p>07/10/2022</p>											
ASSESSMENT:											
<input checked="" type="checkbox"/>	FIT ALL AREAS										
<input type="checkbox"/>	FIT WITH SPECIFIC RESTRICTION										
<input type="checkbox"/>	TEMPORARY UNFIT										
<input type="checkbox"/>	AWAITING SPECIALIST ASSESSMENT										
REVIEW/CONSULTATION											
DATE: 07/10/2022	DOCTOR NAME: DR. MUHAMMAD KAMRAN										SIGNATURE:

DR. MUHAMMAD KAMRAN
General Practitioner
MOH Lic. No. 7638
nmc speciality hospital, Al-Hail