



مجموعة مستشفيات ومستوصفات بدر السماء

BADR AL SAMAA

GROUP OF HOSPITALS & POLYCLINICS

More Than Healthcare ... Humane Care



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

MEDICAL FITNESS CERTIFICATE FOR TRUCKOMAN

NAME	ALI KASHIF	
AGE/D.O.B	31 Y,02.09.1989	DATE 16.03.2021
PASS/ID NO:	89951888	GENDER MALE
VISION-RT-EYE	6/6 WITHOUT GLASSES	HEIGHT 176 CM
LT-EYE	6/6 WITHOUT GLASSES	WEIGHT 73 KG
HEART	NORMAL	BP 106/68 mmHg
LUNGS	NORMAL	PULSE 70/ Min
ABDOMEN	NORMAL	CNS NORMAL
SKIN	NORMAL	ENT NORMAL

INVESTIGATIONS

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

COMMENTS DLP- Advised lifestyle modification

CONCLUSION MEDICALLY FIT

Signature:

Dr.B.VENKATESH KUMAR
CARDIOLOGIST
MOH NO#14581

SEAL



FIT

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. : ١٦٩٣٨٠٨، ص. ب. : ٤٤٣، الرمز البريدي : ١١٢

روي سلطنة عمان، هاتف : ٢٤٧٩٩٧٦٠، فاكس : ٢٤٧٩٩٧٦٥

الكويز : ٢٤٤٨٨٣٢٢ | صحار : ٢٦٨٤٦٦٠ | الخوض : ٢٤٥٤٦٠٩٩ | صلالة : ٢٣٢٩١٨٣٠

بركاء : ٢٦٨٨٤٩١٠ | صور : ٢٥٥٤٦١١٢ | نزوى : ٢٥٤٤٧٧٧٧ | فلج : ٢٦٧٥٤١٣١

البريد الإلكتروني info@badroman.com

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 <u>AL KASHI P</u>	
Forenames :	
Address	
Home telephone number	
Place of examination BADR AL SAMAA	Date
If a dependant enter employee's name here:	
Surname:	
Forenames:	
Birth date: <u>02.09.1984</u>	Nationality:
Country of birth:	
Religion:	
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to employee
<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.)	
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? <u>NIL</u>	
Average daily alcohol consumption <u>NIL</u>	
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>18/03/21</u>	Signature of Applicant:
FOR COMPLETION BY EXAMINING DOCTOR OR NURSE	
Further details of medical history and recreational activities	

[Signature]

Dr. B. VENKATESH KUMAR
CARDIOLOGIST
MOH NO#14581



N = Normal A = Abnormal (please describe)				PHYSICAL EXAMINATION				
N	A							
		1. Eyes & Pupils		<p><i>Normal & Reactive</i></p> <p><i>ear nose throat - normal</i></p> <p><i>mmg</i></p> <p><i>slb</i> <i>NO</i> <i>mmmm</i></p> <p><i>soft, m</i> <i>normal</i></p> <p><i>normal</i></p> <p><i>normal</i></p> <p><i>normal</i></p> <p><i>normal</i></p> <p><i>normal</i></p>				
		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.	PULSE	HEARING	VISION	Colour Vision	Blood Group
176	73.5	23.7	106/68	70/min.	L R	DISTANT NEAR R L R L Uncorrected Corrected	(A)	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 ☒ FIT WITH RESTRICTION ☐ TEMPORARY UNFIT ☐ UNFIT ☐

Date: *16/03/24* Name (Block Capitals): Dr. / Nurse Signature:

REVIEW/CONSULTATION

Date: *16/03/24* Name (Block Capitals): Dr. / Nurse Signature:

Sajila
Dr. SAJILA P.P
MBBS., DNB (ENT), DLO
Specialist Ent Surgeon
MOH Lic No.: 18387

Venkatesh

Dr. B. VENKATESH KUMAR
CARDIOLOGIST
MOH NO#14581



Appendix 20: (Form SQ5): Epworth Screening Quest. For Sleep Apnoea

Employee Data		Date: 16/03/21
Name: AU KASHIF		Department/Company:
I. D No. 89951888	Tel #	Occupation: Heavy Vehicle driver

This questionnaire will help identify if you have any health condition which may need a more detailed medical assessment as part of your fitness to work determination. If you have any queries please contact your local Health Services staff. All information provided on this form and during consultations remains strictly confidential. When further clinical evaluation is required following completion of a screening questionnaire, the details should be recorded on Q1 and E1 forms.

How likely are you to fall asleep in the following situations? (use 0 to 3 score as shown below)

- 0 Would never doze
 - 1 Slight chance of dozing
 - 2 Moderate chance of dozing
 - 3 High chance of dozing
- 1 sitting and reading
- 0 watching TV
- 0 sitting inactive in a public place (e.g. theatre or meeting)
- 2 as a passenger in the car for an hour without a break
- 2 Lying down to rest in the afternoon when circumstances permit
- 0 Sitting a talking with someone
- 2 Sitting quietly after lunch without alcohol
- 0 In a car, while stopped for a few minutes in traffic
- Total 7

If you score a total of 15 or more you should seek advice from medical personnel on site before continuing to drive or operate machinery in the workplace.

Declaration: I (Print Name) certify that to the best of my knowledge the above information supplied by me is true and correct.

Signature: Date: 16/03/21

(Signature)
B. VENKATESH KUMAR
CARDIOLOGIST
MOH NO#14581

